DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1829–F]

RIN 0938–AV48

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2026. As required by statute, this final rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2026. It also continues the second year of the 3-year phaseout of the rural adjustment, which began in FY 2025. Additionally, the final rule includes updates to the IRF Quality Reporting Program.

DATES: These regulations are effective on October 1, 2025.

FOR FURTHER INFORMATION CONTACT:

IRFcoverage@cms.hhs.gov, for general information.

Kimberly Schwartz, (410) 786–2571, for information about the IRF payment policies, payment rates and coverage policies.

Ariel Cress, (410) 786–8571, for information about the IRF quality reporting program.

Availability of Certain Information Through the Internet on the CMS Website

The IRF prospective payment system (IRF PPS) Addenda along with other supporting documents and tables referenced in this final rule are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

We note that prior to 2020, each rule or notice issued under the IRF PPS included a detailed reiteration of the various regulatory provisions that have affected the IRF PPS over the years. That discussion, which has been updated to reflect subsequent years, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-and-legislative-history.pdf.*

Readers who experience any problems accessing any of these online IRF PPS documents should contact *Patricia.Taft@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Fiscal Year (FY) 2026 (that is, for discharges occurring on or after October 1, 2025, and on or before September 30, 2026) under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by section 1886(j)(5) of the Act, this final rule includes the classification and weighting factors for the IRF prospective payment system (PPS) case-mix groups (CMGs), and a description of the methodologies and data used in computing the prospective payment rates for FY 2026.

For the IRF Quality Reporting Program (QRP), this rule finalizes our proposals to remove two quality measures: (1) the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure, beginning with the FY 2026 IRF QRP, and (2) the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, beginning with the FY 2028 IRF QRP. Next, we are finalizing proposals to remove four Standardized Patient Assessment Data Elements under the Social Determinant of Health (SDOH) category from the IRF Patient Assessment Instrument (IRF–PAI) beginning with the FY 2028 IRF QRP. We are also finalizing proposals amending our reconsideration policy. Finally, we provide summaries of the comments received in response to a Request for Information (RFI) on four separate considerations: (1) future measure concepts for the IRF QRP; (2) potential revisions to the IRF-Patient Assessment Instrument (PAI); (3) potential revisions to the data submission deadlines for assessment data collected for the IRF QRP; and (4) advancing digital quality measurement in IRFs.

B. Summary of Major Provisions

In this final rule, we use the methods described in the FY 2025 IRF PPS final rule (89 FR 64276) to update the prospective payment rates for FY 2026 using the most current and complete data available at this time, which is FY 2024 IRF claims and FY 2023 IRF cost report data, as discussed in section VI, of this final rule.

For the IRF QRP, this rule will remove two quality measures, remove four SDOH standardized patient assessment data elements, and amend our reconsideration policy. We also include summaries of comments received in response to Requests for Information (RFIs) on four separate considerations.

C. Summary of Impact

TABLE 1—COST AND TRANSFERS

Provision description	Transfers/costs
FY 2026 IRF PPS payment rate update	The overall economic impact of this final rule is an estimated $340 million increase in payments from the Federal Government to IRFs during FY 2026.
FY 2026 IRF QRP changes	The overall economic impact of this final rule is an estimated decrease in costs of $504,929.84 for IRFs for proposed measure removal in VII.C.1. and revisions to reconsiderations policy in VII.E. beginning with the FY 2026 IRF QRP.
FY 2028 IRF QRP changes	The overall economic impact of this final rule is an estimated decrease in costs of $1,090,580.75 to IRFs for proposed measure and item removals in VII.C.2 and VII.D. beginning with the FY 2028 IRF QRP.

II. Background

A. Statutory Basis and Scope for IRF PPS Provisions

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. A complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880) and we provided a general description of the IRF PPS for FYs 2007 through 2019 in the FY 2020 IRF PPS final rule (84 FR 39055 through 39057). A general description of the IRF PPS for FYs 2020 through 2025, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-and-legislative-history.pdf.*

Under the IRF PPS from FYs 2002 through 2005, the prospective payment rates were computed across 100 distinct CMGs, as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB's) Core-Based Statistical Area market definitions; modifications to the CMGs, tier comorbidities; and CMG relative weights, implementation of a new teaching status adjustment for IRFs; rebasing and revising the market basket used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule.

In response to COVID–19 Public Health Emergency (PHE), we published two interim final rules with comment period affecting IRF payment and conditions for participation. The interim final rule with comment period (IFC) entitled ''Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency,'' published on April 6, 2020 (85 FR 19230) (hereinafter referred to as the April 6, 2020 IFC), included certain changes to the IRF PPS medical supervision requirements at 42 CFR 412.622(a)(3)(iv) and 412.29(e) during the PHE for COVID–19. In addition, in the April 6, 2020 IFC, we removed the post-admission physician evaluation requirement at § 412.622(a)(4)(ii) for all IRFs during the PHE for COVID–19. In the FY 2021 IRF PPS final rule, to ease documentation and administrative burden, we permanently removed the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning in FY 2021.

A second IFC, entitled ''Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program,'' was published on May 8, 2020 (85 FR 27550) (hereinafter referred to as the May 8, 2020 IFC). Among other changes, the May 8, 2020 IFC included a waiver of the ''3-hour rule'' at § 412.622(a)(3)(ii) to reflect the waiver required by section 3711(a) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116–136, enacted on March 27, 2020). In the May 8, 2020 IFC, we also modified certain IRF coverage and classification requirements for freestanding IRF hospitals to relieve acute care hospital capacity concerns in States (or regions, as applicable) experiencing a surge during the PHE for COVID–19. In addition to the policies adopted in our IFCs, we responded to the PHE with numerous blanket waivers [1] and other

[1] CMS, ''COVID–19 Emergency Declaration Blanket Waivers for Health Care Providers,''

Continued

flexibilities,[2] some of which are applicable to the IRF PPS. CMS finalized these policies in the Calendar Year 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule with comment period (87 FR 71748). Subsequently, on May 11, 2023, the U.S. Department of Health and Human Services (''HHS'') declared the expiration of the COVID–19 PHE. (See *https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.*) As a result, the ''3-hour rule'' waiver at § 412.622(a)(3)(ii) and other IRF flexibilities were terminated.

The regulatory history previously included in each rule or notice issued under the IRF PPS, including a general description of the IRF PPS for FYs 2007 through 2025, is available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-and-legislative-history.pdf.*

B. Provisions of the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Affecting the IRF PPS in FY 2012 and Beyond

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the ''Affordable Care Act'' or ''ACA''.

The ACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the ACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for FY 2012 and each subsequent FY). The productivity adjustment for FY 2026 is discussed in section VI. of this final rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of the productivity adjustment to the market basket percentage increase may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY.

Section 3004(b) of the ACA and section 411(b) of the MACRA (Pub. L. 114–10, enacted on April 16, 2015) also addressed the IRF PPS. Section 3004(b) of ACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) of the Act and inserted a new section 1886(j)(7) of the Act, which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction to the IRF market basket percentage increase otherwise applicable to an IRF (after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a FY if the IRF does not comply with the requirements of the IRF QRP for that FY. Application of the 2-percentage point reduction may result in an update that is less than 0.0 for a FY and in payment rates for a FY being lower than payment rates for the preceding FY. Reporting-based reductions to the IRF market basket percentage increase are not cumulative; they only apply for the FY involved. Section 411(b) of the MACRA amended section 1886(j)(3)(C) of the Act by adding paragraph (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A fee-for-service (FFS) patient, the IRF is required to complete the appropriate sections of a Patient Assessment Instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each MA patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762) and the FY 2010 IRF PPS correction notice (74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. A free download of the Grouper software is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* The Grouper software is also embedded in the internet Quality Improvement and Evaluation System (iQIES) User tool available in iQIES at *https://www.cms.gov/medicare/quality-safety-oversight-general-information/iqies.*

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, 110 Stat. 1936 August 21, 1996) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (ASCA) (Pub. L. 107–105, enacted on December 27, 2002) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once a MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. 100–04), hospitals (including IRFs) must submit to their MAC an informational-only bill (type of bill (TOB) 111) that includes Condition Code 04. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for FY 2007 and beyond. Claims submitted to Medicare must comply with- both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final

(updated Feb. 19, 2021) (available at *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf*).

[2] CMS, ''COVID–19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,'' (updated March 5, 2021) (available at *https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf*).

rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at *https://www.cms.gov/manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR part 160 and part 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *https://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600.)

The MAC processes the claim through its software system. This software system includes pricing programming called the ''Pricer'' software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

III. Summary of Provisions of the Final Rule

In this FY 2026 IRF PPS final rule, we are finalizing our proposal to update the IRF PPS for FY 2026 and the IRF QRP for FY 2026 and FY 2028.

The finalized policy changes and updates to the IRF prospective payment rates for FY 2026 will be as follows:

- Update the CMG relative weights and average length of stay values for FY 2026 in a budget neutral manner, as discussed in section V of this final rule.
- Update the IRF PPS payment rates for FY 2026 by the IRF market basket percentage increase, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section VI.
- Update the FY 2026 IRF PPS payment rates by the FY 2026 wage index, applying the second year of the phase-out of the rural adjustment for IRFs transitioning from rural to urban, and the labor-related share in a budget-neutral manner, as discussed in section VI.
- Describe the calculation of the IRF standard payment conversion factor for FY 2026, as discussed in section VI.
- Update the outlier threshold amount for FY 2026, as discussed in section VI.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2026, as discussed in section VI.

The policy changes and updates to the IRF QRP for FY 2026 will be as follows:

- Remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure.
- Amend the Reconsideration Policy.

The proposed policy changes and updates to the IRF QRP for FY 2028 will be as follows:

- Remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.
- Remove four SDOH standardized patient assessment data elements items from the IRF–PAI.

We summarize the comments we received on the following four RFIs:

- Request for information on future measure concepts for the IRF QRP.
- Request for information on potential revisions to the IRF–PAI.
- Request for information on potential revisions to the data submission deadlines for assessment data collected for the IRF QRP.
- Request for information on advancing digital quality measurement in IRFs.

IV. Public Comments

A. Analysis of and Responses to Public Comments

We received 69 timely responses from the public, many of which contained multiple comments on the FY 2026 IRF PPS proposed rule (90 FR 18534). We received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, healthcare industry organizations, healthcare consulting firms, technology vendors, academic institutions, and anonymous persons. The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

B. General Comments on the FY 20206 IRF PPS Proposed Rule

In addition to the comments we received on specific proposals contained within the proposed rule (which we address later in this final rule), commenters also submitted more general observations on the IRF PPS and IRF care generally.

Comment: We received comments that were outside the scope of the FY 2026 IRF PPS proposed rule. These comments related to adopting a national healthcare system, updating the facility level adjustments based on a 3-year average that is capped for the teaching coefficient, and considering a future proposal to expand the role of PAs in IRFs and modify paragraphs (a)(3)(iv) and (a)(4)(ii) of § 412.622. Although comments also raised concerns regarding several issues related to MA plans, we did not propose changes to MA and Medicaid managed care plan regulations in this rule. One commenter urged CMS to allow the rehabilitation physician the opportunity to determine which disciplines should provide care within the 3-hour or level of intensity of services rule and recommended recreational therapy interventions (when applicable) to be counted towards the level of intensity rule.

Response: We thank the commenters for bringing these issues to our attention, and we will take these comments into consideration for potential policy refinements or direct the comments to the appropriate subject matter experts.

V. Updates to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2026

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed for an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this final rule, we update the CMG relative weights and ALOS values for FY 2026. Typically, we use the most recent available data to update the CMG relative weights and ALOS values. For FY 2026, we are using the FY 2024 IRF claims and FY 2023 IRF cost report data (CMS Form 2552–10, OMB No 0938–0050). These data are the most current and complete data available at the time of this final rule. Currently, only a small portion of the FY 2024 IRF cost report data is available for analysis, but the

majority of the FY 2024 IRF claims data are available for analysis.

In the FY 2026 IRF PPS proposed rule, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule, we would use such data to determine the FY 2026 CMG relative weights and ALOS values in this final rule.

We proposed to apply these data using the same methodologies that we have used to update the CMG relative weights and ALOS values each FY since we implemented an update to the methodology. The detailed cost-to-charge ratio (CCR) data from the cost reports of IRF provider units of primary acute care hospitals is used for this methodology, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate the operating (routine and ancillary services) and capital costs of IRFs. The process to calculate the CMG relative weights for this final rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in Step 1.

Step 3. We use the adjusted costs from Step 2 to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2026 CMG relative weights using a normalization factor that results in the average CMG relative weights in FY 2026 being the same as the average CMG relative weights in the FY 2025 IRF PPS final rule (89 FR 64276).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are updating the CMG relative weights for FY 2026 in such a way that total estimated aggregate payments to IRFs for FY 2026 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2026 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2026 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2026 by applying the proposed changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in Step 1 by the amount calculated in Step 2 to determine the budget neutrality factor of 0.9985 that would maintain the same total estimated aggregate payments in FY 2026 with and without the proposed changes to the final CMG relative weights.

Step 4. Apply the budget neutrality factor from Step 3 to the FY 2026 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V of this final rule, we discuss the proposed use of the existing methodology to calculate the proposed standard payment conversion factor for FY 2026.

In Table 2, ''Relative Weights and Average Length of Stay Values for Case -Mix Groups,'' we present the CMGs, the comorbidity tiers, the corresponding relative weights, and the ALOS values for each CMG and tier for FY 2026. The ALOS for each CMG is used to determine when an IRF discharge meets the definition of a short stay transfer, which results in a per diem case level adjustment.

TABLE 2—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE CASE-MIX-GROUPS

CMG	CMG description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity tier	Tier 1	Tier 2	Tier 3	No Comorbidity tier
0101	Stroke M >=72.50	0.9669	0.8586	0.7779	0.7379	8	9	9	8
0102	Stroke M >=63.50 and M <72.50.	1.2306	1.0928	0.9901	0.9392	11	11	11	10
0103	Stroke M >=50.50 and M <63.50.	1.5798	1.4029	1.2710	1.2056	14	15	13	13
0104	Stroke M >=41.50 and M <50.50.	2.0177	1.7918	1.6234	1.5398	16	17	16	16
0105	Stroke M <41.50 and A >=84.50.	2.5146	2.2330	2.0231	1.9190	23	21	20	19
0106	Stroke M <41.50 and A <84.50.	2.8325	2.5153	2.2789	2.1616	24	24	22	22
0201	Traumatic brain injury M >=73.50.	1.0614	0.8440	0.7710	0.7244	10	9	8	9
0202	Traumatic brain injury M >=61.50 and M <73.50.	1.3861	1.1021	1.0069	0.9460	12	11	11	10
0203	Traumatic brain injury M >=49.50 and M <61.50.	1.7233	1.3702	1.2518	1.1761	14	14	13	12
0204	Traumatic brain injury M >=35.50 and M <49.50.	2.1239	1.6887	1.5428	1.4495	17	17	15	15
0205	Traumatic brain injury M <35.50.	2.7248	2.1665	1.9793	1.8596	28	22	19	18
0301	Non-traumatic brain injury M >=65.50.	1.1939	0.9462	0.8822	0.8259	10	10	9	9
0302	Non-traumatic brain injury M >=52.50 and M <65.50.	1.5445	1.2241	1.1412	1.0683	12	12	11	11

TABLE 2—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE CASE-MIX-GROUPS—Continued

CMG	CMG description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity tier	Tier 1	Tier 2	Tier 3	No Comorbidity tier
0303	Non-traumatic brain injury M >=42.50 and M <52.50.	1.8262	1.4474	1.3494	1.2633	14	14	13	13
0304	Non-traumatic brain injury M <42.50 and A >=78.50.	2.1635	1.7147	1.5985	1.4965	18	17	16	15
0305	Non-traumatic brain injury M <42.50 and A <78.50.	2.3699	1.8783	1.7511	1.6393	19	19	17	16
0401	Traumatic spinal cord injury M >=56.50.	1.3548	1.1074	1.0783	0.9757	12	12	11	11
0402	Traumatic spinal cord injury M >=47.50 and M <56.50.	1.6985	1.3883	1.3518	1.2232	15	14	14	13
0403	Traumatic spinal cord injury M >=41.50 and M <47.50.	1.9604	1.6024	1.5602	1.4118	17	15	15	16
0404	Traumatic spinal cord injury M <31.50 and A <61.50.	3.1765	2.5964	2.5281	2.2877	23	33	25	22
0405	Traumatic spinal cord injury M >=31.50 and M <41.50.	2.5161	2.0566	2.0025	1.8121	19	20	21	19
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50.	3.3100	2.7055	2.6343	2.3838	23	29	26	24
0407	Traumatic spinal cord injury M <24.50 and A >=61.50.	4.5328	3.7050	3.6075	3.2644	42	36	33	33
0501	Non-traumatic spinal cord injury M >=60.50.	1.3090	1.0060	0.9359	0.8625	11	10	10	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50.	1.6251	1.2489	1.1618	1.0707	14	13	12	12
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50.	1.8402	1.4142	1.3156	1.2124	16	14	14	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50.	2.1989	1.6898	1.5720	1.4487	18	16	16	15
0505	Non-traumatic spinal cord injury M <39.50.	3.1242	2.4009	2.2336	2.0584	26	23	22	20
0601	Neurological M >=64.50.	1.3095	0.9918	0.9341	0.8390	11	10	9	9
0602	Neurological M >=52.50 and M <64.50.	1.6289	1.2337	1.1619	1.0437	13	12	11	11
0603	Neurological M >=43.50 and M <52.50.	1.9370	1.4670	1.3817	1.2411	15	14	13	13
0604	Neurological M <43.50.	2.4498	1.8553	1.7475	1.5696	20	17	16	16
0701	Fracture of lower extremity M >=61.50.	1.2269	0.9809	0.9316	0.8513	11	11	10	9
0702	Fracture of lower extremity M >=52.50 and M <61.50.	1.5165	1.2125	1.1515	1.0523	13	13	12	11

TABLE 2—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE CASE-MIX-GROUPS—Continued

CMG	CMG description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity tier	Tier 1	Tier 2	Tier 3	No Comorbidity tier
0703	Fracture of lower extremity M >=41.50 and M <52.50.	1.8578	1.4854	1.4108	1.2892	16	15	14	14
0704	Fracture of lower extremity M <41.50.	2.2940	1.8342	1.7420	1.5918	18	18	17	16
0801	Replacement of lower-extremity joint M >=63.50.	1.1781	0.9922	0.8869	0.8310	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50.	1.3428	1.1310	1.0109	0.9472	10	10	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50.	1.4778	1.2447	1.1126	1.0424	13	12	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50.	1.6788	1.4140	1.2639	1.1842	14	14	12	12
0805	Replacement of lower-extremity joint M <42.50.	2.0910	1.7611	1.5742	1.4749	17	17	15	14
0901	Other orthopedic M >=63.50.	1.2385	0.9381	0.8862	0.8084	11	10	9	9
0902	Other orthopedic M >=51.50 and M <63.50.	1.5733	1.1917	1.1257	1.0270	13	12	12	11
0903	Other orthopedic M >=44.50 and M <51.50.	1.8670	1.4141	1.3358	1.2187	15	14	13	13
0904	Other orthopedic M <44.5.	2.2482	1.7029	1.6086	1.4675	18	17	16	15
1001	Amputation lower extremity M >=64.50.	1.2289	1.0211	0.9268	0.8605	11	10	10	9
1002	Amputation lower extremity M >=55.50 and M <64.50.	1.4929	1.2405	1.1259	1.0454	13	13	12	11
1003	Amputation lower extremity M >=47.50 and M <55.50.	1.7768	1.4764	1.3400	1.2442	15	16	14	13
1004	Amputation lower extremity M <47.50.	2.3634	1.9638	1.7824	1.6550	19	19	17	17
1101	Amputation non-lower extremity M >=58.50.	1.3524	1.2804	1.1019	0.9641	12	13	11	11
1102	Amputation non-lower extremity M >=52.50 and M <58.50.	1.5444	1.4621	1.2582	1.1009	13	13	13	11
1103	Amputation non-lower extremity M <52.50.	1.9344	1.8313	1.5760	1.3789	16	17	15	13
1201	Osteoarthritis M >=61.50.	1.3247	1.0514	0.9396	0.8702	11	11	9	10
1202	Osteoarthritis M >=49.50 and M <61.50.	1.5576	1.2362	1.1047	1.0231	13	12	12	11
1203	Osteoarthritis M <49.50 and A >=74.50.	2.0850	1.6548	1.4788	1.3696	16	16	15	14
1204	Osteoarthritis M <49.50 and A <74.50.	2.1465	1.7037	1.5225	1.4100	17	16	15	15
1301	Rheumatoid other arthritis M >=62.50.	1.2527	1.0015	0.9176	0.8336	10	10	9	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50.	1.5360	1.2280	1.1252	1.0221	12	12	11	11

TABLE 2—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE CASE-MIX-GROUPS—Continued

CMG	CMG description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity tier	Tier 1	Tier 2	Tier 3	No Comorbidity tier
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50.	1.7752	1.4192	1.3004	1.1812	14	14	13	12
1304	Rheumatoid other arthritis M <44.50 and A >=64.50.	2.2912	1.8318	1.6784	1.5246	16	17	16	15
1305	Rheumatoid other arthritis M <51.50 and A <64.50.	2.2867	1.8281	1.6750	1.5216	17	18	16	14
1401	Cardiac M >=68.50.	1.1175	0.9002	0.8323	0.7654	10	9	9	8
1402	Cardiac M >=55.50 and M <68.50.	1.4236	1.1468	1.0603	0.9751	12	12	11	10
1403	Cardiac M >=45.50 and M <55.50.	1.7207	1.3861	1.2816	1.1786	14	14	13	12
1404	Cardiac M <45.50	2.1468	1.7294	1.5991	1.4705	18	17	15	15
1501	Pulmonary M >=68.50.	1.3103	1.0536	0.9867	0.9432	10	10	9	9
1502	Pulmonary M >=56.50 and M <68.50.	1.6022	1.2883	1.2065	1.1534	12	12	11	11
1503	Pulmonary M >=45.50 and M <56.50.	1.8680	1.5020	1.4066	1.3446	15	14	13	13
1504	Pulmonary M <45.50.	2.3425	1.8835	1.7639	1.6862	20	16	16	15
1601	Pain syndrome M >=65.50.	1.0512	0.9420	0.8617	0.7811	9	10	9	9
1602	Pain syndrome M >=58.50 and M <65.50.	1.2648	1.1335	1.0368	0.9399	11	12	11	10
1603	Pain syndrome M >=43.50 and M <58.50.	1.5317	1.3727	1.2557	1.1382	13	14	13	12
1604	Pain syndrome M <43.50.	2.0049	1.7968	1.6436	1.4898	14	19	16	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50.	1.3191	1.0450	0.9702	0.8932	12	10	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50.	1.6260	1.2881	1.1960	1.1010	13	13	12	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50.	1.9078	1.5114	1.4033	1.2919	15	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50.	2.1953	1.7392	1.6148	1.4866	18	17	16	15
1705	Major multiple trauma without brain or spinal cord injury M <36.50.	2.5557	2.0247	1.8799	1.7306	19	19	18	17
1801	Major multiple trauma with brain or spinal cord injury M >=67.50.	1.1189	0.9154	0.8421	0.7904	12	10	9	9

TABLE 2—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE CASE-MIX-GROUPS—Continued

CMG	CMG description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity tier	Tier 1	Tier 2	Tier 3	No Comorbidity tier
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50.	1.4223	1.1636	1.0704	1.0047	14	13	11	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50.	1.7694	1.4475	1.3316	1.2498	17	15	14	13
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50.	2.0665	1.6906	1.5552	1.4597	19	17	15	16
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50.	2.4792	2.0282	1.8658	1.7512	23	20	18	18
1806	Major multiple trauma with brain or spinal cord injury M <30.50.	3.5919	2.9385	2.7032	2.5372	36	28	27	24
1901	Guillain-Barré M >=66.50.	1.3407	0.9475	0.8237	0.8240	11	10	9	9
1902	Guillain-Barré M >=51.50 and M <66.50.	1.9505	1.3785	1.1984	1.1987	15	14	13	13
1903	Guillain-Barré M >=38.50 and M <51.50.	2.7597	1.9504	1.6956	1.6960	20	18	17	18
1904	Guillain-Barré M <38.50.	4.2436	2.9991	2.6072	2.6080	37	30	25	25
2001	Miscellaneous M >=66.50.	1.1884	0.9531	0.8864	0.8114	10	10	9	9
2002	Miscellaneous M >=55.50 and M <66.50.	1.4755	1.1833	1.1004	1.0074	12	12	11	11
2003	Miscellaneous M >=46.50 and M <55.50.	1.7326	1.3895	1.2922	1.1830	14	13	13	12
2004	Miscellaneous M <46.50 and A >=77.50.	2.1131	1.6946	1.5760	1.4427	17	16	15	15
2005	Miscellaneous M <46.50 and A <77.50.	2.2118	1.7738	1.6496	1.5101	18	17	16	15
2101	Burns M >=52.50	1.6061	1.3503	1.0183	0.9765	15	15	10	11
2102	Burns M <52.50 ...	2.5451	2.1397	1.6136	1.5474	19	18	16	16
5001	Short-stay cases, length of stay is 3 days or fewer.	0.0000	0.0000	0.0000	0.1755	0	0	0	3
5101	Expired, orthopedic, length of stay is 13 days or fewer.	0.0000	0.0000	0.0000	0.8539	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more.	0.0000	0.0000	0.0000	2.0485	0	0	0	20
5103	Expired, not orthopedic, length of stay is 15 days or fewer.	0.0000	0.0000	0.0000	0.9118	0	0	0	8
5104	Expired, not orthopedic, length of stay is 16 days or more.	0.0000	0.0000	0.0000	2.1881	0	0	0	20

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 3 shows how we estimate that the application of the revisions for FY 2026 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. We note that, because we implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2026 would not be affected as a result of the CMG relative weight revisions. However, the revisions would affect the distribution of payments within CMGs and tiers.

TABLE 3—DISTRIBUTIONAL EFFECTS OF THE CHANGES TO THE CMG RELATIVE WEIGHTS

Percentage change in CMG relative weights	Number of cases affected	Percentage of cases affected (%)
Increased by 15% or more	80	0.0
Increased by between 5% and 15%	2,634	0.6
Changed by less than 5%	439,183	99.2
Decreased by between 5% and 15%	794	0.2
Decreased by 15% or more	11	0.0

As shown in Table 3, 99.2 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2026. The changes in the ALOS values for FY 2026, compared with the FY 2025 ALOS values, are small and do not show any particular trends in IRF length of stay patterns.

We invited public comment on our proposed updates to the CMG relative weights and ALOS values for FY 2026.

The following is a summary of the public comments received on the proposed updates to the CMG relative weights and ALOS and our responses:

Comment: Public comments generally supported CMS' update to the CMG relative weights and average length of stay values and encouraged CMS to use the latest available data to update these values in the final rule. A few commenters recommend future refinements to computing the CMGs and use of the ALOS.

Response: We appreciate these commenters' support for updating the relative weights and ALOS values for FY 2026. We have updated our data between the FY 2026 IRF PPS proposed and this final rule to ensure that we use the most recent available data in calculating IRF PPS payments.

The methodology that we use to update the CMG relative weights uses the most recent cost data reported by IRFs to compute relative weights that reflect the relative costliness of different IRF cases in a budget neutral manner. We increase or decrease relative weights of the CMGs annually, including for those CMGs associated with the 13 conditions that qualify for the 60 percent rule, under 42 CFR 412.29(b)(2), based only on the cost data reported to us by IRFs each year.

We believe that these data accurately reflect the severity of the IRF patient population and the associated costs of caring for these patients in the IRF setting. The CMG relative weights are updated each year based on the most recent available data for the full population of IRF Medicare fee-for-service beneficiaries. This ensures that the IRF case -mix system is as reflective as possible of changes in the IRF patient populations and the associated coding practices and ensures that IRF payments appropriately reflect the relative costs of caring for all types of IRF patients.

Comment: The Medicare Payment Advisory Commission (MedPAC) submitted a comment recommending that CMS consider using an average-cost weighting method, rather than the current hospital-specific relative value method (HSRV), for calculating the CMG relative weights, to improve the relationship between costs and payments and increase the uniformity of profitability across IRF cases.

Response: We did not propose any changes to the current HSRV method used to assign payment weights for FY 2025 and believe that a careful evaluation of the advantages and disadvantages of moving to an average-cost weighting method is essential, given the major distributional shifts that would be associated with such a change. The purpose of the HSRV method is, in part, to place a greater emphasis on more efficient IRF providers (that is, those that treat complex IRF patients at lower costs). CMS believes moving to an average-cost weighting method places more emphasis on high cost IRF providers, which could have higher costs because they are operating less efficiently. We will continue evaluating the effects of changing from HSRV weighting to average-cost weighting. The results of this analysis will inform future rulemaking.

After consideration of the comments we received, we are finalizing our proposal to update the CMG relative weights and ALOS values for FY 2026 using the same methodologies that we have used to update the CMG relative weights and ALOS values for each FY since we implemented an update to the methodology in FY 2009, as shown in Table 2 of this final rule. These updates are effective for FY 2026, that is, for discharges occurring on or after October 1, 2025, and on or before September 30, 2026.

VI. FY 2026 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Thus, we proposed to update the IRF PPS payments for FY 2026 by a market basket percentage increase as required by section 1886(j)(3)(C) of the Act based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We have utilized various market baskets through the years in the IRF PPS. For a discussion of these market baskets, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47046).

Beginning with FY 2024, we finalized a rebased and revised IRF market basket

to reflect a 2021 base year. The FY 2024 IRF PPS final rule (88 FR 50966 through 50988) contains a complete discussion of the development of the 2021-based IRF market basket.

B. FY 2026 Market Basket Update and Productivity Adjustment

1. FY 2026 Market Basket Update

For FY 2026 (that is, beginning October 1, 2025, and ending September 30, 2026), we proposed to update the IRF PPS payments by a market basket percentage increase as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. For FY 2026, we proposed to use the same methodology described in the FY 2025 IRF PPS final rule (89 FR 64285 through 64286).

Consistent with historical practice, we proposed to estimate the market basket update for the IRF PPS for FY 2026 based on IHS Global Inc.'s (IGI's) [3] forecast using the most recent available data at the time of rulemaking. IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. Based on IGI's fourth quarter 2024 forecast with historical data through the third quarter of 2024, the proposed 2021-based IRF market basket percentage increase for FY 2026 was projected to be 3.4 percent. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the FY 2026 IRF market basket update in this final rule. Based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the 2021-based IRF market basket percentage increase for FY 2026 is 3.3 percent.

2. FY 2026 Productivity Adjustment

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the U.S. economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act, was referred to by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of this change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business total factor productivity. However, as mentioned above, the data and methods are unchanged. Please see *www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information.* In addition, in the FY 2022 IRF final rule (86 FR 42374), we noted that effective with FY 2022 and forward, CMS changed the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment.

As stated in the proposed rule, using IGI's fourth quarter 2024 forecast, the 10-year moving average growth of TFP for FY 2026 was projected to be 0.8 percent. In accordance with section 1886(j)(3)(C) of the Act, we proposed to base the FY 2026 IRF market basket percentage increase, which is used to determine the applicable percentage increase for the IRF payments, on IGI's fourth quarter 2024 forecast of the 2021-based IRF market basket. We proposed to then reduce the market basket percentage increase by the proposed productivity adjustment for FY 2026 of 0.8 percentage point (the 10-year moving average growth of TFP for the period ending FY 2026 based on IGI's fourth quarter 2024 forecast). Therefore, the proposed FY 2026 IRF market basket update was 2.6 percent (3.4 percent market basket percentage increase reduced by the 0.8 percentage point productivity adjustment). Furthermore, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket percentage increase and productivity adjustment), we would use such data, if appropriate, to determine the FY 2026 IRF market basket percentage increase and productivity adjustment in this final rule.

Using IGI's second quarter 2025 forecast, the 10-year moving average growth of TFP for FY 2026 is projected to be 0.7 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, the FY 2026 market basket percentage increase, which is used to determine the applicable percentage increase for the IRF payments, is equal to 3.3 percent using IGI's second quarter 2025 forecast of the 2021-based IRF market basket. We then reduce this percentage increase by the estimated productivity adjustment for FY 2026 of 0.7 percentage point (the 10-year moving average growth of TFP for the period ending FY 2026 based on IGI's second quarter 2025 forecast). Therefore, more recent data would provide a FY 2026 IRF update equal to 2.6 percent (3.3 percent market basket percentage increase reduced by the 0.7 percentage point productivity adjustment).

In its March 2025 Report to Congress, MedPAC recommended that Congress should reduce the IRF PPS base payment rate by 7 percent for FY 2026.[4] As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary proposed to update the IRF PPS payment rates for FY 2026 by the proposed IRF market basket update of 2.6 percent.

Based on more recent data, the current estimate of the productivity-adjusted IRF market basket increase factor for FY 2026 remains 2.6 percent. Section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2026.

We invited public comments on the proposed FY 2026 market basket percentage increase and productivity adjustment. The following is a summary of the public comments received and our responses.

[3] *https://www.spglobal.com/en.*

[4] *https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_ReportToCongress_SEC.pdf.*

Comment: Several commenters expressed agreement with the general strategy of increasing the standard payment conversion factor. However, many raised concerns that the proposed FY 2026 IRF payment increase is insufficient. Respondents indicated that the proposed payment adjustment fails to keep up with the significant cost increases faced by IRFs, including those related to labor, drugs, medical supplies, personal protective equipment (PPE), and capital investments. Additionally, they highlighted other challenges such as staffing shortages, supply chain disruptions, escalating cybersecurity investment needs, higher administrative costs due to MA and commercial plan practices, and uncertain inflation expectations resulting from recent and proposed tariff adjustments on goods like medical supplies and pharmaceuticals from key supplier countries.

Several commenters mentioned that the increasing disparity between payment inflation and cost inflation is exerting significant financial pressure on hospitals, leading to a substantial reduction in their profit margins. A few commenters have expressed that an analysis of the data in CMS' IRF Rate-Setting File suggests that nearly 40 percent of all IRFs are projected to experience negative total PPS profit margins for FY 2025, including over half of hospital-based IRF units and teaching IRFs. Additionally, one commenter referred to MedPAC's March 2025 Report to Congress, which highlighted that non-profit IRFs tend to have lower profit margins compared to for-profit IRFs. The report recommends that Congress reduce the IRF base payment by 7 percent for FY 2026. However, the commenter suggested that this recommendation might not be applicable if the analysis had distinctly considered for-profit and non-profit IRFs, as non-profit IRFs typically exhibit smaller profit margins. One commenter, MedPAC, stated that the Secretary is required to update the IRF PPS rates by the market basket minus a productivity adjustment; however, based on the review of many payment adequacy indicators, including beneficiary access to IRF services, the supply of providers, and aggregate IRF Medicare margins (which have been above 13 percent since 2015), the Commission concluded that Medicare's current payment rates for IRFs are more than adequate.

Most commenters highlighted that persistent labor shortages and high-cost inflation necessitate increased payment rates for all IRFs. They urged CMS to consider the most current inflation data or update the market basket to reflect actual input costs. One commenter noted that rural IRFs face even more cost pressures amplified by severe workforce shortages, heavy dependence on traveling clinicians and contract staff, lack of community-based alternatives leading to longer patient stays, and significant transportation and access issues.

Several commenters indicated that the underlying construction of the IRF market basket may have limitations that do not adequately capture inflation pressures. They stated that it is perplexing how hospitals, especially labor-intensive IRFs, could experience a change in the market basket that is significantly below general inflation. The commenters noted that the IRF market basket relies on projected growth in generalized hospital goods and services, which does not consider the specialized training and experience required by therapists, nurses, and other clinicians in IRFs. Additionally, some commenters highlighted that IRFs often incur higher costs for advanced rehabilitation technologies and specialized medications, which may not be adequately reflected in the market basket. An example the commenter provided was CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket. The commenters stated that the ECI might not fully capture growth in employment and labor costs, as it does not account for changes driven by shifts between different categories of labor. However, the commenters emphasized that this is just one potential issue and encouraged CMS to comprehensively reexamine the market basket to identify other areas for refinement.

Several commenters suggested that CMS review the current forecasting approach used for determining the IRF PPS market basket update, indicating there may be a systemic issue with IGI's forecasting that tends toward under-forecasting growth. They observed that since the COVID–19 PHE, IGI's forecasted growth for the IRF market basket has consistently been lower than the actual market basket growth. While acknowledging that forecasts are inherently imperfect, they asserted that past forecasts were more balanced. The commenters expressed concern that without action from CMS, these missed forecasts will become permanently embedded in the standard payment rate for IRFs and will continue to accumulate. Additionally, they pointed out that these underpayments affect other payments as well, including those for the growing MA patient population and commercial insurer payment rates. Some commenters mentioned that CMS has provided larger increases to MA plans, such as a recent 5.06 percent rate increase for 2026, and questioned why there is a significant difference between the MA rate increase and the IRF FFS rate increase. One commenter noted that the authorizing statute for the IRF PPS allows CMS to determine a suitable index for the market basket update and to make appropriate adjustments to IRF PPS payments and this implies that CMS is not required to use IGI data, or solely such data, as the basis for the IRF PPS increase factor.

Response: We acknowledge and appreciate commenters' concerns regarding recent trends in inflation. We are required to update IRF PPS payments by the market basket update adjusted for productivity, as directed by section 1886(j)(3)(C) of the Act. Specifically, section 1886(j)(3)(C)(i) of the Act states that the increase factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made. In the FY 2024 IRF PPS final rule, we rebased the IRF market basket to reflect a 2021 base year (88 FR 50966 through 50982). We believe the increase in the 2021-based IRF market basket adequately reflects the average change in the price of goods and services hospitals purchase to provide IRF medical services and is technically appropriate to use as the IRF payment update factor.

The IRF market basket is a fixed-weight, Laspeyres-type index that measures the change in price over time of the same mix of goods and services purchased by IRFs in the base period. As we discussed in response to similar comments in the FY 2024 IRF PPS final rule (88 FR 50983) and the FY 2025 IRF PPS final rule (89 FR 64286), the IRF market basket update would reflect the prospective price pressures described by the commenters as increasing during a high inflation period but would inherently not reflect other factors that might increase the level of costs (such as increases in volume or intensity). We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period.

We respectfully disagree that the IRF market basket does not consider the specialized costs faced by IRFs, as the market basket weights are derived directly from IRF cost report data, which inherently captures and reflects the specific cost structures of inpatient rehabilitation facilities, including expenditures for specialized

rehabilitation technologies, advanced therapeutic equipment, and the unique staffing mix required for IRF services, ensuring that these facility-specific costs are appropriately represented in the market basket calculation. Additionally, we note that the IRF market basket is designed to reflect national-level inflationary price pressures affecting IRFs, and separate payment adjustments, such as rural add-on payments and wage index adjustments, exist to address geographic cost variations and specific challenges faced by rural facilities. Therefore, we believe the 2021-based IRF market basket appropriately reflects IRF cost structures.

To measure price growth for IRF wages and salaries costs in the IRF market basket, since IRF-specific information is unavailable, we use the ECI for Wages and Salaries for All Civilian workers in Hospitals. As stated in the FY 2024 IRF final rule (88 FR 50978) and FY 2025 IRF final rule (89 FR 64286), we believe that this ECI is the best available price proxy to account for the occupational skill mix within IRFs and in the absence of an IRF-specific ECI, we believe that the highly skilled hospital workforce captured by the ECI for Wages and Salaries for All Civilian workers in Hospitals (inclusive of therapists, nurses, other clinicians, etc.) is a reasonable price proxy for the compensation component of the IRF market basket. The FY 2024 IRF and FY 2025 IRF final rules provide a detailed discussion as it relates to contract labor in IRFs and their share of overall IRF compensation costs and hours.

To reflect expected price growth for each of the cost categories in the IRF market basket, we rely on impartial economic forecasts of the price proxies used in the market basket from IGI, which is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. At the time of the FY 2026 IRF PPS proposed rule, based on IGI's fourth quarter 2024 forecast with historical data through the third quarter of 2024, the 2021-based IRF market basket update was forecasted to be 3.4 percent for FY 2026, reflecting forecasted compensation price growth of 3.6 percent. We also note that when developing its forecast for labor prices, IGI considers overall labor market conditions (including rise in contract labor employment due to tight labor market conditions) as well as trends in contract labor wages, which both have an impact on wage pressures for workers employed directly by the hospital.

As is our general practice, in the FY 2026 IRF PPS proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2026 IRF market basket update for the final rule. For this final rule, we now have an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy and expected price inflation for FY 2026. Based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, we are projecting a FY 2026 IRF market basket percentage increase of 3.3 percent (reflecting forecasted compensation price growth of 3.4 percent). Based on IGI's second quarter 2025 forecast, we are also projecting a productivity adjustment of 0.7 percentage point. Therefore, for FY 2026 a final IRF productivity-adjusted market basket update of 2.6 percent (3.3 percent less 0.7 percentage point) will be applicable, this update is unchanged from the proposed IRF market basket update of 2.6 percent. We note that the final FY 2026 IRF market basket increase is slightly lower than in the proposed rule (by 0.1 percentage point) reflecting economic uncertainty. Additionally, the expectation for slower economic growth contributes to a slightly lower productivity adjustment for FY 2026.

CMS understands that the market basket updates may differ from other overall inflation indexes such as the topline CPI; however, we would reiterate that these topline indexes are not comparable since they measure different mixes of products, services, or wages than the IRF market basket. Additionally, the market basket updates appropriately differ from other payment updates (such as projected increase in the average per capita payments to Medicare Advantage organizations) that are not consistent in concept with the statutory requirement as they would reflect anticipated volume and intensity of services.

Regarding whether IRF PPS payments are adequate to cover costs, MedPAC's analysis and recommendations as published in MedPAC's March 2025 [5] Report to Congress concluded that Medicare's current payment rates for IRFs are more than adequate based on aggregate Medicare margins above 13 percent since 2015. With respect to the commenters' concern about payments to non-profits, MedPAC acknowledged that margins continued to vary widely across types of IRFs, with higher margins in IRFs that were freestanding, for profit, urban, larger, and with a greater share of FFS Medicare days.

We do not have statutory authority to vary payment under the IRF PPS according to non-profit status but are continuing to explore changes to the IRF PPS within our regulatory authority, such as alternative approaches to case mix groups (replacing the hospital-specific relative value weighting with average cost weighting), which has been recommended by MedPAC's 2024 *Report to Congress*.[6]

Finally, we acknowledge the commenter's recommendation that we reexamine the market basket to identify other potential areas for refinement. We will continue to review the IRF market basket, and any future changes will be proposed in rulemaking.

Comment: Several commenters recommended that we not apply the productivity adjustment. One commenter urged CMS to consider its regulatory authority to modify the productivity adjustment or make a PHE- and inflation-related exception in its application for the FY 2026 update. Additionally, one commenter requested a temporary suspension of the productivity adjustment to the IRF market basket due to recent declines in hospital productivity. A commenter asserted an imbalance between economy-wide productivity measures and IRF-specific productivity changes, encouraging CMS to explore all available avenues within the agency's existing authority to provide additional financial relief for IRFs. Other commenters requested that CMS carefully monitor the impact of these productivity adjustments on the rehabilitation hospital sector, provide feedback to Congress as appropriate, and reduce the productivity adjustment.

Response: Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment, described in section 1886(b)(3)(B)(xi)(II), to the IRF PPS market basket increase factor. As required by statute, the FY 2026 productivity adjustment is derived based on the 10-year moving average growth in economy-wide, private nonfarm business total factor productivity for the period ending FY 2026. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, as we explained in response to similar comments in the

[5] *https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_ReportToCongress_SEC.pdf.*

[6] *https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy.*

FY 2023, FY 2024 and FY 2025 IRF PPS final rules, we are required under section 1886(j)(3)(C)(ii)(I) of the Act to apply the specific productivity adjustment described here.

We have always made available on the CMS website the general method for calculating the productivity adjustment. This includes providing a link (*http://www.bls.gov/productivity/*) to the most recent BLS historical TFP data, which allows interested parties to obtain historical TFP annual index levels for 1987 through 2024. We also provided the IGI projection model (*https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf*), which is used to derive annual TFP growth rates for 2025 and 2026. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2026 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2026, relative to the 40-quarter moving average projected level for the period ending September 30, 2025. We believe our methodology for the productivity adjustment is consistent with section 1886(b)(3)(B)(xi)(II) of the Act, which states that the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

At the time of this final rule, the FY 2026 productivity adjustment reflects BLS historical TFP data through 2024 (released on March 21, 2025) and IGI's forecasted TFP growth for 2025 and 2026. The average annual growth rate of historical TFP published by BLS for 2017 through 2024 is currently 0.9 percent and IGI is projecting average TFP growth of about 0.0 percent for 2025 and 2026 based on IGI's second-quarter 2025 forecast. Combining the historical and projected TFP data over the entire 10-year time period results in a compound annual growth rate of TFP of 0.7 percent for 2026. The productivity adjustment (based on the 10-year period ending with FY 2026) for the FY 2026 IRF final rule is 0.1 percentage point lower than in the FY 2026 IRF proposed rule and primarily reflects the incorporation of a revised outlook from IGI that has lower projected economic growth over 2025 and 2026. The 0.7 percent productivity adjustment in the FY 2026 final rule is larger than the productivity adjustment in prior final rules for FY 2023 and 2024 mainly due to the incorporation of updated BLS historical data.

In response to commenters' concerns about the productivity adjustment only being applied if it reduces the payment update, we note that the productivity adjustment was established under the Affordable Care Act with a specific policy intent to encourage efficiency improvements in healthcare delivery by linking Medicare payment updates to economy-wide productivity gains. The statutory language in section 1886(j)(3)(C)(ii) of the Act requires that the Secretary reduce (not increase) the market basket percentage increase by changes in economy-wide productivity, therefore, only positive productivity adjustments are applied.

Comment: Many commenters have noted concerns about CMS's estimation of the IRF market basket updates since the COVID–19 pandemic, stating that it has resulted in underpayments to IRF providers. Organizations report cumulative underpayments between 3.5 to 4.6 percentage points for fiscal years 2021 to 2024, with an annual financial impact of approximately $450 million, highlighting discrepancies between forecasted and actual market basket rates. Commenters suggest that CMS address these forecast errors as it does in the Skilled Nursing Facility (SNF) Prospective Payment System and recommend extending this approach to IRFs. Most organizations are requesting a retrospective adjustment of 3.5 to 4.6 percentage points for FY 2026, along with policy changes for ongoing forecast error correction mechanisms like the SNF PPS.

Concerns have been raised about the IGI forecasting methodology, which is perceived to lean towards under-forecasting in the post-pandemic environment. Commenters highlight that inadequate reimbursement may affect patient access to rehabilitation services and challenge the long-term stability of IRF providers, potentially causing care disruptions. According to the commenters, without correction, these forecast errors become embedded in future payment rates, widening the gap between actual costs and reimbursement. The consensus among commenting organizations is that CMS should implement a one-time market basket adjustment for FY 2026 to account for the cumulative underpayments due to market basket forecast errors from recent years and establish mechanisms to prevent similar issues in the future. Commenters assert that CMS has the statutory and regulatory authority to make these adjustments, given the precedent set in the SNF payment system and the agency's general authority over market basket calculations.

Response: The IRF market basket updates are set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2026 market basket update in this final rule reflects historical data through the first quarter of CY 2025 and forecasted data through the third quarter of CY 2026.

The forecast error has been both positive and negative during past years, and over longer periods of time the cumulative forecast has not deviated significantly from the historical measures. Only considering the forecast error for years when the IRF market basket update was lower than the actual market basket update would not fully account for forecast error. After careful consideration of public comments, we are finalizing a FY 2026 IRF productivity-adjusted market basket increase of 2.6 percent based on the most recent data available. This reflects a 3.3 percent market basket percentage increase, less the 0.7 percentage point productivity adjustment required by law.

C. Labor-Related Share for FY 2026

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act, for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We proposed to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2021-based IRF market basket, we proposed to calculate the labor-related share for FY 2026 as the sum of the FY 2026 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-

Related Services, and a portion of the Capital-Related relative importance from the 2021-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2021-based IRF labor-related share, see the FY 2024 IRF PPS final rule (88 FR 50985 through 50988).

The relative importance reflects the different rates of price change for these cost categories between the base year (2021) and FY 2026. We calculate the labor-related relative importance from the IRF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2026. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Based on IGI's fourth quarter 2024 forecast of the 2021-based IRF market basket, the sum of the FY 2026 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services was 70.8 percent. We proposed that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs was 8.1 percent of the 2021-based IRF market basket for FY 2026, we proposed to take 46 percent of 8.1 percent to determine the labor-related share of Capital-Related costs for FY 2026 of 3.7 percent. Therefore, we proposed a total labor-related share for FY 2026 of 74.5 percent (the sum of 70.8 percent for the proposed labor-related share of operating costs and 3.7 percent for the proposed labor-related share of Capital-Related costs). We also proposed that if more recent data subsequently became available after publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the labor-related share), we would use such data, if appropriate, to determine the FY 2026 IRF labor-related share in this final rule.

Based on IGI's second quarter 2025 forecast for the 2021-based IRF market basket, the sum of the FY 2026 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 70.7 percent. The portion of Capital-Related costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2016-based IRF market basket (84 FR 39088 through 39089). Since the relative importance for Capital is 8.1 percent of the 2021-based IRF market basket in FY 2026, we took 46 percent of 8.1 percent to determine the labor-related share of Capital-Related costs for FY 2026 of 3.7 percent. Therefore, the total labor-related share for FY 2026 based on more recent data is 74.4 percent (the sum of 70.7 percent for the operating costs and 3.7 percent).

We invited public comments on the proposed labor-related share for FY 2026.

The following is a summary of the public comments received and our responses.

Comment: One commenter stated that the proposed 0.1 percent increase to the labor-related share is inadequate in the context of the current economic climate of rising labor costs, inflationary pressures, and workforce shortages. The commenter respectfully requests that CMS reconsider the proposed labor-related share allocations to ensure they more accurately reflect the increased resource requirements necessary to maintain compliance and sustain high-quality patient care.

Response: We proposed to use the FY 2026 relative importance values for the labor-related cost categories from the 2021-based IRF market basket because it accounts for more recent data regarding price pressures and cost structure of IRFs. This methodology is consistent with the determination of the labor-related share since the implementation of the IRF PPS. As stated in the FY 2026 IRF proposed rule, we also proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2026 labor-related share for the final rule. Based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the FY 2026 labor-related share for the final rule is 74.4 percent, reflecting expectations of a slight softening of the labor market cost pressures since the proposed rule forecast. We note the FY 2026 labor-related share is unchanged from the FY 2025 labor-related share. After consideration of the public comments we received, we are finalizing a FY 2026 labor-related share of 74.4 percent.

Table 4 shows the estimate of the FY 2026 labor-related share and the FY 2025 final labor-related share using the 2021-based IRF market basket relative importance.

TABLE 4—FY 2026 IRF LABOR-RELATED SHARE AND FY 2025 IRF LABOR-RELATED-SHARE

	FY 2026 labor-related share [1]	FY 2025 final labor-related share [2]
Wages and Salaries	49.4	49.4
Employee Benefits	11.8	11.8
Professional Fees: Labor-Related [3]	5.5	5.5
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance, and Repair Services	1.5	1.5
All Other: Labor-Related Services	1.8	1.8
Subtotal	70.7	70.7
Labor-related portion of Capital-Related (46%)	3.7	3.7
Total Labor-Related Share	74.4	74.4

[1] Based on the 2021-based IRF market basket relative importance, IGI's 2nd quarter 2025 forecast.
[2] Based on the 2021-based IRF market basket relative importance as published in the **Federal Register** (89 FR 64276).
[3] Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office contract labor costs.

D. Wage Adjustment for FY 2026

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustments or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

In the FY 2023 IRF PPS final rule (87 FR 47054 through 47056) we finalized a policy to apply a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. We amended IRF PPS regulations at § 412.624(e)(1)(ii) to reflect this permanent cap on wage index decreases. Additionally, we finalized a policy that a new IRF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IRF would not have a wage index in the prior FY. A full discussion of the adoption of this policy is found in the FY 2023 IRF PPS final rule.

For FY 2026, we proposed to maintain the policies and methodologies described in the FY 2025 IRF PPS final rule (89 FR 64276) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we use the core based statistical areas (CBSAs) labor market area definitions and the FY 2026 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2026 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022 (that is, FY 2022 cost report data).

In addition, we will continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2026 IRF PPS wage index. For FY 2026, the only rural area without wage index data available is in North Dakota. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA as proposed and finalized in FY 2006 (70 FR 47927). For FY 2026, the only urban area without wage index data available is CBSA 25980, Hinesville Fort Stewart, Georgia.

We invited public comments on our proposals regarding the Wage Adjustment for FY 2026.

The following is a summary of the public comments received and our responses on the proposed revisions to the Wage Adjustment for FY 2026.

Comment: Many commenters supported the existing 5 percent wage index cap and expressed appreciation of having a policy to cap and phase in the wage index changes that a provider can experience in a given year. One commenter expressed frustration that the wage index values of the hospitals subject to the cap differ from the currently published tables and urged CMS to release wage index tables in the final rule that incorporates the cap on Core Based Statistical Areas (CBSAs) that meet the 5 percent decrease criteria.

Response: We appreciate the commenters' support of the permanent cap on wage index decreases. We realize that the 5-percent cap on annual decreases in the wage index values does not entirely eliminate the effects of annual changes in the wage index, but we believe that it does substantially reduce the financial impact on IRFs of these annual changes. The wage index tables for IRF PPS are provided at the CBSA level. The 5-percent cap policy is applied at the provider level. Hence, when the 5-percent cap is applicable, each IRF should work directly with its Medicare Administrative Contractor (MAC) to understand how the 5-percent cap is applied. MACs have more detailed information about the location of each IRF and the applicability of the 5-percent cap to each IRFs situation, and CMS has provided careful instructions to the MACs on applying the 5-percent cap policy (see publication 100–04 Medicare Claims Processing Manual, Chapter 3).

Comment: Multiple commenters urged CMS to refine the wage index calculations to create parity across provider types in the same market areas. They expressed concern over the use of the pre-classification and pre-floor IPPS wage index. They noted that since IPPS hospitals can reclassify their wage indices, acute care hospitals across the country are receiving wage index increases higher than would be assigned their Core Based Statistical Areas (CBSAs). One commenter also voiced concerns that IPPS hospitals that have benefited from IPPS-specific geographic reclassification or other wage adjustments no longer put the same resources into the completion of Occupational Mix Surveys. One commenter highlighted rural and low-wage index IRFs are particularly disadvantaged by the use of the pre-floor IPPS wage index.

Another commenter noted IRF distinct part units (DPUs) are particularly impacted by this and urged CMS to leverage existing data to evaluate the policy change using the CMS Form 2552–96, Worksheet S–3, which captures ''excluded area'' salaries and wage-related costs. They urged CMS to also reconsider its policy on the out-migration adjustment application to IRF DPUs as they noted they face the same challenges in the marketplace as IPPS hospitals. Another commenter suggested that CMS utilize more up to date cost reports to calculate the IRF PPS wage index.

Response: We appreciate the commenters' suggestion to adopt the IPPS post-classification and post-floor hospital IPPS wage index and other IPPS wage index adjustments for the IRF wage index. We also acknowledge and appreciate the commenters' concerns regarding competition for labor resulting from different applicable wage index policies across different settings of care. While we and other interested parties have explored potential alternatives to the current wage index system in the past, we are not considering a replacement system at this time. These concerns will be taken into consideration while we continue to explore future potential wage index reforms and monitor IRF wage index policies using the most up to date information.

As most recently discussed in the FY 2025 IRF PPS final rule (89 FR 64276), we would like to note that the IRF wage index is derived from IPPS wage data, that is, the pre-reclassification and pre-floor hospital wage index discussed in section VI. of this final rule. As such, any effects of this policy on the wage data of IPPS hospitals would be extended to the IRF setting, as this data would be used to establish the wage index for IRFs in the future. We note that IPPS wage index values are based on historical data and typically lag by 4 years.

As stated in prior years, as we do not have an IRF-specific wage index, we are unable to determine the degree, if any, to which these IPPS policies under the IRF PPS would be appropriate. However, we acknowledge that

commenters have suggested that such data may be available in CMS Form 2552–96, Worksheet S–3 and will take this into consideration. Data pertaining to any IPPS policies that are applied to the pre-reclassification/pre-floor wage index is available in the FY 2025 IRF PPS FR (89 FR 64276). A full history of the IRF PPS rules is available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-and-legislative-history.pdf.*

After consideration of the comments we received, we are finalizing our proposals regarding the wage adjustment for FY 2026.

2. Core-Based Statistical Areas (CBSAs) for the FY 2026 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor hospital wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established- revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010, **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. Additionally, OMB occasionally issues updates and revisions to the statistical areas in between decennial censuses to reflect the recognition of new areas or the addition of counties to existing areas. In some instances, these updates merge formerly separate areas, transfer components of an area from one area to another or drop components from an area. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012, and July 1, 2013.

In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 IRF wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule. In the FY 2019 IRF PPS final rule (83 FR 38527), we continued to use the OMB delineations that were adopted beginning with FY 2016 to calculate the area wage indexes, with updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

On August 15, 2017, OMB issued OMB Bulletin No. 17–01, which provided updates to and superseded OMB Bulletin No. 15–01 that was issued on July 15, 2015. The attachments to OMB Bulletin No. 17–01 provide detailed information on the update to statistical areas since July 15, 2015, and are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2014, and July 1, 2015. In the FY 2020 IRF PPS final rule (84 FR 39090 through 39091), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IRF wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03, which superseded the August 15, 2017, OMB Bulletin No. 17–01, and on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.*

To this end, as discussed in the FY 2021 IRF PPS proposed (85 FR 22075 through 22079) and final (85 FR 48434 through 48440) rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 1804 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1 year transition for FY 2021 under which we applied a 5-percent cap on any decrease in an IRF's wage index compared to its wage index for the prior fiscal year (FY 2020). The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the IRF PPS. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, we did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*) which updates and supersedes OMB Bulletin No. 20–01 based upon the 2020 Standards for Delineating Core Based Statistical Areas (''the 2020 Standards'') published by OMB on July 16, 2021 (86 FR 37770). OMB Bulletin No. 23–01 revised CBSA delineations that are comprised of counties and equivalent entities (for example, boroughs; a city and borough; and a municipality in Alaska; planning regions in Connecticut; parishes in Louisiana; municipios in Puerto Rico; and independent cities in Maryland, Missouri, Nevada, and Virginia). As discussed in the FY 2025 IRF PPS final rule (89 FR 64291 through 64304), we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01.

3. Second Year of the 3-Year Phase Out of the Rural Adjustment

For FY 2026, CMS is continuing the 3-year budget-neutral phase-out of the rural adjustment for FY 2024 IRFs transitioning from rural to urban status in FY 2025 under the revised CBSA delineations. As stated in the FY 2025 IRF PPS final rule (89 FR 64276), the purpose of this gradual phase-out of the rural adjustment for these facilities is to reduce the potential negative financial impacts associated with this reclassification. In FY 2026, the second year of this phase-out, affected IRFs will receive the full FY 2026 wage index along with one-third of the FY 2024 rural adjustment. This step is part of a gradual reduction of the 14.9 percent rural adjustment over three fiscal years

-FYs 2025, 2026, and 2027. Furthermore, this policy does not apply to urban IRFs transitioning to rural status, as they will receive the full rural adjustment.

The following is a summary of the public comments received and our responses on the proposal regarding the second year of the 3-year phase out of the rural adjustment.

Comment: Public comments supported the phase-out policy for IRFs being reclassified from rural to urban CBSAs. Commenters expressed that this phase-out policy for loss of the rural adjustment is a reasonable way to ensure that no IRF faces a dramatic cut to its reimbursement as a result of the new CBSA delineation. One commenter urged CMS to evaluate whether the policy disproportionately impacts rural IRFs with more low-income patients.

Response: We appreciate the commenters' feedback on the continued phase out policy for IRFs reclassification from rural to urban CBSAs. We will continue to monitor whether CBSA delineation changes disproportionately impact certain provider populations, such as low-income patients. Separately, the low-income patient (LIP) adjustment will continue to be applied because we did not propose to change the low-income patient adjustment (LIP) policy at § 412.624(e)(2).

After consideration of the comments we received, we are finalizing our proposal to continue the 3-year budget-neutral phase-out of the rural adjustment for FY 2024 IRFs transitioning from rural to urban status in FY 2026 under the revised CBSA delineations.

4. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the payment rates set forth in this rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2026 labor-related share based on the 2021-based IRF market basket relative importance (74.4 percent) to determine the labor-related portion of the standard payment amount. (A full discussion of the calculation of the labor-related share appears in section VI of this final rule.) We then multiply the labor-related portion by the applicable IRF wage index. The wage index tables are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689) and codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2026 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2022 hospital cost report data) and the update to the labor-related share, in a budget-neutral manner:

Step 1. Calculate the total amount of estimated IRF PPS payments using the labor-related-share and the wage indexes from FY 2025 (as published in the FY 2025 IRF PPS final rule (89 FR 64276)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2026 wage index values (based on updated hospital wage data and taking into account the permanent 5-percent cap on wage index decreases when applicable) and the FY 2026 labor-related share of 74.4 percent.

Step 3. Divide the amount calculated in Step 1 by the amount calculated in Step 2. The resulting quotient is the proposed FY 2026 budget-neutral wage adjustment factor of 1.0001.

Step 4. Apply the budget neutrality factor from Step 3 to the FY 2026 IRF PPS standard payment amount after the application of the market basket percentage increase to determine the FY 2026 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2026 in section VI.E. of this final rule.

We invited public comments on our proposals regarding the Wage Adjustment for FY 2026.

The following is a summary of the public comments received and our responses to the proposed revisions to the Wage Adjustment for FY 2026:

Comment: Several commenters specified that the wage index cap policy should be implemented without applying a budget neutrality adjustment.

Response: We do not believe that the permanent 5-percent cap policy for the IRF wage index should be applied in a non-budget-neutral manner. The statute at section 1886(j)(6) of the Act requires that adjustments for geographic variations in labor costs for a FY be made in a budget-neutral manner. We refer readers to the FY 2023 IRF PPS final rule (87 FR 47054 through 47056) for a detailed discussion on the wage index cap policy.

After consideration of the comments we received, we are finalizing our proposals regarding the IRF budget neutral wage adjustment factor methodology for FY 2026 without modification.

E. Description of the IRF Standard Payment Conversion Factor Methodology and Payment Rates for FY 2026

To calculate the IRF standard payment conversion factor for FY 2026, as illustrated in Table 5, we begin by applying the IRF market basket update for FY 2026, as adjusted in accordance with sections 1886(j)(3)(C) of the Act, to the standard payment conversion factor for FY 2025 ($18,907). Applying the 2.6 percent IRF market basket update for FY 2026 to the standard payment conversion factor for FY 2025 of $18,907 yields a FY 2026 standard payment amount of $19,399. Then, we apply the budget neutrality factor for the FY 2026 wage index (taking into account the policy placing a permanent 5-percent cap on decreases to a provider's wage index), and labor-related share of 1.0001, which results in an IRF standard payment amount of $19,401. We next apply the budget neutrality factor for the CMG relative weights of 0.9985, which results in the IRF standard payment conversion factor of $19,371 for FY 2026.

We received no comments on the proposed FY 2026 IRF standard payment conversion factor methodology and are finalizing the FY 2026 IRF standard payment conversion factor methodology as proposed.

TABLE 5—CALCULATIONS TO DETERMINE THE FY 2026 IRF STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
FY 2025 IRF Standard Payment Conversion Factor	$18,907
Market Basket Update for FY 2026 of 2.6 percent*	× 1.026
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	× 1.0001
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	× 0.9985

TABLE 5—CALCULATIONS TO DETERMINE THE FY 2026 IRF STANDARD PAYMENT CONVERSION FACTOR—Continued

Explanation for adjustment	Calculations
FY 2026 Standard Payment Conversion Factor	= $19,371

* Reflects a FY 2026 3.3 percent IRF market basket percentage increase reduced by 0.7 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We then apply the CMG relative weights described in section V.E of this rule to the FY 2026 standard payment conversion factor ($19,371), to determine the unadjusted IRF prospective payment rates for FY 2026. The unadjusted IRF prospective payment rates for FY 2026 are shown in Table 6.

TABLE 6—FY 2026 IRF PPS PAYMENT RATES

CMG	Payment rate Tier 1	Payment rate Tier 2	Payment rate Tier 3	Payment rate no comorbidity
0101	$18,729.82	$16,631.94	$15,068.70	$14,293.86
0102	23,837.95	21,168.63	19,179.23	18,193.24
0103	30,602.31	27,175.58	24,620.54	23,353.68
0104	39,084.87	34,708.96	31,446.88	29,827.47
0105	48,710.32	43,255.44	39,189.47	37,172.95
0106	54,868.36	48,723.88	44,144.57	41,872.35
0201	20,560.38	16,349.12	14,935.04	14,032.35
0202	26,850.14	21,348.78	19,504.66	18,324.97
0203	33,382.04	26,542.14	24,248.62	22,782.23
0204	41,142.07	32,711.81	29,885.58	28,078.26
0205	52,782.10	41,967.27	38,341.02	36,022.31
0301	23,127.04	18,328.84	17,089.10	15,998.51
0302	29,918.51	23,712.04	22,106.19	20,694.04
0303	35,375.32	28,037.59	26,139.23	24,471.38
0304	41,909.16	33,215.45	30,964.54	28,988.70
0305	45,907.33	36,384.55	33,920.56	31,754.88
0401	26,243.83	21,451.45	20,887.75	18,900.28
0402	32,901.64	26,892.76	26,185.72	23,694.61
0403	37,974.91	31,040.09	30,222.63	27,347.98
0404	61,531.98	50,294.86	48,971.83	44,315.04
0405	48,739.37	39,838.40	38,790.43	35,102.19
0406	64,118.01	52,408.24	51,029.03	46,176.59
0407	87,804.87	71,769.56	69,880.88	63,234.69
0501	25,356.64	19,487.23	18,129.32	16,707.49
0502	31,479.81	24,192.44	22,505.23	20,740.53
0503	35,646.51	27,394.47	25,484.49	23,485.40
0504	42,594.89	32,733.12	30,451.21	28,062.77
0505	60,518.88	46,507.83	43,267.07	39,873.27
0601	25,366.32	19,212.16	18,094.45	16,252.27
0602	31,553.42	23,898.00	22,507.16	20,217.51
0603	37,521.63	28,417.26	26,764.91	24,041.35
0604	47,455.08	35,939.02	33,850.82	30,404.72
0701	23,766.28	19,001.01	18,046.02	16,490.53
0702	29,376.12	23,487.34	22,305.71	20,384.10
0703	35,987.44	28,773.68	27,328.61	24,973.09
0704	44,437.07	35,530.29	33,744.28	30,834.76
0801	22,820.98	19,219.91	17,180.14	16,097.30
0802	26,011.38	21,908.60	19,582.14	18,348.21
0803	28,626.46	24,111.08	21,552.17	20,192.33
0804	32,520.03	27,390.59	24,483.01	22,939.14
0805	40,504.76	34,114.27	30,493.83	28,570.29
0901	23,990.98	18,171.94	17,166.58	15,659.52
0902	30,476.39	23,084.42	21,805.93	19,894.02
0903	36,165.66	27,392.53	25,875.78	23,607.44
0904	43,549.88	32,986.88	31,160.19	28,426.94
1001	23,805.02	19,779.73	17,953.04	16,668.75
1002	28,918.97	24,029.73	21,809.81	20,250.44
1003	34,418.39	28,599.34	25,957.14	24,101.40
1004	45,781.42	38,040.77	34,526.87	32,059.01
1101	26,197.34	24,802.63	21,344.90	18,675.58
1102	29,916.57	28,322.34	24,372.59	21,325.53
1103	37,471.26	35,474.11	30,528.70	26,710.67
1201	25,660.76	20,366.67	18,200.99	16,856.64
1202	30,172.27	23,946.43	21,399.14	19,818.47
1203	40,388.54	32,055.13	28,645.83	26,530.52
1204	41,579.85	33,002.37	29,492.35	27,313.11
1301	24,266.05	19,400.06	17,774.83	16,147.67

TABLE 6—FY 2026 IRF PPS PAYMENT RATES—Continued

CMG	Payment rate Tier 1	Payment rate Tier 2	Payment rate Tier 3	Payment rate no comorbidity
1302	29,753.86	23,787.59	21,796.25	19,799.10
1303	34,387.40	27,491.32	25,190.05	22,881.03
1304	44,382.84	35,483.80	32,512.29	29,533.03
1305	44,295.67	35,412.13	32,446.43	29,474.91
1401	21,647.09	17,437.77	16,122.48	14,826.56
1402	27,576.56	22,214.66	20,539.07	18,888.66
1403	33,331.68	26,850.14	24,825.87	22,830.66
1404	41,585.66	33,500.21	30,976.17	28,485.06
1501	25,381.82	20,409.29	19,113.37	18,270.73
1502	31,036.22	24,955.66	23,371.11	22,342.51
1503	36,185.03	29,095.24	27,247.25	26,046.25
1504	45,376.57	36,485.28	34,168.51	32,663.38
1601	20,362.80	18,247.48	16,691.99	15,130.69
1602	24,500.44	21,957.03	20,083.85	18,206.80
1603	29,670.56	26,590.57	24,324.16	22,048.07
1604	38,836.92	34,805.81	31,838.18	28,858.92
1701	25,552.29	20,242.70	18,793.74	17,302.18
1702	31,497.25	24,951.79	23,167.72	21,327.47
1703	36,955.99	29,277.33	27,183.32	25,025.39
1704	42,525.16	33,690.04	31,280.29	28,796.93
1705	49,506.46	39,220.46	36,415.54	33,523.45
1801	21,674.21	17,732.21	16,312.32	15,310.84
1802	27,551.37	22,540.10	20,734.72	19,462.04
1803	34,275.05	28,039.52	25,794.42	24,209.88
1804	40,030.17	32,748.61	30,125.78	28,275.85
1805	48,024.58	39,288.26	36,142.41	33,922.50
1806	69,578.69	56,921.68	52,363.69	49,148.10
1901	25,970.70	18,354.02	15,955.89	15,961.70
1902	37,783.14	26,702.92	23,214.21	23,220.02
1903	53,458.15	37,781.20	32,845.47	32,853.22
1904	82,202.78	58,095.57	50,504.07	50,519.57
2001	23,020.50	18,462.50	17,170.45	15,717.63
2002	28,581.91	22,921.70	21,315.85	19,514.35
2003	33,562.19	26,916.00	25,031.21	22,915.89
2004	40,932.86	32,826.10	30,528.70	27,946.54
2005	42,844.78	34,360.28	31,954.40	29,252.15
2101	31,111.76	26,156.66	19,725.49	18,915.78
2102	49,301.13	41,448.13	31,257.05	29,974.69
5001	.....	.....	.....	3,399.61
5101	.....	.....	.....	16,540.90
5102	.....	.....	.....	39,681.49
5103	.....	.....	.....	17,662.48
5104	.....	.....	.....	42,385.69

F. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 7 illustrates the methodology for adjusting the prospective payments (as described in section V of this final rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified as CMG 0104 (without comorbidities). The unadjusted prospective payment rate for CMG 0104 (without comorbidities) appears in Table 6.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8565, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454), a wage index of 0.9145, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the prospective payment, we begin by taking the FY 2026 unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 6. Then, we multiply the labor-related share for FY 2026 (74.4 percent) described in section VI of this final rule by the unadjusted prospective payment rate. To determine the non-labor portion of the prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted prospective payment.

To compute the wage-adjusted prospective payment, we multiply the labor portion of the Federal payment by the appropriate wage index located in the applicable wage index table. This table is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

The resulting figure is the wage-adjusted labor amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the Federal payment.

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP

adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 7 illustrates the components of the adjusted payment calculation.

TABLE 7—EXAMPLE OF COMPUTING THE FY 2026 IRF PROSPECTIVE PAYMENT

Steps	Rural facility A (Spencer Co., IN)		Urban facility B (Harrison Co., IN)	
1. Unadjusted Payment		$29,827.47		$29,827.47
2. Labor-Related Share	×	0.744	×	0.744
3. Labor Portion of Payment	=	$22,191.64	=	$22,191.64
4. CBSA-Based Wage Index	×	0.8565	×	0.9145
5. Wage-Adjusted Amount	=	$19,007.14	=	$20,294.25
6. Non-Labor Amount	+	$7,635.83	+	$7,635.83
7. Wage-Adjusted Payment	=	$26,642.97	=	$27,930.08
8. Rural Adjustment	×	1.149	×	1.000
9. Wage- and Rural-Adjusted Payment	=	$30,612.77	=	$27,930.08
10. LIP Adjustment	×	1.0156	×	1.0454
11. Wage-, Rural- and LIP-Adjusted Payment	=	$31,090.33	=	$29,198.11
12. Wage- and Rural-Adjusted Payment		$30,612.77		$27,930.08
13. Teaching Status Adjustment	×	0	×	0.0784
14. Teaching Status Adjustment Amount	=	$0.00	=	$2,189.72
15. Wage-, Rural-, and LIP-Adjusted Payment	+	$31,090.33	+	$29,198.11
16. Total Adjusted Payment	=	$31,090.33	=	$31,387.83

Thus, the adjusted payment for Facility A would be $31,090.33 and the adjusted payment for Facility B would be $31,387.83.

VII. Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2026

A. Update to the Outlier Threshold Amount for FY 2026

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall Cost-to-Charge Ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the FY 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high- cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2025 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, 82 FR 36238, 83 FR 38514, 84 FR 39054, 85 FR 48444, 86 FR 42362, 87 FR 47038, 88 FR 50956, and 89 FR 64276 respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 through 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2026, we proposed to use FY 2024 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2025. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2026, we estimated the amount of FY 2026 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2024) and the proposed FY 2026 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-neutrality adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 2.8 percent in FY 2025. Therefore, we proposed to update the outlier threshold amount from $12,043 for FY 2025 to $11,971 for FY 2026 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2026.

We note that, with our longstanding practice when developing previous IRF PPS fiscal year rules, we update our data between the FY 2026 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments. We are finalizing the outlier threshold amount of $10,062 to maintain estimated outlier

payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2026.

We invited public comment on the proposed update to the IRF outlier threshold for FY 2026.

The following is a summary of the public comments received on our proposed update to the FY 2026 IRF outlier threshold.

Comment: Commenters were supportive of the update to the outlier threshold for FY 2026 and setting outlier payments at 3 percent of total payments. Several commenters advised CMS to continue to monitor its approach due to the ongoing impacts of the PHE and total cost of care. We received one comment urging CMS to consider a 10 percent cap on IRF's outlier payments (as a percentage of total IRF PPS revenues) due to a concern that a small number of IRF providers are receiving large outlier payments despite their case-mix index being similar to average IRFs. The commenter believed that factors other than patient complexity and case-mix may be driving these payments and presented analysis to support their claim that inefficient cost structures, rather than highly complex patients, appear to be driving the distribution of overall IRF outlier payments, potentially resulting in patients at IRFs that warrant an outlier payment not receiving one.

Response: We continue to believe that maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs of caring for highest-cost patients, while still providing for adequate payments for non-outlier cases. We continue to monitor our approach to assess whether IRFs who treat medically complex patients are adequately compensated.

We acknowledge commenters' concerns that outlier payments may be concentrated among a small subset of providers and may not be consistently targeted towards patients with intensive or complex needs. As most recently discussed in the FY 2025 IRF PPS Final Rule (89 FR 64276), our outlier policy is intended to reimburse IRFs for treating extraordinarily costly cases. We appreciate the commenters' suggestions for additional analysis on our methodology and will take them into consideration as we continue to assess our outlier threshold.

Comment: We received multiple comments that recommended that CMS implement a new methodology to set the outlier fixed loss amount using a 3-year average approach to promote stability in the outlier threshold value and to account for the true cost of care for medically complex patients. One commenter noted this method would be consistent with facility specific adjustments, including teaching, rural, and Low-Income Percentage (LIP). Multiple commenters also suggested that CMS include historical reconciliation dollars in the outlier projection to increase accuracy. Moreover, many commenters expressed concern that outlier payments are being concentrated among an increasingly small number of providers. One commenter suggested that CMS evaluate the variation in outlier spending by provider.

Response: We thank the commenters for their suggestions regarding the outlier threshold. We appreciate the suggestion to modify the outlier threshold methodology to use a 3-year average; however, it has been our long-standing practice to utilize the most recent full fiscal year of data to update the prospective payment rates and determine the outlier threshold amount as this data is generally considered to be the best overall predictor of experience in the upcoming fiscal year. Any future consideration given to imposing a limit on outlier payments or adjusting the outlier threshold to account for historical outlier reconciliation would need to be carefully assessed and take into consideration the effect on access to IRF care for certain high-cost populations. We continue to believe maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs of caring for highest-cost patients while still providing for adequate payments for other cases. We appreciate the commenters' suggestions for refinements to the outlier methodology as well as the suggested areas of analysis and will take them into consideration as we continue to assess our outlier methodology.

Comment: Multiple commenters suggested CMS reduce the 3 percent outlier pool threshold to a lower percentage which would increase the number of complex patients that qualify for the outlier threshold and provide appropriate compensation to IRFs.

Response: We appreciate the suggestion regarding the outlier threshold methodology. As most recently discussed in the FY 2025 IRF PPS Final Rule (89 FR 64276) our outlier policy is intended to reimburse IRFs for treating extraordinarily costly cases. We continue to believe that maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs of caring for highest-cost patients, while still providing adequate payments for all other cases. We will continue to examine ways of enhancing the stability and predictability of the outlier threshold from year to year. We appreciate the commenters' suggestion for refinements to the outlier methodology as well as the suggested areas of analysis and will take them into consideration, as we continue to assess our outlier threshold policy to ensure it continues to compensate IRFs' appropriately.

Based on our analysis using this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.4 percent in FY 2025. Therefore, we will update the outlier threshold amount from $12,043 for FY 2025 to $10,062 for FY 2026 to account for the increases in IRF PPS payments and estimated costs to maintain estimated outlier payments at approximately 3 percent of total aggregate IRF payments for FY 2026. After consideration of the comments received and considering the most recent available data, we are finalizing the outlier threshold amount of $10,062 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2026.

B. Update to the IRF Cost-to-Charge Ratio (CCR) Ceiling and Urban/Rural Averages for FY 2026

CCRs are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from Medicare Cost Reports (MCRs). IRF-specific CCRs are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF PPS. In accordance with the methodology described in the FY 2004 IRF PPS final rule (68 FR 45692 through 45694), we proposed to apply a ceiling to IRFs' CCRs. Using that methodology, we proposed to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2026, based on analysis of the most recent data available. We apply the national urban and rural CCRs to:

- New IRFs that have not yet submitted their first MCR.
- IRFs with an overall CCR that exceeds the national CCR ceiling for FY 2026, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2026, we proposed to estimate a national average CCR of 0.467 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data.

Similarly, we proposed to estimate a national average CCR of 0.398 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We applied weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this final rule, we used the most recent available cost report data (FY 2023). This includes all IRFs whose cost reporting periods begin on or after October 1, 2022, and before October 1, 2023. If, for any IRF, the FY 2023 cost report was missing or had an ''as submitted'' status, we used the most recent FY for which a settled cost report was available (that is, from a FY between FY 2004 and FY 2022) for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care. Using updated FY 2023 cost report data for this final rule, we estimate a national average CCR of 0.463 for rural IRFs and a national average CCR of 0.398 for urban IRFs.

In accordance with past practice, we proposed to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.54 for FY 2026. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.54 for FY 2026, we will replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in Step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in Step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from Step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from Step 1.

We also proposed that if more recent data become available after the publication of the proposed rule and before the publication of this final rule, we would use such data to determine the FY 2026 national average rural and urban CCRs and the national CCR ceiling in the proposed rule. Using the FY 2023 cost report data for this proposed rule, we estimate a national average CCR ceiling of 1.54, using the same methodology.

We invited public comments on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2026 and did not receive any comments. Consistent with the methodology outlined in the proposed rule, and using the most recent cost report data, we are finalizing a national average urban CCR at 0.398, the national average rural CCR at 0.463, and the national average CCR ceiling at 1.54 for FY 2026.

VIII. Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

A. Background and Statutory Authority

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or Critical Access Hospitals (CAHs) paid by Medicare under the IRF PPS. Section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual increase factor for discharges occurring during a FY for any IRF that does not submit data in accordance with the IRF QRP requirements set forth in subparagraphs (C) and (F) of section 1886(j)(7) of the Act. We have codified our program requirements in our regulations at § 412.634.

In the proposed rule, we proposed to remove two quality measures: (1) the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure, beginning with the FY 2026 IRF QRP, and (2) the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, beginning with the FY 2028 IRF QRP. We also proposed to remove four items previously adopted as standardized patient assessment data elements under the social determinants of health (SDOH) category beginning with the FY 2028 IRF QRP: one item for Living Situation, two items for Food, and one item for Utilities. We also proposed to amend our reconsideration policy and process.

We also sought public comment on several Requests for Information (RFIs), specifically on: (1) future measure concepts for the IRF QRP in section VII.E of the proposed rule; (2) potential revisions to the IRF–PAI as described in section VII.F of the proposed rule; (3) potential revisions to the data submission deadlines for assessment data collected for the IRF QRP as described in section VII.G of the proposed rule; (4) advancing digital quality measurement in IRFs as described in section VII.H of the proposed rule.

B. General Considerations Used for the Selection of Measures for the IRF QRP

For a detailed discussion of the considerations we use for the selection of IRF QRP quality, resource use, or other measures, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084).

1. Quality Measures Currently Adopted for the IRF QRP

The IRF QRP currently has 17 adopted measures, which are listed in Table 8.

For a discussion of the factors, we use to evaluate whether a measure should be removed from the IRF QRP, we refer readers to our regulations at § 412.634(b)(2). We refer readers to the CY 2013 OPPS/ASC PPS final rule (77 FR 45194 and 45195) for discussion of our policy that allows any quality measure adopted for use in the IRF QRP to remain in effect until the measure is removed, suspended, or replaced, the FY 2018 IRF PPS final rule (82 FR 36276) which applied this policy to standardized patient assessment data we adopt for the IRF QRP, and the FY 2019 IRF PPS final rule (83 FR 38556 and 38557) for more information on the factors we consider for removing measures and standardized patient assessment data.

TABLE 8—QUALITY MEASURES CURRENTLY ADOPTED FOR THE IRF QRP

Short name	Measure name & data source
Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF–PAI) Assessment-Based Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

TABLE 8—QUALITY MEASURES CURRENTLY ADOPTED FOR THE IRF QRP—Continued

Short name	Measure name & data source
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients.
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients.
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues—Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).
TOH-Provider	Transfer of Health Information to the Provider—Post-Acute Care (PAC).
TOH-Patient	Transfer of Health Information to the Patient—Post-Acute Care (PAC).
DC Function	Discharge Function Score.
Patient/Resident COVID–19 Vaccine	COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date.
National Healthcare Safety Network	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure.
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel.
HCP COVID–19 Vaccine	COVID–19 Vaccination Coverage among Healthcare Personnel (HCP).
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) IRF QRP.
DTC	Discharge to Community—PAC IRF QRP.
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP.
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs.

C. Overview of Quality Measure Proposals

In the proposed rule, we proposed to remove two measures: (1) the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure, beginning with the FY 2026 IRF QRP and (2) the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, beginning with the FY 2028 IRF QRP.

1. Removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning With the FY 2026 IRF QRP

We refer readers to the FY 2022 IRF PPS final rule where we adopted the COVID–19 Vaccination Coverage among HCP measure (HCP COVID–19 measure) into the IRF QRP (86 FR 42385 through 42396) and the FY 2024 IRF PPS final rule where we modified the HCP COVID–19 measure to account for updated vaccine guidance (88 FR 50999 through 51009). To report this measure, an IRF must report data on COVID–19 vaccination coverage among HCP for at least one week each month. This requires IRFs to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers and other contract personnel and log in to the National Healthcare Safety Network (NHSN) to report the data monthly either manually in the NHSN or by uploading a CSV file (86 FR 42388). The estimated burden of collecting this information annually across all 1,166 IRFs is 13,992 hours at a cost of $503,991.84. We refer readers to section VIII.A.1. of this final rule for more details on this estimated burden calculation.

We proposed to remove the HCP COVID–19 measure beginning with the FY 2026 IRF QRP under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program (§ 412.634(b)(2)(viii)). When we first adopted the HCP COVID–19 measure, the United States was in the midst of a Public Health Emergency (PHE) with millions of cases and over 550,000 COVID–19 deaths (86 FR 42385 and 42386). While preventing the spread of COVID–19 remains a public health goal, the PHE ended on May 11, 2023.[7] In March 2021, when this measure was being proposed, the United States was averaging over 5,000 deaths per week. In April 2023, the last full month of the PHE, weekly number of deaths due to COVID–19 averaged around 1,300.[8] With the end of the PHE and the decrease in COVID–19 deaths, we expect the continued costs and burden to providers of tracking and monthly reporting on this measure to outweigh the benefit of continued information collection on COVID–19 vaccination coverage among HCP in IRFs.

If finalized, IRFs that did not report their CY 2024 reporting period data for the HCP COVID–19 measure would still be considered compliant with the IRF QRP for purposes of their FY 2026 payment determination (that is, IRFs that do not report CY 2024 HCP COVID–19 vaccination data would not be penalized for FY 2026 payments). Any HCP COVID–19 Vaccination measure data received by CMS would not be used for payment determination.

We invited public comment on our proposal to remove the COVID–19 Vaccination Coverage among HCP measure from the IRF QRP beginning with the FY 2026 IRF QRP. The following is a summary of the public comments received and our responses:

Comment: Many commenters supported the removal of the COVID–19 Vaccination Coverage among HCP measure, agreeing that the burden required to collect this measure outweighs the benefits. Several commenters cited the end of the Public Health Emergency and changes to vaccination and booster recommendations in their support. A few commenters stated that the availability of vaccines, improved treatments, and declining rates of severe

[7] *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.*

[8] Provisional COVID–19 Deaths, by Week, in The United States, Reported to CDC. Accessed on March 27, 2025, via *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00.*

illness have reduced the need for reporting of HCP vaccination rates.

A few commenters stated that confusion about the ''up to date'' definition led to inaccurate reporting and increased administrative tracking and noted that the requirements were not consistent with federal and state mandates. These commenters also cited concerns about the measure's consideration of medical contraindications and religious beliefs. Another commenter stated that the measure has been administratively challenging, and that the inclusion of non-employees created difficulties for providers.

Response: We thank these commenters for their support and feedback about the measure. We agree that the costs associated with a measure outweigh the benefit of its continued use in the program, given the end of the PHE.

Comment: One commenter was opposed to removing the measure, recommending that CMS retain one of the COVID–19 vaccine measures to ensure public health surveillance for vulnerable populations.

Response: We appreciate the commenter's concerns for the IRF population. However, we note that since the end of the PHE there has been an increase in the availability of treatments, including antiviral medications used to treat mild to moderate COVID–19 infections in vulnerable populations.[9] Since the number of COVID–19 cases and deaths is declining, and the availability of treatments has increased, we believe the threat to vulnerable populations, such as IRF patients, is also reduced. On these bases, we believe the continued costs and burden to providers of reporting this measure outweigh the benefit of continued information collection on COVID–19 vaccination coverage among HCP in IRFs.

After consideration of the public comments, we are finalizing our proposal to remove the COVID–19 Vaccination Coverage among HCP measure from the IRF QRP beginning with the FY 2026 IRF QRP.

2. Removal of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2028 IRF QRP

We refer readers to the FY 2024 IRF PPS final rule where we adopted the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure into the IRF QRP (88 FR 51026 through 51035). In the FY 2026 IRF PPS proposed rule (90 FR 18550), we proposed to remove the Patient/Resident COVID–19 Vaccine measure beginning with the FY 2028 IRF QRP under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program (§ 412.634(b)(2)(viii)). The estimated burden of collecting this information annually across all 1,166 IRFs is 3,111.5 hours at a cost of $218,116.15. We refer readers to section IX.A.2. of this final rule for more details on this estimated burden reduction.

When we adopted the Patient/Resident COVID–19 Vaccine measure, COVID–19 continued to be a major challenge for IRFs, with older adults at a significantly higher risk of mortality, severe disease, and death following infection (88 FR 51026).

IRFs have expressed concerns about data collection challenges and increased provider burden in collecting patient immunization data.[10] This is especially true considering the shorter length of stay for IRF patients compared to other post-acute settings. While preventing the spread of COVID–19 remains a public health goal, the number of COVID–19 cases and deaths [11] is declining, and we believe the continued costs and burden to providers of reporting this measure outweigh the benefit of continued information collection on COVID–19 vaccination coverage among patients in IRFs.

We proposed that, beginning with patients discharged on or after October 1, 2025, IRFs would not be required to collect and submit the Patient/Resident COVID–19 Vaccine measure data to CMS. We proposed to remove the Patient/Resident COVID–19 Vaccine data item (O0350) from the IRF–PAI effective October 1, 2026, since it is not technically feasible to remove this item earlier. However, under our proposal, this item will become voluntary and IRFs would not be required to collect and submit Patient/Resident COVID–19 Vaccine data beginning with patients discharged on or after October 1, 2025.

We invited public comment on our proposal to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the IRF QRP beginning with the FY 2028 IRF QRP.

The following is a summary of the public comments received on our proposed update to remove the COVID–19 Vaccine:

Comment: We received many comments in support of the proposal to remove the Patient/Resident COVID–19 Vaccine measure, agreeing that the administrative burden required to collect this measure outweighs the benefits. Several commenters noted the end of the Public Health Emergency and changes to vaccination and booster recommendations in their support for removing the measure. A few commenters noted that IRF patients are medically complex and appreciated the flexibility to determine how to support infection control among their patients. A few commenters stated that COVID–19 vaccination is driven by primary and acute care providers and was not appropriate for the IRF setting. One commenter asserted that this measure did not have any benefit to the public or Medicare program. A few commenters noted the difficulty of collecting accurate patient vaccination status. A few commenters supported removal, citing issues with the measure response options, including the definition of ''up to date'' and the lack of an option to indicate patient refusal or exclusion for medical contraindications or religious beliefs. These commenters also noted that some IRFs are not able to provide the vaccine to patients and also noted that vaccine side effects may impede patients from participating in therapy.

Response: We thank commenters for their support. We acknowledge commenters' difficulty with assessing patient's vaccination status in the IRF, given that the IRF length of stay is shorter compared to other post-acute care settings. We agree that the costs associated with this measure, including the resources spent by IRF staff in trying to ascertain patients' vaccination status, outweigh the benefit of its continued use in the program, given the end of the PHE, the decrease in COVID cases as well as the availability of treatments.

Comment: We received a few comments that were supportive of the measure removal, but requested an earlier timeframe, citing data collection burden. These commenters requested that CMS not penalize IRFs for failing to report data for the Patient/Resident COVID–19 Vaccine measure for CY 2024 and January through September 2025. Another commenter requested that the Patient/Resident Vaccine item be removed from the IRF–PAI on October

[9] COVID–19 Treatment Options, *https://www.cdc.gov/covid/treatment/index.html.*

[10] Standing Technical Expert Panel for the Development, Evaluation, and Maintenance of Post-Acute Care (PAC) and Hospice Quality Reporting Program (QRP) Measurement Sets Summary Report December 15, 2023. *https://www.cms.gov/files/document/december-2023-pac-and-hospice-cross-setting-tep-summary-report.pdf-1.*

[11] Provisional COVID–19 Deaths, by Week, in The United States, Reported to CDC. Accessed on March 18, 2025, via *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00.*

1, 2025, to avoid confusion and workflow delays.

Response: IRFs have been required to report this measure on the IRF–PAI since October 1, 2024. According to internal CMS analysis of IRF–PAI data, IRFs have a data submission rate of approximately 99 percent with regard to the required IRF QRP data elements on the IRF PAI. We do not anticipate a substantial number of IRFs to be non-compliant with FY 2026 IRF QRP due to non-submission of this measure for CY 2024 quarter 4. We are consistently monitoring these data as they are submitted for trends that may indicate barriers to data submission and will continue to do so as we conclude the FY 2026 IRF QRP program year.

Regarding the suggestion to remove the item from the IRF–PAI on October 1, 2025, it is not operationally feasible to remove this measure from the IRF–PAI, since CMS, IRFs and vendors need more time to prepare for an update to the item set and data specifications. Instead, we proposed, and are finalizing, that reporting the data on this measure using the IRF–PAI will be optional beginning October 1, 2025. Because data collected in Q4 of 2025 (October 1, 2025–December 31, 2025) are used in determining the minimum data completion threshold for the FY 2027 IRF QRP determination, we intend to provide updates to the website to indicate that the Patient/Resident COVID–19 Vaccine data item (O0350) is optional for the final quarter of the data collection period for the FY 2027 Annual Increase Factor Determination (that is, Q4 of 2025) and we will not penalize IRFs who select not complete this item during Q4 of 2025. The item will be optional until it can be removed from the IRF–PAI with the next iteration of the IRF–PAI scheduled for release October 1, 2026.

Comment: One commenter was opposed to removing the measure, recommending that CMS retain one of the COVID–19 vaccine measures to ensure public health surveillance for vulnerable populations.

Response: We appreciate the commenter's concerns for the IRF population. However, we wish to clarify that this measure did not provide surveillance data about COVID–19 cases among IRF patients; rather it assessed whether patients in submitting IRFs were up to date in their COVID–19 vaccinations. Removing this measure will not impact the public health surveillance of COVID–19. We also note that since the end of the PHE, there has been an increase in the availability of treatments, including antiviral medications used to treat mild to moderate COVID–19 in vulnerable populations.[12] As we stated in the proposed rule, because the number of COVID–19 cases and deaths is declining and the availability of treatments has increased, we believe the threat to vulnerable populations, such as IRF patients, is also reduced. On these bases, we believe the continued costs and burden to providers of reporting this measure outweigh the benefit of continued information collection on COVID–19 vaccination coverage among patients in IRFs.

After consideration of the public comments, we are finalizing our proposal to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the IRF QRP beginning with the FY 2028 IRF QRP. Beginning with patients discharged on or after October 1, 2025, IRFs would not be required to collect and submit the Patient/Resident COVID–19 Vaccine measure data to CMS, and IRFs who do not report this data for Q4 of 2025 will not be penalized for the FY 2027 Annual Increase Factor Determination.

D. Removal of Four Standardized Patient Assessment Data Elements Beginning With the FY 2028 IRF QRP

We refer readers to the FY 2025 IRF PPS final rule (89 FR 64310 through 64322) where we finalized the adoption of four items as standardized patient assessment data elements under the SDOH category from the IRF–PAI: one item for Living Situation (R0310); two items for Food (R0320A and R0320B); and one item for Utilities (R0330). As finalized in the FY 2025 IRF PPS final rule, IRFs would be required to report these data elements using the IRF–PAI beginning with patients discharged on or after October 1, 2026 through December 31, 2026 for purposes of the FY 2028 IRF QRP and each program year after (89 FR 64326 through 64327).

In the proposed rule, we proposed to remove these four standardized patient assessment data elements under the SDOH category from the IRF–PAI as we acknowledge the burden associated with these items at this time. We continuously look for ways to balance the need for data collections regarding quality care and the burden that such data collections may have on healthcare providers. One goal we have is to facilitate improved healthcare delivery by requiring different systems and software applications to communicate and exchange data. Therefore, we would like to work towards the workflow for these specific data elements being part of a low burden interoperable electronic system. The focus will turn towards how these data and associated recommendations can improve care coordination, efficiency, reduction in errors and patient experience. As health information technology (IT) advances and interoperability of data becomes more standardized, the burden to collect and share clinical data on these and other relevant patient information will become less burdensome, allowing for better outcomes for IRF patients and their families. The objectives of the IRF QRP continue to be the improvement of care, quality and health outcomes for all patients through transparency and quality measurement, while not imposing undue burden on essential health providers. We proposed that IRFs would not be required to collect and submit Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) items using the IRF–PAI beginning with the patients discharged on or after October 1, 2026, removing the required collection and reporting of these items that we previously finalized. We also proposed that collecting these items would not be required to meet the IRF QRP requirements to avoid a 2 percent payment reduction beginning with the FY 2028 IRF QRP.

In the proposed rule, we calculated that removing these items from the data collection for the FY 2028 IRF QRP would keep the 1,166 IRFs from incurring 12,446 hours of administrative burden at a cost of $872,464.60 (or $748.25 per IRF) at this time (90 FR 18557 and 18558). We refer readers to section IX.A.3. of this final rule for more details on this estimated burden reduction.

We invited public comments on our proposal to remove four standardized patient assessment data elements collected under the SDOH category from the IRF QRP beginning with the FY 2028 IRF QRP.

The following is a summary of the public comments received on our proposal to remove these four standardized patient assessment data elements.

Comment: Many commenters supported the proposed removal of the four SDOH assessment data elements, citing that these added complexity and administrative burden to the patient assessment process. A few commenters expressed concerns about how these data elements can be time-consuming to collect and detract from direct patient care. Several commenters acknowledged that CMS must work towards a balance of provider burden and data collection efforts for quality, ensuring data adds

[12] COVID–19 Treatment Options, *https://www.cdc.gov/covid/treatment/index.html.*

value to its program and advances health care.

Many commenters in support of removing the four SDOH data elements noted that these SDOH data are important to patient outcomes and continue to be a priority among IRFs. They stated, however, this information is already part of the best practices for discharge planning, used for uncovering barriers to a safe transition and preventing readmissions. Several of these commenters believed that most IRFs already collect these elements and signaled they will continue to do so as they find it beneficial to their patient population, if they need it to meet accreditation standards, such as The Joint Commission, and for internal quality improvement efforts and population health initiatives. By removing the four SDOH data elements from the IRF QRP, this commenter asserted that we are preserving flexibility in IRFs addressing risk factors in ways that are more clinically relevant.

Response: We thank commenters for their support. We continue to monitor the IRF QRP data collection requirements to look for ways to reduce the administrative burden where appropriate while maintaining a high standard of quality care. We agree that removing these particular items at this time will alleviate some of the burden on providers associated with IRF QRP data collection and submission. We intend to align the IRF QRP more closely with CMS's overarching goal for improved healthcare delivery through health IT advances and less burdensome interoperable electronic systems. As we stated in the proposed rule (90 FR 18534), we plan to refocus efforts on how data elements can improve care coordination, efficiency, reduction in errors, and patient experience.

Additionally, we acknowledge that many IRF providers have already been tracking SDOH. We agree that collecting this information is beneficial for IRFs regardless of the requirements of the IRF QRP, as it facilitates discharge planning and contributes to quality improvement as well as accreditation efforts.

Comment: A few commenters support removal of the four SDOH data elements from the IRF–PAI because they are not currently used in any quality measures or risk adjustment models, or being utilized by CMS in an actionable way, and their collection is therefore an unnecessary burden on IRFs participating in the QRP. A few other commenters stated there was no clear evidence that collecting these items has led to measurable improvements in care transitions or outcomes in the IRF setting.

Response: Regarding the comments stating that the data elements have not been utilized by CMS in an actionable way, we wish to clarify that IRFs have not begun any data collection on the SDOH data elements for the IRF QRP. While we finalized the adoption of the four SDOH data elements in the FY 2025 IRF PPS final rule, IRFs would have been required to report these data elements using the IRF–PAI beginning with patients discharged on or after October 1, 2026 (89 FR 64326 through 64327).

Regarding comments about evidence for measurable improvements in case transitions or outcomes in the IRF setting, while we are not aware of evidence in the IRF setting at this time, we will continue to monitor this topic as we consider future data elements in the IRF QRP. In response to the comments about the SDOH data elements not being used in quality measures or for risk adjustment, we note that the IRF QRP requires data collections that are not strictly limited to quality measures or risk adjustment. Section 1886(j)(7)(F)(ii) of the Act requires IRFs to submit standardized patient assessment data required under section 1899B(b)(1) of the Act.

Comment: Many commenters were opposed to CMS's proposal to remove the four SDOH data elements from the IRF–PAI and urged CMS to reconsider the proposal. These commenters believe that this data adds value to IRFs, citing existing literature on how SDOH improves health outcomes and how this information facilitates discharge planning by providing a proactive approach to risks and earlier intervention. The commenters felt that clinical care provided by the IRF can be undermined when basic needs are not met. A few commenters noted that these items can help reduce healthcare costs by allowing IRFs to address these factors as part of a comprehensive and preventative approach to care. Other commenters stated the SDOH data elements were particularly important in caring for patients with complex or chronic conditions and geriatric patients, and that the data can help reduce hospital readmissions, emergency department visits and hospitalizations when paired with interventions and community support services. Two commenters further stated that understanding SDOH factors can illuminate drivers behind poor patient outcomes and supports efforts towards finding evidence-based, measurable solutions to differences in health care among certain populations.

Response: We appreciate commenters' concerns and feedback regarding the importance of collecting these SDOH data elements from IRF patients to capture and address unmet needs and particularly highlighting their importance for complex patient populations such as those with chronic conditions and geriatric patients. We acknowledge commenters' experiences using SDOH data to monitor and improve health care outcomes may be different for those experiencing unstable housing, food insecurity or challenges paying utilities, and recognize feedback from some commenters stating that they currently collect and will continue to collect this information.

However, in reviewing the data collection and reporting requirements for the FY 2028 IRF QRP, we determined that these SDOH items should be removed from the IRF–PAI prior to the start of data collection and submission. We have re-evaluated the value of adding these SDOH items for the purposes of the IRF QRP against their burden at this time. Collecting these SDOH items is not a one-time task but an ongoing requirement for every IRF patient admitted to the facility if the items became part of the IRF QRP.

We considered that IRFs have not yet begun to report these data, that we do not currently use these items in the IRF QRP for measures or risk adjustment, and that these SDOH items are not clinical items related to direct patient care while a patient is admitted to an IRF. We also have refocused our efforts on modernization of health care and health care systems which may support a less burdensome way of collecting SDOH items in the future. We continuously review and reassess the balance of data collection and IRF provider burden for the IRF QRP, and at this time determined these SDOH items should be removed prior to implementation.

The objectives of the IRF QRP continue to be the improvement of care, quality and health outcomes for all patients through transparency and quality measurement, while balancing burden for IRF providers. As outlined in our request for information in the FY 2026 IRF PPS proposed rule (90 FR 18554), we are refocusing our efforts to include ways for data elements, such as those related to SDOH, being part of a less burdensome, more streamlined, and interoperable electronic system. Given these administrative goals and efforts to reduce burden for IRFs, we do not believe that the value of collecting SDOH data elements via the IRF–PAI outweighs the cost and burden of collecting them at this time.

At this time, we believe that halting the implementation of the four SDOH items prior to their being added to the IRF–PAI on October 1, 2025, removes the burden these data collection and submission requirements would impose on IRFs. While we understand some IRFs may have taken time and resources to build technical infrastructure to collect these items, this accounts for only a portion of the overall cost we considered when evaluating whether to remove the SDOH items from the IRF–PAI at this time. Once implementation occurred, IRFs would need to engage in training activities, continuous data collection and submission to CMS, reviews of the guidance manuals, and other implementation tasks. To the extent IRFs may find collecting this or similar information from their patients helpful, including those patients with complex or chronic conditions and geriatric patients, the removal of collecting and reporting this information to CMS to comply with IRF QRP requirements does not, in any way, preclude IRFs from collecting and using this information on their own.

Comment: A few commenters stated that, while some IRFs may already collect this information for discharge planning purposes, they believe standardized items on the IRF–PAI improve consistency and support IRF providers in administering a comprehensive plan of care in accordance with CMS's regulation. These commenters stated that IRFs do not have coverage criteria like other post-acute care settings that make this data collection redundant. A few commenters also state that the cost and burden does not meaningfully outweigh the value of collecting this information, which includes being able to more accurately measure the quality of care in IRFs by determining whether the influence of poor outcomes is through factors outside the influence of the IRF. One commenter stated that assessing SDOH for patients improves coordination between facilities and community care providers ensuring that Medicare dollars are spent efficiently and facilitating high quality care across settings. Another commenter cited that this data collection can facilitate meaningful partnerships with community-based organizations that are needed to improve outcomes for patients. Another commenter noted that value-based care can only be achieved when nonmedical factors are taken into account to inform the cost and outcomes of care.

Response: We acknowledge the value that commenters ascribe to the collection of this information for discharge planning and care coordination, and commenters' experiences with improving outcomes and facilitating high quality care. We intend to work towards the workflow and data exchange for data elements being part of a less burdensome interoperable electronic system, to improve care coordination, efficiency, reduction in errors and patient experience. In response to commenters concerned about a lack of standardization among IRFs in administering a comprehensive plan of care that includes information about unmet needs outside of the facility, we acknowledge these concerns but reiterate that our renewed focus on interoperable electronic systems and modernizations to health IT will streamline data standardization and do so in a way that is less burdensome on IRFs and their staff. Although we will no longer require that IRFs collect and submit these four items to CMS using the IRF–PAI, IRFs can still collect and use SDOH information to support a comprehensive plan of care that includes these and other unmet needs.

By streamlining the number of data elements required for reporting under the IRF QRP, IRFs can focus efforts and resources to address the quality issues that matter most to their patients. As we stated in the FY 2026 IRF PPS proposed rule (90 FR 18553), we are soliciting comment on measurement concepts that address patient well-being while more appropriately reflecting factors that are within practitioners' and facilities' scope of care or where practitioners can provide actionable care that will help reduce the prevalence of chronic diseases, including nutrition, increased adherence to expected daily thresholds for physical activity, minimization of chronic stressors, and improvements in mental health. We would also like to acknowledge that implementation efforts to collect and submit any data elements for the purposes of meeting IRF QRP requirements comes with inherent burden on IRF providers, particularly new data elements since they involve adjustments to health IT systems and EHRs, IRF provider workflows, and staff training. We are always reviewing and reassessing this balance of data collection and IRF provider burden for the IRF QRP, striving to balance that burden with the value of measuring the quality of care that patients receive. As we are finalizing our proposal, removal of these four data elements from the IRF–PAI means IRFs would not need to submit this information to meet requirements of the IRF QRP and that resources can be distributed toward efforts to improve or enhance clinical care, health IT, or other areas as determined by the IRF.

Regarding the commenters' statement that IRFs do not have coverage criteria like other post-acute care settings that make this data collection redundant, we do believe that IRFs collect information that informs care coordination and discharge planning. For instance, IRFs are required by our regulation at § 482.43(a) to identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients.

Comment: One commenter stated that CMS provided extensive support and rationale for adopting these four data elements in the FY 2025 IRF PPS final rule, developing a policy that was well-vetted and examined in detail. This commenter asserted that CMS has not provided any reasoning or explanation in our proposal in the FY 2026 IPF PPS proposed rule as to why these are no longer important or how circumstances have changed to necessitate their removal. Other commenters believed that removal of these data elements prior to implementation is premature and that keeping them would support alignment of payment, data and accountability mechanisms to improve care.

Response: In response to comments requesting a rationale for this policy, in the proposed rule, we explained that the removal of these items is a result of our focus on balancing the need for data collections regarding quality care and the burden of these data collections on IRF providers at this time (90 FR 18551). We would also like to reiterate that IRFs and their staff independently may determine to screen their patients for factors that may affect their clinical decision-making and discharge planning, even in the absence of a reporting requirement. We did not intend to suggest with our proposal to remove these items from the IRF QRP means that IRFs should cease collecting this or similar information for their own purposes, such as the development of a discharge plan. Rather, we are removing the four SDOH items from the IRF–PAI to reduce the burden of data collection and submission for the IRF QRP. Reducing the burden of IRF QRP requirements would enable IRFs and their staff to focus their efforts on clinical decision making by preserving clinicians' flexibility to address social risk factors in other ways that are tailored to the needs of and make the most sense for their resident

populations. As noted, we are always considering the balance of burden against data collection and submission and for these SDOH data elements, we reconsidered the value for the purposes of the IRF QRP against their burden at this time. We specifically considered that these items are not clinical in nature. While these items inform clinical decisions and resource allocation after discharge, they are not factors within the scope of care of an IRF and its staff while the patient is still admitted to an IRF. Furthermore, if maintained on the IRF–PAI, there was currently no use for these data elements in risk adjustment models, reporting of IRF measure results, or the development of new quality measures. We proposed removal of the four SDOH data elements from the IRF–PAI because IRFs have not started data collection for these data elements yet, we are not utilizing the information for any purpose at this time, and there is an agency-wide refocusing on modernization of health care and health care systems in interoperability and on engaging IRF providers with these health IT efforts . We are working towards developing less burdensome data collection methods as we believe leveraging technological advances and data modernization can streamline standardization of the IRF–PAI in ways that support interoperable patient data and reduce time spent collecting this data by IRFs and their staff. We strive to collaborate with IRF providers in these efforts as exhibited in our request for information on advancing digital quality measurement (dQM) in the FY 2026 IRF PPS proposed rule (90 FR 18554). This collaboration includes reducing the burden of paperwork for participating in the IRF QRP, where possible, to support IRF providers in moving towards health data technology and interoperability that promotes spending more time with patients. IRFs are welcome to continue collecting this information to inform care coordination and discharge planning.

Comment: Many commenters believe the elements provide important insights into housing, food, and utility insecurity, which affect patient outcomes and that removing these SDOH items is counter to national efforts aimed at improving health outcomes, including current CMS agency goals related to the development of patient nutrition, physical activity, and well-being measures. The commenters cited that the SDOH items could be utilized to support the Make America Healthy Again initiative's core mission of a more efficient, prevention-focused healthcare system which can be achieved through early identification of risks and treatment of expensive but preventable complications.

Response: We disagree but understand why IRF providers believe that removing the four SDOH items is counter to our current goals and initiatives aimed at improving health outcomes, including Make America Healthy Again initiative's core mission. In response to comments about the agency's goals related to nutrition and well-being, we do not believe these four SDOH items are the only foundational items that can be included for future measure development related to nutrition or other measure concepts that support the agency's goals. Please see where we described in our request for information on a future measure concept of nutrition in the FY 2026 IRF PPS proposed rule (90 FR 18553). As we finalized in the FY 2025 IRF PPS final rule (89 FR 64314), the two Food items (R0320A and R0320B) each assess one particular aspect of nutrition: for example, food availability and food security. These items do not encompass other relevant, meaningful information to improve patients' health outcomes, including healthy nutrition, sleep, and physical activity levels. In addition, we believe there are existing data elements on the IRF–PAI that could support the development of measure concepts we are considering in the future. For example, the IRF–PAI includes nutrition items in Section K of the IRF–PAI. To reiterate, we are currently removing these SDOH items to refocus efforts and resources towards a less burdensome interoperable system for IRFs participating in the IRF QRP. The existing IRF–PAI items, such as the standardized patient assessment data elements in Section K regarding Nutritional Approach (*e.g.,* Parenteral/IV Feeding, Feeding Tube, Mechanically Altered Diet, Therapeutic Diet) that were finalized in the FY 2020 IRF PPS final rule (84 FR 39136 through 39140), provide a foundation for building out nutrition measures.

We are soliciting comments on ways to improve patient well-being across the Medicare program and remains committed to identifying the needs of patients and supporting IRFs in addressing those risks in a way that best accounts for patients' clinical circumstances with minimal burden. We remain committed to supporting providers in addressing health risks and needs of at-risk populations such as those experiencing challenges with maintaining healthy nutrition and physical activity levels and managing or improving chronic stressors, mental health concerns, and chronic diseases.

Comment: A few commenters were concerned that many healthcare facilities across the country have already made substantial investments to incorporate the screening of these SDOH data elements into setting up systems, EHRs, and workflows. These commenters believed that this would amount to more than ongoing implementation costs, and that hospitals and other settings expecting to report these data elements have already expended the necessary resources to set up their systems and referral programs. These commenters stated that removing these measures does not negate their prior investments and may result in additional resources to rework their systems.

Response: We acknowledge the commenters' concerns and understand the time and resources that IRFs may have spent on anticipating for the requirement to collect these data elements as part of the IRF QRP. Since the inception and initial development of the IRF QRP, interested parties have requested we provide draft specifications for the upcoming release of the revised IRF–PAI earlier and earlier. We have been responsive to this request and aim to provide as much information as possible when that information is available. For our proposal to remove the four SDOH items, we posted two sets of draft IRF–PAI data specifications so IRFs and their staff could understand what would need to be done if the proposal was finalized. However, we would like to emphasize that the information released in these draft IRF–PAI specification files are not final, and that the IRF–PAI specifications cannot be finalized until CMS policies are finalized after the final rule is released. The time and resources spent to build technical infrastructure accounts for only a portion of the overall cost, which also includes training activities, data collection, reviews of the guidance manuals, and other implementation tasks. As a result, we believe removing these items before data collection begins will still save IRF providers time, money, and resources.

After consideration of the public comments, we are finalizing our proposal to remove four standardized patient assessment data elements (one item for Living Situation (R0310); two items for Food (R0320A and R0320B); and one item for Utilities (R0330)) collected under the SDOH category from the IRF QRP beginning with the FY 2028 IRF QRP.

E. Amend the Reconsideration Request Policy and Process

1. Background

In the FY 2014 IRF PPS final rule (78 FR 47919), we finalized the IRF QRP Reconsideration policy and process whereby an IRF may request reconsideration of an initial determination that the IRF did not comply with the IRF QRP reporting requirements, warranting the reduction of the IRF's annual payment update by 2 percent for the applicable fiscal year as required by section 1886(j)(7)(A)(i) of the Act. In that rule, we stated that the IRF may file a request for reconsideration if they believe that the finding of non-compliance is erroneous, or if they were non-compliant, they have a valid and justifiable excuse for this non-compliance (78 FR 47919). We further stated that, after we review the request for reconsideration, we may reverse our initial finding of non-compliance if: (1) the IRF provides proof of compliance with all requirements during the reporting period; or (2) the IRF provides adequate proof of a valid or justifiable excuse for non-compliance if the IRF was not able to comply with requirements during the reporting period (78 FR 47919). Finally, we stated that we will uphold an initial finding of non-compliance if the IRF cannot show any justification for non-compliance (78 FR 47919).

In the FY 2015 IRF PPS final rule (79 FR 45918 and 45919), we finalized amendments to the IRF QRP reconsideration policy and process. Specifically, we stated that each IRF would receive a notification of noncompliance with IRF QRP requirements if we determine it had not correctly submitted data with respect to the applicable fiscal year (79 FR 45919). Then, the IRF would have 30 days from the date of our initial notification of noncompliance to submit a request for reconsideration via email. We also provided that, in very limited circumstances, we may grant a request by an IRF to extend the deadline to submit its reconsideration request, so long as the IRF requested the extension and demonstrated that extenuating circumstances existed that prevented it filing a reconsideration request by the 30-day deadline (79 FR 45919). Finally, we provided that, as part of its reconsideration request, the IRF must submit all supporting documentation and evidence demonstrating: (1) full compliance with all IRF QRP reporting requirements during the reporting period; or (2) extenuating circumstances that affected noncompliance if the IRF was not able to comply with the requirements during the reporting period (79 FR 45919). We stated that we would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request (79 FR 45919).

In the FY 2016 IRF PPS final rule (80 FR 47138), we codified the reconsideration policy and process for the IRF QRP at § 412.634(d). In subsequent rulemaking, we have amended our reconsideration policy and process at § 412.634(d) for minor clarifications and technical updates (FY 2019 IRF PPS final rule (83 FR 38561 and 62 and 83 FR 38573) and FY 2020 IRF PPS final rule (84 FR 39161 and 39172 through 73)). As codified, our regulation at § 412.634(d) addresses how we send our written notification of noncompliance to an IRF, the process for an IRF to request reconsideration, what information an IRF must include with its reconsideration request (for example, documentation that demonstrates the IRF's compliance with IRF QRP requirements), and how we notify the IRF of our final decision regarding its reconsideration request.

We have become aware that there are inconsistencies in our preamble and regulation text regarding IRF requests for reconsideration. On this basis, in this proposed rule, we seek to clarify these areas.

2. Allowing IRFs To Request an Extension To File a Request for Reconsideration

As noted previously, in the FY 2015 IRF PPS final rule (79 FR 45918 and 45919), we provided that, in very limited circumstances, we may grant a request by an IRF to extend the deadline to submit its reconsideration request, so long as the IRF requested the extension and demonstrated that extenuating circumstances existed that prevented it filing a reconsideration request by the 30-day deadline (79 FR 45919). We did not codify this policy—permitting IRFs to request an extension to file their reconsideration request—in our regulation text at § 412.634(d). In implementing this finalized policy, we have noted two areas where further clarity would be beneficial to IRFs.

First, we have not clearly defined or explained the term ''extenuating circumstances'' as used in our reconsideration policy. In contrast, we use the term ''extraordinary circumstances'' in our Extraordinary Circumstances Exception and Extension (ECE) policy, as codified at § 412.634(c). We did explain ''extraordinary circumstances'' in detail when we originally finalized this ECE policy in the FY 2014 IRF PPS final rule (78 FR 47920).

On this basis, we proposed to remove the term ''extenuating circumstances'' as used currently in our reconsideration policy and replace it with ''extraordinary circumstances.'' Specifically, we proposed that an IRF may request, and CMS may grant, an extension to file a reconsideration request if the IRF was affected by an extraordinary circumstance beyond the control of the IRF (for example, a natural or man-made disaster). By modifying the basis by which an IRF may request an extension to file a reconsideration request in this manner, we also proposed to incorporate our prior explanation regarding the meaning of extraordinary circumstances, as set forth in the FY 2014 IRF PPS final rule (78 FR 47920) as part of our Extraordinary Circumstance Exception and Extension (ECE) policy. Second, we have noted some areas in our policy where IRFs may benefit from clearly demarcated deadlines. Although we believe an IRF would have an interest in asking for an extension to file a reconsideration request prior to the deadline, our policy currently does not specify a deadline for an IRF to submit its request for such an extension (78 FR 47919). Our policy also provides that, to support such request, the IRF must demonstrate that extenuating circumstances existed that prevented filing the reconsideration request by the 30-day deadline (78 FR 47919). However, we have not specified a temporal relationship between when the extenuating circumstances occurred and the reconsideration request deadline. We believe IRFs may benefit from further specificity regarding these requirements for submitting a request to extend the deadline to file a reconsideration request.

On this basis, we proposed to amend our reconsideration policy as codified at § 412.634(d) to permit a IRF to request, and CMS to grant, an extension to file a request for reconsideration of a noncompliance determination if, during the period to request a reconsideration as set forth in § 412.634(d), the IRF was affected by an extraordinary circumstance beyond the control of the IRF (for example, a natural or man-made disaster). We proposed that the IRF must submit its request for an extension to file a reconsideration request to CMS via email no later than 30 calendar days from the date of the written notification of noncompliance. We proposed that the IRF's extension request, submitted to CMS, must contain all of the following information: (1) the CCN for the IRF; (2) the business name of the IRF; (3) the

business address of the IRF; (4) certain contact information for the IRF's chief executive officer or designated personnel; (5) a statement of the reason for the request for the extension; and (6) evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media. We proposed to codify this process at § 412.634(d)(6).

We further proposed that CMS notify the IRF in writing of its final decision regarding its request for an extension to file a reconsideration of a noncompliance request via an email from CMS. We proposed to notify the IRF in writing via email because this will allow for more expedient correspondence with the IRF, given the 30-day reconsideration timeframe. We proposed to codify this process at § 412.634(d)(7).

We note that we considered proposing similar modifications across all post-acute care setting quality reporting programs to more closely align the reconsideration processes.

We invited comments on these proposals to amend the IRF QRP Reconsideration policy to permit IRFs to request an extension to file a reconsideration request and to codify this proposed policy and process at § 412.634(d)(6) and (d)(7). The following is a summary of the public comments received on the proposal to amend the IRF QRP Reconsideration policy:

Comment: We received a few comments in support of the proposal to amend the Reconsideration Request Policy and process, citing that these changes better define the process and timelines for reconsideration requests as well as noting CMS's recognition that extraordinary circumstances may inhibit the ability of IRFs to file reconsideration requests.

Response: We thank commenters for their support.

Comment: A couple of commenters voiced concerns regarding the feasibility of shortening the request timeframe to 30 days. One of these commenters supported CMS's proposal to modify the ECE policy to give the agency more flexibility in granting reporting extensions. However, this commenter opposed a 30-day request window and suggested that CMS should set the minimum timeframe to no less than 60 days. Another of these commenters urged CMS to maintain the existing exception or extension submission timeline of ''within ninety (90) days of the event'' for extraordinary circumstances.

Response: We appreciate the commenters' concerns and recommendations. However, we wish to clarify that the proposed policies do not modify either of these deadlines but specifically address the annual Reconsideration Request timeline. This policy establishes that providers impacted by an extraordinary circumstance within the reconsideration time frame will have 30 days to request an extension to file their reconsideration request after receipt of the initial notice of noncompliance for a given fiscal year annual payment update. IRFs still have 90 days to submit an exception and extension request from the time of an event occurring due to extraordinary circumstances, and 30 days from the initial notification of noncompliance to submit a request for reconsideration. Because our policy, as finalized in the FY 2014 IRF PPS final rule (78 FR 47919) does not specify a deadline for an IRF to submit its request for such an extension during the reconsideration period, we are providing a clear timeframe of 30 days for this process.

Comment: One commenter noted it is unclear how long it typically takes for a decision to be issued following the submission of a request for reconsideration and clearer guidance should be provided on the expected timeline for CMS's response to such requests.

Response: There is currently no fixed timeframe for CMS to make a determination on a request for reconsideration. Submissions are thoroughly reviewed, and determinations are made as promptly as possible. We understand the payment implications that a determination of non-compliance can have on an IRF and perform all due diligence when making such determinations.

Comment: Several commenters expressed support for amending and clarifying the definition of extraordinary circumstances and appreciated CMS's efforts to improve policy clarity but had concerns about the definition of ''extraordinary circumstances.'' A few of these commenters asked whether significant staffing shortages or cybersecurity issues would be included in the definition, citing that they believed these are currently included in the definition of ''extenuating circumstances.'' A few commenters recommended that CMS include EHR down time, including those as a result of cyberattacks and vendor outages, in the definition of extraordinary circumstances.

Response: As stated in the proposed rule, we define extraordinary circumstances as ''events beyond the control of the IRF (for example, a natural or man-made disaster)'' (90 FR 18551). While we recognize that events like cyberattacks or EHR outages may disrupt operations, the agency expects providers to maintain contingency plans to mitigate such risks regarding patients' personal health information. As such, these events are not automatically considered extraordinary circumstances. This is also the case for staffing shortages as facilities are responsible for ensuring adequate and safe staffing. However, we evaluate each request on a case-by-case basis and will consider whether certain situations can qualify as an ''extraordinary circumstance.''

Comment: A couple commenters expressed concern about CMS's proposed change from ''extenuating circumstances'' to ''extraordinary circumstances.'' They requested more information on the implications of this terminology shift and emphasized the need for consistent application that fully considers situations beyond IRF's control. They also sought clarification on whether the threshold for reconsideration would change under the new definition.

Response: We appreciate the commenters' concerns about the historical use of the term ''extenuating circumstances'' in prior rulemaking. identified inconsistencies between regulatory text and preamble language and our intent is to clarify and standardize the reconsideration process by defining and consistently applying the term ''extraordinary circumstances'' to refer to events beyond the IRF's control (for example, natural or man-made disasters). This clarification ensures a single, clear standard and promotes consistency and transparency moving forward. This approach aligns with policies used in other CMS quality reporting programs. We remain committed to reviewing documentation on a case-by-case basis and will continue to consider all relevant evidence demonstrating that circumstances outside of the IRF's control impacted data reporting.

Comment: A few commenters supported the proposed change but urged CMS to issue sub-regulatory guidance to clarify expectations and documentation requirements, emphasizing that clear and timely guidance is essential to prevent financial harm to IRFs and protect patient access to care.

Response: We appreciate the commenters' support for the proposed change and their emphasis on the importance of clear guidance, especially given commenters' concerns for the potential implications for IRFs' financial stability and patient access to care. The intent behind codifying the term ''extraordinary circumstances'' is to

establish a single, consistent and clearly defined standard for reconsideration requests. To support this, we outline expectations for documentation and qualifying circumstances in both the regulatory text and preamble of this final rule. Additional guidance is also available on CMS's Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Reconsideration and Exception & Extension web page,[13] which will be uploaded to reflect the policies and new regulations finalized in this rule. CMS believes these resources provide adequate guidance and encourage IRFs to consult them when preparing reconsideration requests.

Comment: Several commenters opposed CMS's proposal to replace the ''extenuating circumstances'' standard, which includes a valid and justifiable excuse for noncompliance, with what they believed to be a more restrictive ''extraordinary circumstances'' threshold. These commenters stated that the existing standard provides essential flexibility and better reflects the complex realities providers face. They expressed concern that codifying a narrower definition would raise the bar for relief, making it harder for IRFs to contest penalties, even in good faith situations. While some supported the proposal to allow reconsiderations deadline extensions, they stressed that this flexibility does not offset the risks of adopting a more rigid reconsideration standard.

Response: Regarding the commenters' recommendation to retain ''extenuating circumstances'' as the standard for granting reconsiderations extension requests, our goal is to align the reconsideration process with other post-acute quality reporting programs and reconsideration processes. We intend to remove the use of two separate terms and instead adopt a single, consistent standard, ''extraordinary circumstances'', to refer to events beyond the control of the IRF (for example, a natural or man-made disaster). The goal of this proposal is not to reduce flexibility but to clarify that this policy is only applicable in the case of an extraordinary circumstance beyond the control of an IRF, which aligns the IRF QRP policy with the LTCH QRP (90 FR 18350 through 18352) and SNF QRP (90 FR 18605 and 18606) proposals. We believe that the proposed standard provides more clarity about the circumstances that will be considered for a request for an extension to file a reconsideration request.

After consideration of the public comments, we are finalizing our proposal to amend the IRF QRP Reconsideration policy to permit IRFs to request an extension to file a reconsideration request and to codify this proposed policy and process at § 412.634(d)(6) and (d)(7).

3. Update to the Bases on Which CMS Can Grant a Reconsideration Request

As discussed previously, in the FY 2014 IRF PPS final rule, we stated that, after we review an IRF request for reconsideration, we may reverse our initial finding of non-compliance if: (1) the IRF provides proof of compliance with all requirements during the reporting period; or (2) the IRF provides adequate proof of a valid or justifiable excuse for non-compliance if the IRF was not able to comply with requirements during the reporting period (78 FR 47919). We also stated that we will uphold an initial finding of non-compliance if the IRF cannot show any justification for non-compliance (78 FR 47919).

In the FY 2015 IRF PPS final rule (79 FR 45918 and 45919), we reiterated this position, and provided that, as part of its reconsideration request, the IRF must submit all supporting documentation and evidence demonstrating: (1) full compliance with all IRF QRP reporting requirements during the reporting period; or (2) extenuating circumstances that affected noncompliance if the IRF was not able to comply with the requirements during the reporting period (79 FR 45919). We stated that we would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request (79 FR 45919).

As previously discussed, we codified our reconsideration policy at § 412.634(d) in the FY 2014 IRF PPS final rule (78 FR 47919). Our regulation at § 412.634(d)(3) requires that an IRF's request for reconsideration include accompanying documentation that demonstrates the IRF's compliance with the IRF QRP requirements. Then, we will notify the IRF in writing regarding our final decision on its reconsideration request (§ 412.634(d)(5)).

We believe it would be beneficial for IRFs if we codify our specific bases for granting a reconsideration request in our regulation at § 412.634(d).

On these bases, we proposed to modify our reconsideration policy to provide that we will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the IRF was in full compliance with the IRF QRP requirements for the applicable program year. We stated that we would consider full compliance with the IRF QRP requirements to include CMS granting an exception or extension to IRF QRP reporting requirements under our ECE policy at § 412.634(c). However, to demonstrate full compliance with our ECE policy, CMS stated that the IRF would need to comply with our ECE policy's requirements, including the specific scope of the exception or extension as granted by CMS.

We proposed to revise § 412.634 (d)(5) to codify this modified policy in our regulation. We proposed that the remainder of the text at § 412.634(d)(5) would remain the same. We noted that we considered proposing similar modifications across all post-acute care setting quality reporting programs to more closely align the reconsideration processes.

We invited comment on these proposals to amend the bases by which we grant a reconsideration request under the IRF QRP Reconsideration policy and to codify this proposed policy at § 412.634(d)(5).

We did not receive any comments on our proposal to update the bases on which CMS can grant a Reconsideration Request.

We are finalizing our proposal to amend the bases by which we grant a reconsideration request under the IRF QRP Reconsideration policy, and to codify this proposed policy at § 412.634(d)(5), with a minor technical modification to refer to the regulated entity in the singular instead of the plural form (that is, the IRF instead of IRFs).

F. IRF QRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI): Interoperability, Well-Being, Nutrition & Delirium

In the proposed rule, we sought input on the importance, relevance, appropriateness, and applicability of each of the quality measure concepts under consideration listed in Table 9 for future years in the IRF QRP. In the FY 2025 IRF PPS proposed rule (89 FR 22280 through 22281), we included a request for information (RFI) on a set of principles for selecting and prioritizing IRF QRP measures, identifying measurement gaps and suitable measures for filling these gaps. We refer readers to the FY 2025 IRF PPS final rule (89 FR 64323 and 64325) for a summary of the public comments we received in response to the RFI.

[13] Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Reconsideration and Exception & Extension. *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension.*

We sought input on four concepts for future measures for the IRF QRP. We refer readers to the FY 2026 IRF PPS proposed rule (90 FR 18552 through 18553) for a description of each of the quality measure concepts under consideration for this RFI.

TABLE 9—FUTURE MEASURE CONCEPTS UNDER CONSIDERATION FOR THE IRF QRP

Quality measure concepts
Interoperability.
Well-being.
Nutrition.
Delirium.

We received public comments on this RFI. The following is a summary of the comments we received:

1. Interoperability

Comments: A few commenters supported a measure of interoperability, saying that seamless exchange of information across care settings is critical for timely care and safety and improves care coordination and communication. Commenters also noted that the effort to capture the extent of adoption of these systems is a step towards encouraging interoperability. These commenters noted the importance of data collection and use, but some commenters suggested CMS focus on improving transparency in certified health IT and promoting standards-based data exchange.

Some commenters provided recommendations for CMS to consider on interoperability. One commenter suggested CMS collaborate with IRFs to ensure that any measures related to interoperability account for the differences between the data elements used in IRFs and those collected in other settings. Another commenter recommended the measure to be standard- based, outcome driven, and clinically meaningful when considering implementation of interoperability. Other commenters noted that there are two existing assessment-based quality measures related to interoperability that exist in IRFs already and are an indication of IRF readiness for interoperable data exchange.

Other commenters stated they were concerned about a measure of interoperability. One commenter stated that CMS has not supported IT systems in IRFs and has not provided financial support for it. Another commenter voiced their concerns about the measure, noting that there are differences in EHRs for acute care hospitals and IRFs.

2. Well-Being

Comments: A few commenters provided recommendations on the measure of well-being. One commenter recommended CMS to consider the quality measure Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (''Feeling Heard and Understood''). This is a performance measure (PRO–PM) that focuses on palliative care patients' experience. Another commenter recommended that the measure should reflect the amount of independence and physical activity achieved during the IRF stay, and ensure patients receive enough therapy to achieve the agency's goals on well-being. Another commenter recommended CMS to consider HR 6110, Access to Inpatient Rehabilitation Therapy Act of 2023 when considering the measure of well-being. Another commenter recommended CMS to consider using Person-Centered Outcome measures to promote a patient-centric approach to the measure. One commenter suggested CMS to be mindful of provider burden and encourages CMS to conduct a technical expert panel to consider the implementation of well-being measures.

Several commenters noted the importance of a well-being measure but also voiced concerns about the measure. Some commenters stated that well-being is a broad and difficult concept to define, while other commenters noted that it is challenging to determine well-being measurements and recommend CMS to identify tools related to well-being. A few commenters noted that well-being is already captured in existing measures and recommend avoiding duplication, which would be a new burden for staff. Another commenter noted that the measure must be validated, feasible to collect and sensitive to the IRF setting while one commenter recommends CMS to work closely with nurses for data collection.

Some commenters opposed a measure of well-being, saying that well-being is a general concept that is difficult to define and assess while others stated that this would be redundant, based on items currently on the IRF–PAI.

3. Nutrition

Comments: A few commenters supported a measure of nutrition, saying that malnutrition contributes to poor rehab outcomes and that a nutrition measure will be cost-effective and essential for improving clinical outcomes. Other commenters recommended CMS work closely with nurses for data collection and noted that nutrition is important and suggested patients should be provided with an individualized nutrition plan during their stay and at the time of discharge. A couple of commenters noted that the medical and therapeutic intervention provided in an IRF are promoting healthy eating habits, exercise, nutrition, or physical activity for optimal health and well-being.

A few commenters provided recommendations for the nutrition measure. One commenter recommended CMS collaborate with IRFs on the development of tools and measures appropriate to the setting to ensure there is no additional burden on staff and suggested CMS to work with the provider community on how to measure nutrition. Some commenters suggested that CMS focus on whether patients have the necessary information they need and have the support to address nutrition-related concerns, and a nutrition measure related to adequate nutrition and hydration in patients with feeding and swallowing disorders. Some commenters suggested that new measures should build on existing practices to avoid duplication or better suited as assessment items in the IRF–PAI than as a quality measure in the IRF QRP because the concept is not tied to the care patients receive in an IRF setting. Another commenter recommended the focus be on provision and documentation of patient education on nutrition while another commenter provided a list of principles for CMS to consider on nutrition including improving outcomes, meeting patient needs, screening intervals and duplication, and strength-based approach.

Some commenters voiced their concerns on the measure, noting that the additional requirement for data collection and documentation would be redundant and burdensome for staff while others stated that nutrition aspects are covered in existing measures or protocols.

4. Delirium

Comments: A few commenters were supportive of the measure but also provided recommendations on the process. A commenter voiced their support for a measure of delirium and recommended CMS to work closely with nurses for data collection and another commenter recommended CMS consider the use of nonpharmacological treatments for delirium such as caregiver training and staff education. They also shared a list to CMS on delirium severity measure assessment tools including Confusion Assessment Methods and Delirium-Ometer. Other commenters recommended CMS utilize

the ICD–10 in the IRF–PAI for delirium. Some commenters recommended the use of ICD–10 to evaluate delirium but suggest that the Signs and Symptoms of Delirium from the IRF–PAI assessment data elements be removed.

A few commenters suggested CMS consider the additional burden on providers to report the measure. Another commenter noted that delirium is not prevalent in IRFs and suggested the use of Signs and Symptoms of Delirium (from the Confusion Assessment Methods CAM©) to measure delirium.

A few commenters voiced their concerns about a delirium measure, stating that CMS should not develop a delirium measure as it is already collected through the IRF–PAI and will create additional burden on providers. Other commenters voiced similar concerns, noting that the prevalence of delirium in IRFs is low and that delirium is already reported in the IRF–PAI and that CMS should consider the potential additional burden of a new measure. One commenter had concerns about the measure stating that IRFs will have to be accountable for treatment of patients with delirium and recommended CMS to evaluate the efficacy of the measure and the inclusion to be endorsed by a Consensus-Based Entity.

5. Other Suggestions for Future Measure Concepts

Comments: In addition to comments received on the four measure concepts of interoperability, well-being, nutrition, and delirium, we also received comments on concerns and recommendations on future measure concepts in this RFI. One commenter recommended CMS to use measures in the Universal Foundation for the IRF QRP and noted that the measures benefit patient care while lowering provider reporting burden. A couple of commenters noted that the future measures should focus on data collection and reducing provider burden and recommended CMS to apply guiding principles including actionability, comprehensiveness, and conciseness to support finalizing new measures or making changes to existing measures. Another commenter suggested CMS to examine what data are already being collected, determine what data that is available, and provide transparency about the planned uses of the data collected. Finally, one commenter recommended CMS consider whether additional measures will contribute to improved outcomes as additional assessment requirements may compromise clinical efficiency.

Response: We thank all the commenters for responding to this RFI. While we are not responding to specific comments in response to the RFI in this final rule, we will take this feedback into consideration for our future measure development efforts for the IRF QRP.

G. Potential Future Revisions Under Consideration for the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI)—Request for Information (RFI)

1. Background

In the Fiscal Year (FY) 2002 IRF PPS final rule (66 FR 41324 through 41328), we finalized the use of the IRF–PAI, which IRFs must use to assess Medicare Part A Fee-for-Service (FFS) patients admitted to or discharged from an IRF. The FY 2010 IRF PPS final rule (74 FR 39762 and 39799) established the requirement to submit an IRF–PAI for each Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009. In the FY 2023 IRF PPS final rule (87 FR 47074 through 47082), CMS finalized that IRFs are required to report these data with respect to admission and discharge for all patients, regardless of payer, discharged on and after October 1, 2024. For each patient, an IRF must complete an IRF–PAI, as specified at §§ 412.606 and 412.610(c), and must transmit both the admission patient assessment and the discharge patient assessment at the same time to the CMS patient data system as described at § 412.614.

Unlike other Post Acute Care (PAC) settings, such as Skilled Nursing Facilities (SNFs) and Long-Term Care Hospitals (LTCHs), the IRF–PAI does not distinguish discharge types into unplanned, expired, and planned. SNFs and LTCHs do not need to submit certain assessment items depending on the type of discharge a patient has, decreasing the overall assessment submission burden.

Additionally, the IRF–PAI is now collected on all IRF patients, including pediatric patients. This RFI would seek feedback on the potential development of a pediatric assessment that would better measure the quality of care for that patient population.

2. Potential Future Revisions Under Consideration for the IRF–PAI To Reduce Burden and Streamline Data Collection for IRFs

We sought feedback on potential revisions to the IRF–PAI to reduce burden and streamline data collection for IRFs. Specifically, we sought input on the following questions:

- How can CMS increase clarity around the definition of an unplanned discharge and which items would be required for unplanned discharges? How would IRFs recommend CMS implement skip patterns for certain items depending on how an IRF patient is discharged?
- Should CMS consider a pediatric IRF–PAI assessment to reduce burden, streamline the assessment process, and focus on age-appropriate assessment items for the pediatric population?
- Are there other ways to revise the IRF–PAI to reduce burden and streamline data collection in IRFs?

The following is a summary of the comments we received:

Comments: We received many comments with input on the IRF QRP definition of an unplanned discharge, including the types of discharges that should align with the definition. A few commenters requested that CMS provide clear, detailed guidance on planned and unplanned discharges, including timeframes and scenarios. Many commenters stated that they did not support separating the IRF–PAI into multiple assessments but supported an approach that used skip logic to reduce burden in the case of an incomplete stay. One commenter suggested that the skip logic should include admission items in the event of an unplanned discharge within the first 3 days of the IRF stay. Several commenters provided recommendations for which items should be omitted in the event of an incomplete stay. A few commenters recommended that CMS convene a technical expert panel or reach out to a broad range of IRF providers, IRF–PAI coordinators, and interested parties before finalizing the definition.

Many commenters provided feedback about revising the IRF–PAI to reduce provider burden, including removing items they believe are duplicative, not applicable to IRF QRP quality measures, not impactful to patient care and planning, or not tied to payment. Several commenters provided suggestions for adding skip logic and modifying the IRF–PAI to streamline data collection. A few commenters recommended items that they don't believe need to be collected at multiple timepoints (for example, admission and discharge) to reduce burden. One commenter suggested extending the timeframes for the completion of items at admission and discharge.

Several commenters supported the consideration of a separate pediatric IRF–PAI assessment, citing that many items are not applicable to younger

patients. A few commenters made recommendations for existing data collection instruments that could be used for this purpose. However, a few commenters did not recommend a separate pediatric assessment and instead suggested that CMS use skip logic to reduce the number of items that are needed on the existing IRF–PAI.

A few commenters suggested removing the requirement to collect IRF–PAI data on all patients, regardless of payer.

Response: We thank the commenters for their input and recommendations. While we will not be responding to specific comments submitted in response to this RFI in this final rule, we intend to use this input to inform our future IRF–PAI development efforts.

H. Potential Revision of the Final Data Submission Deadline Period From 4.5 Months to 45 Days—Request for Information (RFI)

We requested feedback on this potential future reduction of the IRF QRP data submission deadline from 4.5 months to 45 days that are under consideration. We refer readers to the proposed rule for the full text of the RFI (90 FR 18553 and 18554). Specifically, we requested comment on:

- How this potential change could improve the timeliness and actionability of IRF QRP quality measures;
- How this potential change could improve public display of quality information; and
- How this potential change could impact IRF workflows or require updates to systems.

We noted in the proposed rule that we intend to use this input to inform our program improvement efforts. The following is a summary of the comments we received and our response.

Comments: Several commenters supported the reduction of the data submission timeframe, citing that most facilities already comply with this expectation. These commenters believed that timelier submission would improve the accuracy of the assessments and facilitate the communication of clinical feedback to IRFs more quickly. One commenter stated that a shortened timeframe will prove more value for consumers, professionals, and facilities. Two commenters stated that accelerated submission timelines ensure timely submission for payments, with several citing that most facilities already comply with this expectation.

Many commenters expressed concerns about a reduction in the data submission timeframe. Several cited increased provider burden as a key concern. These commenters noted that a reduced timeline could make it more difficult to meet data completion and accuracy thresholds within a shortened timeframe. Several commenters expressed concerns that there would be increased risk of compromised quality of data and a decrease in the number of completed assessments. Several commenters had concerns about the potential for increased compliance penalties. One commenter stated that the 1.6 percent of assessments submitted after the deadline could translate to hundreds of assessments statewide that might miss the cutoff and put hospitals at risk of noncompliance penalties. Another commenter stated that this reduced timeframe will result in fewer complete assessments, emphasizing that IRF–PAI assessments are not the only data required to report under the IRF QRP. Another commenter expressed concern over the limited technical capabilities and systems in IRFs, stating that it is unclear how shortening the reporting timeframe will increase compliance.

A few commenters were concerned about the effects on the quality of data submitted. One commenter believed that if IRFs are forced to prioritize speed over validation, there is a risk of increased data errors, missing information, or reduced staff engagement with meaningful quality improvement work. They believe that any gains in timeliness would be negated if the data reported is less reliable or actionable due to submission pressures. Another commenter was concerned that with the increase in discharges towards the end of the quarter, coding and clinical administrative staff would be strained to meet the mid-quarter deadlines and would have limited time for quality assurance checks. This commenter noted that IRFs often allow clinicians a reasonable period after discharge to complete and validate documentation, especially for complex cases or situations when therapists and physicians must collaborate on the final functional assessments. A 45-day deadline after the end of the quarter would force an accelerated timeline, potentially requiring staff to input and lock data very soon after discharge, which the commenter believed could compromise the quality of data. A few commenters believed that shortening the time frame could lead to reporting incorrect or misleading information on Care Compare.

Some commenters cited special circumstances that could delay reporting, including system outages or changes of ownership (CHOW) where a new owner must obtain access to the Internet Quality Improvement & Evaluation System (iQIES). Another commenter was concerned about the impact on IRFs with limited IT staff or those undergoing electronic health records (EHR) transitions. These circumstances would delay reporting and verification processes. Commenters expressed concern over the increased risk for small rural providers who have fewer staff dedicated to quality data management and may be at greater risk of missing the deadline and experiencing non-compliance penalties. A few commenters provided recommendations about other ways to reduce the timelines, including 60 or 90 days. A few other commenters recommended a phased implementation approach.

A few commenters recommended that CMS instead implement an expedited public reporting process, focusing on CMS's processing and public reporting timeline. They also suggested that CMS provide real-time feedback reports to IRFs to encourage ongoing data submission throughout the quarter. Another commenter recommended that CMS conduct additional analyses and solicit further input from facilities on what timeframe would strike the best balance of feasibility and timeliness. One commenter emphasized the importance of quality programs remaining in alignment with this revised timeframe.

Response: We appreciate the input provided by commenters. While we will not be responding to specific comments submitted in response to this RFI in this final rule, we intend to use this input to inform our program improvement efforts.

I. Advancing Digital Quality Measurement in the IRF QRP—Request for Information

As part of our effort to advance the digital quality measurement (dQM) transition, we issued this request for information (RFI) to gather broad public input on the dQM transition in IRFs.

1. Background

We are committed to improving healthcare quality through measurement, transparency, and public reporting of quality data, and to enhancing healthcare data exchange by promoting the adoption of interoperable health IT) that enables information exchange using Fast Healthcare Interoperability Resources® (FHIR®) standards. Proposing to require the use of such technology within the IRF QRP in the future could potentially enable greater care coordination and information sharing, which is essential

for delivering high-quality, efficient care and better outcomes at a lower cost (86 FR 25615). In the fiscal years 2020, 2021, 2022, and 2023 IRF PPS proposed rules,[14] we outlined several Department of Health and Human Services (HHS) initiatives aimed at promoting the adoption of interoperable health IT and facilitating nationwide health information exchange. Further, to inform our digital strategy, in the FY 2022 IRF PPS proposed rule (86 FR 25615), we shared and sought feedback on the following:

- Our intent is to explore the use of FHIR®-based standards to exchange clinical information through application programming interfaces (APIs).
- Enabling quality data submission to CMS through our internet Quality Improvement and Evaluation System (iQIES).
- To work with healthcare standards organizations to ensure their standards support our assessment tools.

We considered opportunities to advance FHIR®-based reporting of patient assessment data for the submission of the IRF–PAI and other existing systems such as the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for which IRFs have current CMS reporting requirements. Our objective is to explore how IRFs typically integrate technologies with varying complexity into existing systems and how this affects IRF workflows. In this RFI, we sought to identify the challenges and/or opportunities that may arise during this integration, and determine the support needed to complete and submit quality data in ways that protect and enhance care delivery.

We also sought input on future measures under consideration including applicability of interoperability as a future measure concept in post-acute care settings, including the IRF QRP. Refer to section VII.E. of the proposed rule for more information.

Any updates specific to the IRF QRP program requirements related to quality measurement and reporting provisions would be addressed through separate and future notice-and-comment rulemaking, as necessary.

2. Solicitation for Comment

We sought feedback on the current state of health IT use, including electronic health records (EHRs), in IRF facilities:

- To what extent does your IRF use health IT systems to maintain and exchange patient records? If your facility has transitioned to using electronic records, in part or in whole, what types of health IT does your IRF use to maintain patient records? Are these health IT systems certified under the Office of the National Coordinator for Health Information Technology (ONC Health IT) Certification Program? If your facility uses health, IT products or systems that are not certified under the ONC Health IT Certification Program, please specify. Does your facility use EHRs or other health IT products or systems that are not certified under the ONC Health IT Certification Program? If no, what is the reason for not doing so? Do these other systems exchange data using standards and implementation specifications adopted by HHS? Does your facility maintain any patient records outside of these electronic systems? If so, are the data organized in a structured format, using codes and recognized standards, that can be exchanged with other systems and providers?
- Does your IRF submit patient assessment data to CMS directly from your health IT system without the assistance of a third-party intermediary? If a third-party intermediary is used to report data, what type of intermediary service is used? How does your facility currently exchange health information with other healthcare providers or systems, specifically between IRFs and other provider types? What about health information exchange with other entities, such as public health agencies? What challenges do you face with electronic exchange of health information?
- Are there any challenges with your current electronic devices (for example, tablets, smartphones, computers) that hinder the ability to easily exchange information across systems? Please describe any specific issues you encounter. Does limited internet or lack of internet connectivity impact your ability to exchange data with other healthcare providers, including community-based care services, or your ability to submit patient assessment data to CMS? Please specify.
- What steps does your IRF take with respect to the implementation of health IT systems to ensure compliance with applicable security and patient privacy requirements such as HIPAA?
- Does your IRF refer to the Safety Assurance Factors for EHR Resilience (SAFER) Guides (see newly revised versions published in January 2025 at *https://www.healthit.gov/topic/safety/safer-guides*) to self-assess EHR safety practices?
- What challenges or barriers does your facility encounter when submitting quality measure data to CMS as part of the IRF QRP? What opportunities or factors could improve your facility's successful data submission to CMS?
- What types of technical assistance guidance, workforce trainings, and/or other resources would be most beneficial for the implementation of FHIR®-based technology in your facility for the submission of the IRF–PAI to CMS and other existing systems such as CDC's National Healthcare Safety Network (NHSN) for which IRFs have current CMS reporting requirements? What strategies can CMS, HHS, or other Federal partners take to ensure that technical assistance is both comprehensive and user-friendly? How could Quality Improvement Organizations (QIOs) or other entities enhance this support?
- Is your facility using technology that utilizes APIs based on the FHIR® standard to enable electronic data sharing? If so, with whom are you sharing data using the FHIR® standard and for what purpose(s)? For example, have you used FHIR® APIs to share data with public health agencies? Does your facility use any Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR® applications? If so, are the SMART on FHIR® applications integrated with your EHR or other health IT?
- How do you anticipate the adoption of technology using FHIR®-based APIs to facilitate the reporting of patient assessment data that could impact provider workflows? What impact, if any, do you anticipate it will have on quality of care?
- What benefits or challenges have you experienced with implementing technology that uses FHIR®-based APIs? How can adopting technology that uses FHIR®-based APIs to facilitate the reporting of patient assessment data impact provider workflows? What impact, if any, does adopting this technology have on quality of care?
- Does your facility have any experience using technology that shares electronic health information using one or more versions of the United States Core Data for Interoperability (USCDI) standard? [15]
- Would your IRF and/or vendors be interested in participating in testing to explore options for transmission of assessments, for example testing the

[14] ''Advancing Health Information Exchange'' in: FY 2020 IRF PPS proposed rule (84 FR 19170), FY 2021 IRF PPS proposed rule (85 FR 32470), FY 2022 IRF PPS proposed rule (86 FR 25085), and FY 2023 IRF PPS proposed rule (87 FR 28122).

[15] For more information about USCDI see *https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.*

transmission of a FHIR®-based assessment to CMS?

- How could the Trusted Exchange Framework and Common Agreement™ (TEFCA™) support CMS quality programs' adoption of FHIR®-based assessment submissions consistent with the FHIR® Roadmap (available here: *https://rce.sequoiaproject.org/three-year-fhir-roadmap-for-tefca/*)? How might patient assessment data hold secondary uses for treatment or other TEFCA exchange purposes?
- What other information should we consider facilitating successful adoption and integration of FHIR®-based technologies and standardized data for patient assessment instruments like the IRF–PAI? We invite any feedback, suggestions, best practices, or success stories related to the implementation of these technologies.

We invited feedback, suggestions, best practices, or success stories related to the implementation of these technologies. We noted in the proposed rule that we will use this input to inform our future dQM transition efforts. The following is a summary of the comments we received and our response.

Comments: Many commenters expressed support for a transition to dQMs in the IRF QRP, citing that using FHIR as a standard can alleviate administrative burden and data quality. Many of these commenters supported the transition but had recommendations for CMS on successful implementation for IRFs, including a phased implementation or ''glide path'' approach, reporting flexibility, and more time to update systems after CMS finalizes a change to QRP requirements. One commenter encouraged CMS to work with QIOs, EHR vendors and third-party intermediaries to develop standard protocols for integration. Many commenters also requested robust technical assistance and clear implementation guides for any new dQM requirements.

Several commenters recommended funding or incentive opportunities to obtain resources and technology for improved exchange of health information. A few commenters noted that implementation and updating EHRs is resource intensive, and that IRFs, along with other PAC providers, were not included in Meaningful Use funding through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. Another commenter recommended funding for IRFs to update and modernize their systems for FHIR, as well as recommending updates to all CMS billing, NHSN, and iQIES systems' technical capabilities to support consistency and direct transfer of data from providers. Another commenter suggested that CMS provide rural or hardship exceptions as part of dQM standards.

A few commenters had concerns about the differences in dQM and IT readiness across IRFs. These commenters suggested that CMS should fund pilot programs for small and rural IRFs to test FHIR-based quality reporting. Other commenters believed that for-profit IRFs have historically underinvested in Health IT and recommended that CMS stratify by facility type and ownership status when assessing IRF readiness for dQM.

A few commenters had concerns with the dQM transition. One commenter believed that the issue of different patient identification systems between EHR systems would be a roadblock and recommended that CMS create a unified unique patient identified to facilitate interoperability. Another commenter noted challenges related to creating reliable rehabilitation functionality for CMS regulations within their electronic health records. This commenter also described challenges related to IRF–PAI workflows and encouraged implementing FHIR protocols for integration standardization.

Several commenters provided detailed responses to the RFI's questions about their facility's current state of health IT use, challenges and/or opportunities that may arise during integration of technologies with varying complexity into existing IRF systems, how it affects workflow, and what support may be needed to complete and submit quality data in ways that protect and enhance care delivery.

Response: We thank commenters for their feedback. While we will not be responding to specific comments submitted in response to this RFI in this final rule, we intend to use this input to inform our futured dQM transition work.

J. Form, Manner, and Timing of Data Submission Under the IRF QRP

We did not propose any new policies regarding Form, Manner, and Timing of Data Submission Under the IRF QRP in the proposed rule.

K. Policies Regarding Public Display of Measure Data for the IRF QRP

1. Background

For a more detailed discussion about our policies regarding public display of IRF QRP measure data and procedures for the opportunity to review and correct data and information, we refer readers to the FY 2017 IRF PPS final rule (81 FR 52125 through 52131).

2. Ending the Public Display of COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

In the FY 2022 IRF PPS final rule (86 FR 42402), we finalized our proposal to publicly report the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure beginning with the September 2022 Care Compare refresh on *Medicare.gov.* In the FY 2026 IRF PPS proposed rule (90 FR 18549 and 18550), we proposed to remove the HCP COVID–19 Vaccine Measure beginning with the FY 2026 IRF QRP. We proposed IRFs HCP COVID–19 vaccination coverage rates will be publicly reported for the last time with the September 2025 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2024. Thereafter, we proposed that if finalized, we would no longer display IRFs' HCP COVID–19 rates on the Care Compare tool at *Medicare.gov.*

We invited comment on our proposal to end public display of the HCP COVID–19 Vaccine measure rates after the September 2025 Care Compare refresh on the Care Compare tool at *Medicare.gov.*

The following is a summary of the public comments received on the proposal to end public display of the HCP COVID–19 vaccination coverage.

Comment: One commenter supported the proposal to remove public reporting for this measure as proposed.

Response: We thank the commenter for their support.

Comment: A few commenters recommended that the public reporting for this measure end earlier than proposed, specifically as soon as the rule is finalized.

Response: We plan to cease publicly reporting data for this measure moving forward, as soon as it is technically feasible to do so, which for this measure is after the September 2025 Care Compare refresh. While data from 2024 Q4 will be displayed in that refresh, it would not be used for payment determination. As we note in section VIII.C.1. of this rule, IRFs that did not report their CY 2024 reporting period data for the HCP COVID–19 measure would not be penalized for FY 2026 payments.

Comment: One commenter wanted to retain the public display of the HCP COVID–19 Vaccine measure on Care Compare through 2026 for transparency and accountability, citing that public quality data can motivate compliance and inform consumer choice.

Response: We agree with the commenter on the importance of public reporting. We believe that we can inform consumer choice. Consistent with past practices, all previously reported and archived HCP COVID–19 Vaccine measure data will remain on the Care Compare tool at *Medicare.gov* for the purposes of transparency and accountability. We will not calculate and post any new data for this measure after the September 2025 Care Compare refresh on *Medicare.gov.*

After consideration of the public comments, we are finalizing our proposal that the HCP COVID–19 Vaccine measure rates would be publicly reported for the last time with the September 2025 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2024.

3. Ending the Public Display of Patient/Resident COVID–19 Vaccine Measure

In the FY 2024 IRF PPS final rule (88 FR 51042 and 51042), we finalized our proposal to begin publicly displaying data for the Patient/Resident COVID–19 measure beginning with the September 2025 Care Compare refresh. In the FY 2026 IRF PPS proposed rule (90 FR 18549), we proposed to remove the Patient/Resident COVID–19 Vaccine Measure beginning with the FY 2028 IRF QRP. However, the reporting of data for the Patient/Resident COVID–19 Vaccine data item will be voluntary effective October 1, 2025. We proposed that the Patient/Resident COVID–19 vaccine measure rates would be publicly refreshed for the last time with the September 2025 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2024.

We invited public comment on our proposal to end the public display of Patient/Resident COVID–19 Vaccine measure data after the September 2025 Care Compare refresh on *Medicare.gov.*

The following is a summary of the public comments received on the proposal to end the public display of Patient/Resident COVID–19 Vaccine measure data.

Comment: One commenter supported the proposal to remove public reporting for this measure as proposed.

Response: We thank the commenter for their support.

Comment: A few commenters recommended that the public reporting for this measure end earlier than proposed. One commenter suggested ending public reporting as soon as the rule is finalized, and another suggested ending public reporting as soon as the measure is removed.

Response: We plan to cease publicly reporting data on this measure, moving forward, as soon as it is technically feasible to do so, which is after the September 2025 Care Compare refresh. Consistent with past practices, all previously reported and archived Patient/Resident COVID–19 Vaccine measure data will remain on the Care Compare tool at *Medicare.gov.*

After consideration of the public comments, we are finalizing our proposal that the Patient/Resident COVID–19 vaccine measure rates would be publicly reported for the last time with the September 2025 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2024.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs for Proposed Updates Related to the IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2-percentage point reduction to its otherwise applicable annual increase factor for that fiscal year. We estimate that the burden associated with the IRF QRP is the time and effort associated with complying with the requirements of the IRF QRP. In section VIII.E of this final rule, we finalized our proposal to amend the IRF QRP reconsideration request policy and process. As we noted in the FY 2016 IRF PPS Final rule (80 FR 47131), we believe the reconsideration requirements, and the associated burden would be incurred subsequent to an administrative action. In accordance with the implementing regulations for the PRA (5 CFR 1320.4(a)(2) and (c)), the burden associated with any information collected subsequent to the administrative action is exempt from the requirements of the PRA. We have, however, provided detailed cost burden estimates in section XI.C.6.b. of this final rule. We welcomed public comments on the accuracy of the cost estimate assigned to this administrative burden.

1. Requirements for Proposed Updates Related to the IRF QRP Beginning With the FY 2026 IRF QRP

In section VIII.C.I of the proposed rule, we finalized our proposal to remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19) measure, beginning with the FY 2026 IRF QRP.

We noted that the CDC would account for the burden associated with the HCP COVID–19 measure collection under OMB control number 0920–1317 (expiration 03/31/26). Currently, the CDC does not estimate burden for COVID–19 vaccination reporting under the CDC PRA package currently approved under OMB control number 0920–1317 because the agency has been granted a waiver under section 321 of the National Childhood Vaccine Injury Act of 1986 (Pub. L. 99–660, enacted on November 14, 1986 (NCVIA)).[16] However, CMS is providing an estimate of reduction in burden and cost for IRFs here. Consistent with the CDC's experience of collecting data using the NHSN, we estimate the removal of this measure will result in a reduction of 1 hour per month to collect data for the HCP COVID–19 measure and enter it into NHSN. We believe that this data would be entered by an administrative assistant. However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[17] To account for overhead and fringe benefits, we have doubled the hourly

[16] Section 321 of the NCVIA provides the PRA waiver for activities that come under the NCVIA, including those in the NCVIA at section 2102 of the Public Health Service Act (*https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapXIX-part1-sec300aa-2.pdf*). Section 321 is not codified in the U.S. Code but can be found in a note *(https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapXIX-part1-sec300aa-1.pdf*).

[17] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

wage. These amounts are detailed in Table 10.

TABLE 10—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Administrative Assistants	43–6013	$18.01	$18.01	$36.02

We estimated that the removal of this measure from the IRF QRP will result in a reduction of 12 hours per IRF per year. Using FY 2024 data, we estimate a total of 1,166 IRFs annually for a decrease of 13,992 hours (12 hours × 1,166 IRFs) for all IRFs. Given an estimated $36.02 hourly wage, we estimate a decrease of $432.24 per IRF (12 hours × $36.02), or a decrease of $503,991.84 for all IRFs annually.

We have summarized the comments we received about the burden related to the Removal of the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) Measure in section VIII.C.1 of this final rule and provided responses. We received no comment on these burden estimates specifically.

After consideration of the public comments, we are finalizing our proposal to remove the COVID–19 Vaccination Coverage among HCP Measure.

2. ICRs for Proposed Removal of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2028 IRF QRP

In section VIII.C.2 of this final rule, we finalized our proposal to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure, beginning with the FY 2028 IRF QRP. We identified the staff type based on past IRF burden calculations. We believe that the items would be completed equally by a Registered Nurse (RN) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[18] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 11. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $70.10/hr was calculated by weighting each adjusted hourly wage equally (that is, 50 percent) [($82.76/hr × 0.5) + ($57.44/hr × 0.5) = $70.10].

TABLE 11—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	$41.38	$41.38	$82.76
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29–2061	28.72	28.72	57.44

The net result of removing the related Patient/Resident COVID–19 Vaccine Status item (O0350) beginning with the FY 2028 IRF QRP is a decrease of 0.3 minutes or 0.005 hour of clinical staff time at discharge. We estimated that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would decrease under this proposal. Using FY 2024 data, we estimated a total of 622,300 discharges annually from 1,166 IRFs for a decrease of 3,111.5 hours (622,300 × 0.005 hour) for all IRFs, or 2.67 hours per IRF (3,111.5 hours/1,116 IRFs). Given 0.005 hours at $70.10 per hour to complete an average of 533.7 IRF–PAIs per IRF per year, we estimated the total cost will be decreased by $187.06 per IRF annually, or $218,116.15 for all IRFs annually.

We have summarized the comments we received about the burden related to the Removal of the Patient/Resident COVID–19 Vaccine Measure in section VIII.C.2 of this final rule and provided responses. We received public comments on the accuracy of the cost estimate assigned to this administrative burden, and provide a summary of those comments:

Comment: A few commenters stated that the burden estimate for this measure is not accurate, citing that it does not account for costs associated with the education/training of clinicians, reconciling patient vaccination status among the various sources, administering vaccinations, or providing payment for technological solutions to obtain this.

Response: We appreciate the commenters' feedback. Our current burden estimates do not include the cost of individual provider education and training needs, or those related to technological updates to software and hardware. Our burden estimates are doubled to provide for overhead and fringe benefits, which we believe accounts for the time it takes for staff to report items that are assessed as part of routine clinical care and medical charting in an IRF. Our removal of this item is in line with provider feedback that this item is no longer part of the

[18] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

routine clinical care in IRFs since the end of the PHE.

After consideration of the public comments, we are finalizing our proposal to remove the Patient/Resident COVID–19 Vaccine Measure.

3. ICRs for Proposed Removal of Four Standardized Patient Assessment Data Elements Beginning With the FY 2028 IRF QRP

In section VII.D of the proposed rule, we finalized our proposal to remove four standardized patient assessment data elements under the SDOH category previously adopted for collection and submission on admission beginning October 1, 2026.

We identified the staff type based on past IRF burden calculations. We believe that the items would be completed equally by a Registered Nurse (RN) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[19] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 12. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $70.10/hr was calculated by weighting each adjusted hourly wage equally (that is, 50 percent) [($82.76/hr × 0.5) + ($57.44/hr × 0.5) = $70.10].

TABLE 12—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	$41.38	$41.38	$82.76
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29–2061	28.72	28.72	57.44

We estimated that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would decrease under this proposal. We estimated that removing four SDOH items with respect to admission will result in a reduction of 1.2 minutes, or 0.02 hour. Using FY 2024 data, we estimate a total of 622,300 assessments from 1,166 IRFs annually for a decrease of 12,446 hours in burden for all IRFs (622,300 × 0.02 hour), or a decrease of 10.67 hours per IRF. Given 10.67 hours at $70.10 per hour, to complete an average of 534 IRF–PAI assessments per IRF per year, we estimated the total cost will be decreased by $748.25 per IRF annually, or $872,464.60 for all IRFs annually, as detailed in Table 13.

We invited public comments on the proposed information collection requirements and whether our estimated burden reduction of 0.02 hours per patient and an annual decrease of 10.67 hours in burden per IRF at admission is an accurate estimate.

We have summarized the comments we received about the burden related to the removal of the SDOH data elements in section VIII.D of this final rule and provided responses. We did not receive public comments about the accuracy of the burden estimates.

After consideration of the public comments, we are finalizing our proposal to remove four standardized patient assessment data elements collected under the SDOH category from the IRF QRP beginning with the FY 2028 IRF QRP.

4. Summary of Requirements for Proposed Updates Related to the IRF QRP Beginning With the FY 2028 IRF QRP

The IRF–PAI, in its current form, has been approved under OMB control number 0938–0842 (expiration 10/31/2027). The net result of removing five items beginning with the FY 2028 IRF QRP, as described in sections VII.A.2 and VII.A.3 of the proposed rule, is a decrease of 1.5 minutes or 0.025 hour of clinical staff time. We estimated that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would decrease under these proposals. In summary, we estimated the total cost for the proposed requirements of the FY 2028 IRF QRP will be decreased by $935.32 per IRF annually, or $1,090,580.75 for all IRFs annually. These amounts are detailed in Table 13.

TABLE 13—ESTIMATED CHANGE IN BURDEN BEGINNING WITH THE FY 2028 IRF QRP

Requirement	Per IRF		All IRFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Removal of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date item beginning with the FY 2028 IRF QRP.	−2.67	−$187.06	−3,111.5	−$218,116.15
Removal of four standardized patient assessment data elements beginning with the FY 2028 IRF QRP.	−10.67	−748.25	−12,446	−872,464.60
Total change in burden for FY 2028 IRF QRP	−13.34	−935.32	−15,557.5	−1,090,580.75

[19] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

XI. Regulatory Impact Analysis

A. Statement of Need

This final rule updates the IRF prospective payment rates for FY 2026 as required under section 1886(j)(3)(C) of the Act and in accordance with section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before August 1 before each FY, the classification and weighting factors for CMGs used under the IRF PPS for such FY and a description of the methodology and data used in computing the prospective payment rates under the IRF PPS for that FY. This final rule will also implement section 1886(j)(3)(C) of the Act, which requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2012 and subsequent years.

Furthermore, this rule finalizes the adoption of policy changes to the IRF QRP under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for rules that are significant as per section 3(f)(1) of E.O. 12866 (having an effect on the economy $100 million or more in any 1 year). We estimate the total impact of the policy updates described in this final rule by comparing the estimated payments in FY 2026 with those in FY 2025. This analysis results in an estimated $340 million increase for FY 2026 IRF PPS payments. Additionally, we estimated that costs associated with updating the reporting requirements under the IRF QRP result in an estimated reduction of $504,929.84 in costs for IRFs for purposes of meeting the FY 2026 IRF QRP, and an estimated reduction of $1,090,580.75 in costs for IRFs for purposes of meeting the FY 2028 IRF QRP. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) because it will have an effect on the economy $100 million or more in any 1 year. Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

This final rule is expected to be an E.O. 14192 deregulatory action. We estimated that this rule would generate approximately $1.28 million annualized cost savings at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon.

Anticipated Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $9.0 million to $47.0 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for healthcare industries, at 65 FR 69432 and see *https://www.sba.gov/sites/default/files/2023-06/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%282%29.pdf,* effective January 1, 2022, and updated on March 17, 2023.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,169 IRFs, of which approximately 47 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. Finally, according to the MedPac 2025 Report to Congress, only 51% of IRF stays are Medicare stays (March 2025 Report to the Congress: Medicare Payment Policy—MedPAC at *https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/*). As shown in Table 14, we estimate that the net revenue impact of this final rule on all IRFs is to increase estimated payments by approximately 3.2 percent of Medicare payments. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent of the total revenue. Since Medicare accounts for about half of the stays in IRFs, we do not believe the estimated aggregate revenue impact from Medicare payment of this final rule 3.2 percent) will reach the threshold by the requirements in this final rule, given the decrease in costs related to the IRF QRP for FY 2026 (an estimated decrease in costs of $504,929.84 for IRFs) and FY 2028 (an estimated decrease in costs of $1,090,580.75 to IRFs). Therefore, the Secretary has certified that this final rule would not have a significant economic impact on a substantial number of small entities. The estimated impact on small entities is shown in Table 14. MACs are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 14, we estimate that the net revenue impact of this final rule on rural IRFs is to increase estimated payments by approximately 3.4 percent based on the data of the 131 rural units and 14 rural hospitals in our database of 1,169 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas between 1.6 percent and 7.6 percent. As a result, we anticipate that this final rule

will not have a significant positive impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. This final rule does not mandate any requirements for State, local, or Tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. As stated, this final rule will not have a substantial effect on State and local governments, preempt State law, or otherwise have a federalism implication.

C. Detailed Economic Analysis

This final rule updates the IRF PPS rates contained in the FY 2025 IRF PPS final rule (88 FR 50956). Specifically, this final rule updates to the CMG relative weights and ALOS values, the wage index, and the outlier threshold for high-cost cases. This final rule will apply a productivity adjustment to the FY 2026 IRF market basket percentage increase in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.

1. Impact on IRFs

We estimate that the impact of the changes and updates described in this final rule will be a net estimated increase of $340 million in payments to IRFs for FY 2026. The impact analysis in Table 14 of this final rule represents the projected effects of the updates to IRF PPS payments for FY 2026 compared with the estimated IRF PPS payments in FY 2025. We determined the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2026, we are implementing the standard annual revisions described in this final rule (for example, the update to the wage index and market basket percentage increase used to adjust the Federal rates). We are also reducing the FY 2026 IRF market basket percentage increase by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. We estimate that the total increase in payments to IRFs in FY 2026, relative to FY 2025, will be approximately $340 million.

This estimate is derived from the application of the FY 2026 IRF market basket percentage increase, reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, which yields an estimated increase in aggregate payments to IRFs of $275 million. In addition, there is an estimated $60 million increase in aggregate payments to IRFs due to the update to the outlier threshold amount. We estimate that these updates will result in a net increase in estimated payments of $340 million from FY 2025 to FY 2026.

The effects of the updates that impact IRF PPS payment rates are shown in Table 14. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the update to the outlier threshold amount, from approximately 2.8 percent to 3.2 percent of total estimated payments for FY 2026, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the 2021-based IRF market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and (j)(3)(C) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act, accounting for the permanent cap on wage index decreases when applicable.
- The effects of the budget-neutral changes to the CMG relative weights and ALOS values under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2026 payment changes relative to the estimated FY 2025 payments.

2. Description of Table 14

Table 14 shows the overall impact on the 1,169 IRFs included in the analysis. The next 12 rows of Table 14 contain IRFs categorized according to their geographic location, designated as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 1,024 IRFs located in urban areas included in our analysis. Among these, there are 646 IRF units of hospitals located in urban areas and 378 freestanding IRF hospitals located in urban areas. There are 145 IRFs located in rural areas included in our analysis. Among these, there are 131 IRF units of hospitals located in rural areas and 14 freestanding IRF hospitals located in rural areas. There are 521 for-profit IRFs. Among these, there are 482 IRFs in urban areas and 39 IRFs in rural areas. There are 552 non-profit IRFs. Among these, there are 465 urban IRFs and 87 rural IRFs. There are 96 government-owned IRFs. Among these, there are 77 urban IRFs and 19 rural IRFs.

The remaining four parts of Table 14 show IRFs grouped by geographic location within a region, by teaching status, and by DSH patient percentage (PP). First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10

percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this final rule to the facility categories listed are shown in the columns of Table 14. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2026 analysis file.
- Column (3) shows the number of cases in each category in our FY 2026 analysis file.
- Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the FY 2026 update to the IRF labor-related share, wage index with the 5-percent cap on wage index decreases when applicable, and second year of the 3-year phase-out of the rural adjustment finalized in the FY 2025 IRF PPS final rule, in a budget-neutral manner.
- Column (6) shows the estimated effect of the update to the CMG relative weights and ALOS values, in a budget-neutral manner.
- Column (7) compares our estimates of the payments per discharge, incorporating all of the policies reflected in this final rule for FY 2026 to our estimated payments per discharge in FY 2025.

The average estimated increase in payments for all IRFs is approximately 3.2 percent. This estimated net increase includes the effects of the IRF market basket update for FY 2026 of 2.6 percent, which is based on an IRF market basket percentage increase of 3.3 percent, less a 0.7 percentage point productivity adjustment, as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.6 percent overall increase in estimated IRF outlier payments from the update to the outlier threshold amount. Since we are updating the IRF wage index, labor-related share and the CMG relative weights in a budget-neutral manner, we estimate there is no expected impact to total estimated IRF payments in aggregate from these changes. However, as described in more detail in each section, we estimate there will be expected impacts to the estimated distribution of payments among providers.

TABLE 14—IRF IMPACT FOR FY 2026

[Columns 4 through 7 in percentages]

Facility classification	Number of IRFs	Number of cases	Outlier	FY 2026 wage index (5% cap) and labor-related share	CMG relative weights	Total percent change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,169	447,020	0.6	0.0	0.0	3.2
Urban unit	646	144,074	1.2	−0.2	0.0	3.6
Rural unit	131	18,147	0.9	−0.1	0.1	3.5
Urban hospital	378	277,797	0.2	0.1	0.0	2.9
Rural hospital	14	7,002	0.0	0.4	0.0	3.0
Urban For-Profit	482	276,263	0.3	0.1	0.0	2.9
Rural For-Profit	39	10,714	0.3	0.3	0.0	3.3
Urban Non-Profit	465	127,517	1.0	−0.1	0.0	3.6
Rural Non-Profit	87	12,573	0.9	−0.1	0.1	3.6
Urban Government	77	18,091	1.2	−0.1	0.1	3.9
Rural Government	19	1,862	0.7	−0.6	0.1	2.8
Urban	1,024	421,871	0.6	0.0	0.0	3.2
Rural	145	25,149	0.7	0.1	0.1	3.4
Urban by region						
Urban New England	30	15,484	0.3	1.6	0.1	4.7
Urban Middle Atlantic	113	42,826	0.8	0.3	0.0	3.7
Urban South Atlantic	190	100,441	0.5	0.5	0.0	3.6
Urban East North Central	165	50,402	0.6	0.3	0.0	3.6
Urban East South Central	56	29,048	0.3	0.7	0.0	3.5
Urban West North Central	79	25,322	0.6	0.3	0.0	3.5
Urban West South Central	210	95,608	0.3	−0.7	0.0	2.2
Urban Mountain	81	35,924	0.4	−0.5	0.0	2.5
Urban Pacific	100	26,816	1.5	−1.0	0.0	3.2
Rural by region						
Rural New England	5	1,104	0.9	1.0	0.1	4.7
Rural Middle Atlantic	11	1,408	0.4	−1.4	0.1	1.6
Rural South Atlantic	17	6,383	0.2	0.1	0.0	2.9
Rural East North Central	23	3,022	1.3	0.2	0.0	4.1
Rural East South Central	19	3,284	0.5	−1.2	0.1	2.0
Rural West North Central	19	2,310	1.2	0.2	0.1	4.1
Rural West South Central	44	7,042	0.5	0.4	0.1	3.6
Rural Mountain	5	322	0.9	3.8	0.1	7.6
Rural Pacific	2	274	3.0	0.4	0.3	6.4
Teaching status						
Non-teaching	1,063	398,330	0.5	0.0	0.0	3.2
Resident to ADC less than 10%	59	33,458	0.6	0.0	0.0	3.2

TABLE 14—IRF IMPACT FOR FY 2026—Continued

[Columns 4 through 7 in percentages]

Facility classification	Number of IRFs	Number of cases	Outlier	FY 2026 wage index (5% cap) and labor-related share	CMG relative weights	Total percent change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Resident to ADC 10%−19%	34	12,761	1.5	−0.3	0.0	3.9
Resident to ADC greater than 19%	13	2,471	1.0	0.2	0.1	3.9
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	52	12,309	0.7	−0.6	0.0	2.7
DSH PP <5%	194	98,674	0.4	0.3	0.0	3.3
DSH PP 5%−10%	252	110,048	0.4	−0.1	0.0	3.0
DSH PP 10%−20%	404	150,145	0.6	0.0	0.0	3.2
DSH PP greater than 20%	267	75,844	0.9	−0.2	0.0	3.4

[1] This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF market basket update for FY 2026 of 3.3 percent, reduced by 0.7 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

3. Impact of the Update to the Outlier Threshold Amount

The estimated effects of the update to the outlier threshold adjustment from FY 2025 to FY 2026 are presented in column 4 of Table 14.

For the FY 2026 proposed rule, we used preliminary FY 2024 IRF claims data and based on that preliminary analysis, we estimated that IRF outlier payments as a percentage of total estimated IRF payments would be 2.4 percent in FY 2025. Thus, we are adjusting the outlier threshold amount in this final rule from $12,043 in FY 2025 to $10,062 in FY 2026 to maintain total estimated outlier payments equal to 3 percent of total estimated payments in FY 2026. The estimated change in total IRF payments for FY 2026, therefore, includes an approximate 0.6 percentage point increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.4 percent to 3.0 percent. The impact of this update to the outlier threshold amount (as shown in column 4 of Table 14) is to increase estimated overall payments to IRFs by 0.6 percentage point.

4. Impact of the Wage Index, Labor-Related Share, and Wage Index Cap

In column 5 of Table 14, we present the effects of the budget-neutral update of the wage index and labor-related share, taking into account the permanent 5-percent cap on wage index decreases when applicable. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this final rule, the FY 2026 labor-related share is 74.4 percent, which is the same as the labor-related share for FY 2025. In the aggregate, since these updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we estimate that these changes will have distributional effects. For example, we estimate the largest increase in payments of 7.6 percent for rural IRFs in the Mountain region. We estimate the largest decrease in payments from the update to the wage index and labor-related share to be a 1.4 percent decrease for rural IRFs in the Middle Atlantic region.

5. Impact of the Update to the CMG Relative Weights and ALOS Values

In column 6 of Table 14, we present the effects of the budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects between 0.0 percent to 0.3 percent.

6. Effects of Requirements for the IRF QRP

In accordance with section 1886(j)(7)(A) of the Act, the Secretary must reduce by 2 percentage points the annual market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section IX.A. of this final rule, we discussed the method for applying the 2-percentage points reduction to IRFs that fail to meet the IRF QRP requirements.

a. Effects of Requirements for the IRF QRP Beginning With the FY 2026 IRF QRP

As discussed in section VIII.C.I of the proposed rule, we finalized our proposal to remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure, beginning with the FY 2026 IRF QRP.

Currently, the CDC does not estimate burden for COVID–19 vaccination reporting under the CDC PRA package currently approved under OMB control number 0920–1317 because the agency has been granted a waiver under section 321 of the NCVIA. However, CMS has provided an estimate of reduction in burden and cost for IRFs here. Consistent with the CDC's experience of collecting data using the NHSN, we estimate the removal of this measure will result in a reduction of 1 hour per month to collect data for the COVID–19 Vaccination Coverage among HCP measure and enter it into NHSN. We believe that this data would be entered by an administrative assistant. However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[20] To

[20] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage

Continued

account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 15.

TABLE 15—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Administrative Assistants	43–6013	$18.01	$18.01	$36.02

We estimate that the removal of this measure from the IRF QRP will result in a reduction of 12 hours per IRF per year. Using FY 2024 data, we estimate a total of 1,166 IRFs annually for a decrease of 13,992 hours (12 hours × 1,166 IRFs) for all IRFs. Given an estimated $36.02 hourly wage, we estimate a decrease of $432.24 per IRF (12 hours × $36.02), or a decrease of $503,991.84 for all IRFs annually.

In section VIII.E of this final rule, we finalized our proposal to amend the reconsideration request policy and process. For IRFs that seek to file an extension to file a request for reconsideration of a noncompliance determination, we estimate that this request will take IRFs approximately 15 minutes to complete. We believe that this data would be entered by medical records specialists. However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs we obtained median hourly wages from the BLS May 2023 National Occupational Employment and Wage Estimates.[21] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 16.

TABLE 16—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Medical Records Specialists	29–2072	$23.45	$23.45	$46.90

We estimate that the collection of this request will result in an additional 15 minutes, or 0.25 hours, per request. Based on the number of reconsiderations requests we have received in the previous 3 years, we estimate an average of 81 requests per year, for an additional 20 hours per year (0.25 hours × 81 forms per year) for all IRFs. Given an estimated $46.90 hourly wage, we estimate an increase of $938.00 (20 hours × $46.90) for all IRFs annually or $11.58 per IRF that request reconsiderations.

b. Effects of Requirements for the IRF QRP Beginning With the FY 2028 IRF QRP

In section VIII.C.2 of this final rule, we finalized our proposal to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure and the associated assessment item (O0350), beginning with the FY 2028 IRF QRP. In section VIII.D of this final rule, we finalized our proposal to remove four standardized patient assessment data elements from the IRF–PAI, beginning with the FY 2028 IRF QRP. The net result of removing five items is a decrease of 1.5 minutes or 0.025 hour of clinical staff time at admission. We believe that the items would be completed equally by a Registered Nurse (RN) (50 percent of the time) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN) (50 percent of the time). However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[22] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 17.

TABLE 17—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	41.38	41.38	82.76

Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

[21] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

[22] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

TABLE 17—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2023 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES—Continued

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29–2061	28.72	28.72	57.44

Using FY 2024 data, we estimate a total of 622,300 assessments from 1,166 IRFs annually for a decrease of 15,557.5 hours in burden for all IRFs (622,300 × 0.025 hour), or a decrease of 13.34 hours per IRF. Given 0.025 hour at $70.10 per hour to complete an average of 534 IRF–PAI assessments per IRF per year, we estimate the total cost will be decreased by $935.32 per IRF annually, or $1,090,580.75 for all IRFs annually.

c. Summary of Effects of Requirements for the IRF QRP

In summary, we estimate that the burden and cost for IRFs for complying with requirements of the FY 2026 IRF QRP would decrease under these proposals, by 13,972 hours and $504,929.84 for all IRFs annually. We also estimate that the burden and cost for IRFs for complying with the requirements of the FY 2028 IRF QRP would decrease under these proposals, by 15,557.5 hours and $1,090,580.75 for all IRFs annually. These amounts are detailed in Table 18.

TABLE 18—ESTIMATED IRF QRP PROGRAM IMPACTS FOR FY 2026 AND FY2028

Requirement	All IRFs	
Estimated change in annual burden hours	Estimated change in annual cost	
Proposed Effects of Requirements for the FY 2026 IRF QRP (measure removal and reconsideration policy update)	−13,972	−$504,929.84
Proposed Effects of Requirements for the FY 2028 IRF QRP (measure and item removals).	−15,557.5	−1,090,580.75

We invited public comments on the overall impact of the IRF QRP proposal for FY 2026 and FY 2028. We did not receive any public comments on the effects on requirements and therefore, we are finalizing the revisions as proposed.

D. Alternatives Considered

IRF PPS Updates

As noted previously in this final rule, section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services and section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2026. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are updating the IRF prospective payments in this final rule by 2.6 percent (which equals the 3.3 percent IRF market basket percentage increase for FY 2026 reduced by a 0.7 percentage point productivity adjustment as determined under section 1886(b)(3)(B)(xi)(II) of the Act (as required by section 1886(j)(3)(C)(ii)(I) of the Act)).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2026. However, in light of recently available data, and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case-mix, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered maintaining the existing outlier threshold amount for FY 2026. However, analysis of FY 2024 data indicates that estimated outlier payments would be less than 3 percent of total estimated payments for FY 2026, unless we updated the outlier threshold amount. Consequently, we are adjusting the outlier threshold amount to maintain estimated outlier payments at 3 percent of estimated aggregate payments in FY 2026.

Regarding our proposals to remove both the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) and COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, we considered keeping both measures, but determined the cost and burden associated with maintaining these measures outweigh the benefit of their continued collection and finalized our proposal to remove them.

Regarding our proposal to remove four SDO standardized patient assessment data elements we are removing these in an effort to reduce burden. We considered keeping these but believe that removing would help reduce burden.

Finally, regarding proposals to amend the reconsideration request policy and process, we considered the alternative of leaving the policy language unchanged. However, we have noted some areas in our policy where IRFs may benefit from clearly demarcated deadlines regarding requests for reconsideration.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume at least one staff in IRFs would read the rule. The total number of IRFs would be the proxy of number of reviewers for this rule. We acknowledge that this assumption may understate or overstate the costs of reviewing the proposed rule. We also assume that each reviewer reads 100 percent of the rule.

Using the national mean hourly wage data from the May 2023 BLS for Occupational Employment Statistics (OES) for medical and health service managers (SOC 11–9111), we estimate that the cost of reviewing this rule is

$129.28 per hour, including other indirect costs and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it will take approximately 3 hours for the staff to review the proposed rule. For each reviewer of the rule, the estimated cost is $387.84 (3 hours × $129.28). Therefore, we estimated that the total cost of reviewing this regulation is $452,221.44 ($387.84 × 1,166 reviewers).

F. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf*), in Table 20, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of the final rule. Table 18 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this final rule based on the data for IRFs in our database.

TABLE 19—ACCOUNTING STATEMENT—CLASSIFICATION OF ESTIMATED EXPENDITURE

	Category	Transfers
Change in Estimated Transfers from FY 2025 IRF PPS to FY 2026 IRF PPS.	Annualized Monetized Transfers	$340 million increase.
	From Whom to Whom?	Federal Government to IRF Medicare Providers.
Estimated Savings Associated with the FY 2026 IRF QRP.	Annualized monetized savings in FY 2026 due to proposed data collection requirements.	$504,929.84.
Estimated Savings Associated with the FY 2028 IRF QRP.	Annualized monetized savings in FY 2028 due to proposed data collection requirements.	$1,090,580.75.
Estimated Costs Associated with Review Cost for FY 2026 IRF PPS.	Cost associated with regulatory review cost	$452,221.

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2026 are projected to increase by 3.2 percent, compared with the estimated payments in FY 2025, as reflected in column 7 of Table 14.

IRF payments per discharge are estimated to increase by 3.2 percent in urban areas and 3.4 percent in rural areas, compared with estimated FY 2025 payments. Payments per discharge to rehabilitation units are estimated to increase 3.6 percent in urban areas and 3.5 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.9 percent in urban areas and 3.0 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this final rule. The largest payment increase is estimated to be 7.6 percent for IRFs in the Rural Mountain region. The analysis above, together with the remainder of this preamble, provides an RIA.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

Mehmet Oz, MD, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 28, 2025.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Amend § 412.634 by revising paragraph (d)(5) and adding paragraphs (d)(6) and (7) to read as follows:

§ 412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

* * * * *

(d) * * *

(5) CMS will notify the IRF, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the United States Postal Service, or via email from the CMS Medicare Administrative Contractor (MAC). CMS will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the IRF was in full compliance with the IRF QRP requirements for the applicable program year.

(6) An IRF may request, and CMS may grant, an extension to file a reconsideration request if, during the period to request a reconsideration as set forth in paragraph (d)(2) of this section, the IRF was affected by an extraordinary circumstance beyond the control of the IRF (for example, a natural or man-made disaster). IRFs must submit the reconsideration extension request no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration extension request must be submitted to CMS via email to *IRFQRPReconsiderations@cms.hhs.gov,* and must contain the following information:

(i) The CCN for the IRF.

(ii) The business name of the IRF.

(iii) The business address of the IRF.

(iv) Contact information for the IRF's chief executive officer or designated personnel, including the name, telephone number, title, email address, and physical mailing address, which may not be a post office box.

(v) A statement of the reason for the request for the extension.

(vi) Evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media.

(7) CMS will notify the IRF in writing of its final decision regarding its request for an extension to file a reconsideration of noncompliance request via an email from CMS.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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