REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

June 1, 2026

The Honorable Mehmet Oz
The Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-1845-P
PO Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

Re: CMS-1845-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program, Proposed Rule, Vol. 91, No. 65, Federal Register (April 6, 2026)

Dear Administrator Oz:

With more than 400 members, the majority of who serve over one million Pennsylvanians annually, Rehabilitation and Community Providers Association (RCPA) is among the largest and most diverse state health and human services trade associations in the nation. RCPA provider members offer mental health, substance use disorder, intellectual and developmental disabilities, children and youth, criminal and juvenile justice, brain injury, medical and pediatric rehabilitation, and physical disabilities and aging services, across all settings and levels of care. Visit www.paproviders.org for more information.

RCPA appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) fiscal year (FY) 2027 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS). Our comments focus on CMS' proposal for significant coverage criteria changes for FY 2027 (as well as future years) and on proposed future IRF PPS modernization efforts and the impact these could have on care and quality reporting requirements.

I. CMS' FY 2027 Coverage Reform Proposals

A. Accelerated Team Conference Proposal

CMS proposes to amend IRF coverage regulations to require that the first interdisciplinary team conference (IDT) occur "on or before the fourth day from midnight on the date the patient is admitted," compared to the current regulatory requirement that the IDT "occur at least once per week throughout the duration of the patient's stay." CMS cites numerous reasons for this proposed change, including concerns that IRF patients may receive "up to 7 days of care in an IRF without their full care team coordinating their treatment or discussing progress towards the patient's goals as outlined in the plan of care (IPOC)," and the fact that, by not providing a "timely initial IDT," the team "may be providing suboptimal treatment or inadvertently worsening the patient's health outcomes."

RCPA appreciates CMS' stated goal of promoting timely and coordinated interdisciplinary care throughout the patient's stay; however, we are concerned about the approach to achieving this goal. We believe the proposal fails to understand and capture the extensive and ongoing interdisciplinary collaboration that already occurs throughout an IRF patient's stay — particularly during the first several days following admission. Inpatient rehabilitation is inherently interdisciplinary. Rehabilitation physicians, nurses, therapists, case managers, and other members of the IRF care team engage in frequent and intensive communication beginning immediately upon admission. These communications routinely occur through bedside discussions, therapy coordination meetings, family conferences, physician

consultations, nursing updates, and other less formal but effective clinical interactions designed to address patients' medical and functional needs.

We are concerned that CMS' cited concerns with "limited communications" and failures to make timely updates to patients' plans of care are theoretical, not based on practical experience. Existing regulatory structure already enforces coordinated interdisciplinary planning shortly after admission. Specifically, the four-day timeframe associated with completion of the IPOC requires rehabilitation physicians and the interdisciplinary team to incorporate clinical findings, therapy assessments, and patient-specific goals early in the admission. As such, the proposal appears to assume a lack of interdisciplinary coordination – particularly in the early days of an IRF stay – which is simply unsupported by CMS' own reporting requirements and timeframes currently in practice in IRFs.

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

- Limiting the flexibility that IRF clinical teams currently utilize to conduct clinically meaningful and patient-centered care coordination activities. In many facilities, less formal interdisciplinary huddles — including bedside discussions and meetings involving family members or caregivers — allow teams to respond quickly and efficiently to changing patient conditions.
- Taking clinician time away from direct patient care activities, particularly in high-volume IRFs where additional conference time will require additional staffing or pulling resources from other IRF operations, including direct patient care.

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

B. CMS' Therapy Initiation Proposal

CMS proposes to amend the IRF coverage criteria to specify that all required therapy treatments and/or therapy evaluations ordered for IRF patients must begin within 36 hours from midnight of the day of admission to the IRF.

RCPA supports the proposal to codify a timely initiation standard of all clinically appropriate, ordered therapies; however, clarification is needed to ensure that CMS' policy achieves these shared objectives and provides IRFs with the necessary ability to prescribe therapies based on physician discretion and patient needs. We believe it is critical that the finalized policy appropriately reflects clinical practice and clearly distinguishes between the patient assessments conducted prior to admission and the physician-directed therapy plan established following admission by the treating rehabilitation physician. RCPA feels CMS should clarify that the therapies subject to the proposed 36-hour initiation requirement are those therapies ordered by the rehabilitation physician after the IRF admission (presumably after the patient's history and physical), rather than the therapies referenced in the preadmission screening documentation typically compiled during the preceding short-term acute hospital stay. The distinction between the pre-admission screen and the physician's post-admission therapy orders is needed. The pre-admission screen inevitably occurs prior to admission and often before the rehabilitation physician and interdisciplinary team have had the opportunity to conduct more comprehensive in-

person assessments of the patient's current medical, functional, and cognitive status. By contrast, physician orders that are entered following admission reflect a more recent evaluation of the patient's rehabilitation and therapy needs. In many instances, the patient's therapy needs appropriately progress following admission based on updated physician assessments, therapy evaluations, or changes in medical stability. For this reason, tying compliance expectations to therapies referenced in a pre-admission screening document — rather than to the physician-directed plan of care established after admission — risks creating confusion and potentially inappropriate compliance standards that do not align with individualized patient care.

We encourage CMS to clarify in its final rule that therapies "ordered" by the rehabilitation physician upon admission to the IRF are those that must be initiated within 36 hours, and ensure that the standard is properly and consistently applied across the sector.

It is also important that CMS confirm that therapies can be ordered later in the patient's stay without raising any compliance issues with the 36-hour initiation standard. For example, there can be circumstances where speech and language pathology was not medically appropriate upon admission, but due to changes in the patient's condition, such therapy was ordered later in the patient's stay. Penalizing the IRF clinical team for updating the patient's care and ordering therapy at a clinically appropriate time during the stay (rather than within the 36-hour window from midnight of the day of admission) runs counter to the goal of patient-centered care. Therefore, we recommend that CMS confirm in the final rule that additional therapies can be initiated when medically appropriate at a later time during the patient's stay.

II. Response to and Recommendations on CMS' FY 2027 Quality Reporting Program (QRP) Proposals

A. CMS' Proposal to Revise IRF QRP Data Submission Deadlines Beginning with the FY 2029 IRF QRP

CMS is proposing that, beginning with the FY 2029 IRF QRP, IRFs must complete their data submissions and make corrections to their inpatient rehabilitation facility Patient Assessment Instrument (IRF-PAI) assessment data and Centers for Disease Control and Prevention National Healthcare Safety Network (CDC NHSN) data no later than the 15th day of the second month after the end of the calendar quarter. CMS also proposes that if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 pm EST on the next business day. CMS believes that reducing the deadlines will improve the timeliness of public reporting by three months, which is beneficial to both patients and IRFs, without creating new burdens. Overall, RCPA supports CMS' efforts to reduce QRP data submission deadlines with the goal of improving the timeliness of public reporting. Before CMS finalizes this policy, however, the following technical changes should be considered to avoid unintended reporting challenges and potential compliance concerns:

- **The data submission deadline should follow two full months from the end of a quarter, with the first day of the 3rd month set as the data submission deadline**.

  We believe that the extra 15–16 days will allow CMS and CDC to provide timely, confidential feedback reports to IRFs and allow sufficient time for IRFs to review and correct the IRF-PAI and CDC NHSN data to meet IRF QRP compliance standards. This is especially true for cases discharged towards the end of a quarter. It may take several days or weeks to finalize the data for initial submission to the CMS and CDC databases.

  Additionally, there are no IRF PPS data submission deadlines. Also, payer changes, discharge clarifications, and other clinically meaningful adjustments frequently occur after initial submission. Allowing IRFs at least a month following the end of a quarter to complete initial submissions of IRF-PAI and CDC NHSN data will provide adequate time for confidential feedback reports to be supplied to IRFs; allow IRFs to identify any potential issues with data

adjustments; and correct and resubmit any information into the IRF-PAI and/or CDC NHSN databases.

- **The data submission deadline should not move if the deadline date falls on a Friday, weekend, or federal holiday.**

  IRF physicians, clinicians, and other staff provide services 24 hours a day, seven days a week, negating the need for an extended deadline. Many IRFs also rely on automated reporting systems and scheduled workflows, which function best with fixed, predictable deadlines. Selecting a single fixed date would reduce confusion and align with CMS' stated goals of simplification, burden reduction, and timeliness of reporting. While we appreciate CMS' willingness to grant some flexibility to the IRF field for this reporting deadline, we believe a better approach would be to affix a specific non-variable date for this reporting deadline.

III. FY 2027 Proposed Payment Updates

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

For FY 2027, CMS proposes a 3.2% market basket update reduced by a 0.8% productivity adjustment, resulting in a 2.4% net market basket update. CMS also proposes a FY 2027 labor-related share of 74.5% and a standard payment conversion factor of $19,881 after application of the applicable budget-neutrality adjustments. The combined payment changes, along with the changes to the outlier threshold described below, would result in an estimated 2.8% increase in payments per discharge and a net increase of $355 million in payments to IRFs field-wide. While the proposed update is positive, IRFs report that a positive annual update does not necessarily resolve the broader fiscal pressures facing IRFs.

These findings are particularly relevant given the continued labor and operating cost pressures facing all Medicare providers. It is important to protect Medicare payment adequacy for IRFs and ensure annual positive payment increases that support beneficiary access to medically necessary inpatient rehabilitation care.

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

For FY 2027, CMS proposes to continue using the current IRF wage-index methodology. The proposed rule explains that CMS would continue to use the existing wage index framework for FY 2027, while also soliciting comments on whether it should consider alternative data sources to construct an IRF-specific wage index for potential use in future years. Because CMS has not proposed a specific alternative methodology for FY 2027, RCPA believes the agency should finalize the current wage index policy for this year and proceed carefully with any future changes.

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

CMS proposes to lower the outlier threshold amount for FY 2027 to $8,689 in order to maintain outlier payments at 3% of total estimated IRF PPS payments. This represents a reduction from the FY 2026 threshold of $10,141 and would increase overall payments to IRFs by approximately 0.4% compared with FY 2026 levels. RCPA supports CMS' approach to updating the outlier threshold annually in a manner intended to maintain aggregate outlier payments at the target level. Because IRFs provide intensive interdisciplinary services to medically complex patients, an

appropriately calibrated outlier policy remains an important component of the IRF PPS payment structure.

IV. CMS' Requests for Information (RFI) Related to Future IRF PPS & QRP Reforms

A. CMS' Request for Information on the "Modernization" of the IRF Payment System & Adopting Advance Care Planning as an IRF QRP Measure Concept

CMS is requesting feedback on the "modernization" of the IRF payment system, including how primary diagnoses and comorbidities are used to classify patients by case-mix. Per CMS, this RFI is intended to assess whether the IRF PPS can move "toward a more robust, modernized system that is better aligned with other post-acute payment systems settings," particularly the Skilled Nursing Facility Patient Driven Payment Model (PDPM).

CMS is also seeking feedback on one measure topic that is being considered in future years for the IRF QRP: advanced care planning. Advanced care planning is a continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values, and preferences, in the event they become unable to make those decisions.

RCPA has concerns regarding the proposed consideration of IRF PPS modernization using elements of the Skilled Nursing Facility Patient Driven Payment Model. The IRF patient population, clinical complexity, and interdisciplinary care model differs from other post-acute care settings. A potential redesign, as proposed, must continue to maintain alignment with IRF-specific clinical complexity and continue to keep post-acute patient populations and diagnoses preserved.

Proposed changes, such as these, must be transparent with providers and clinicians and should include engagement to obtain feedback from these groups before advancing any structural changes to the IRF PPS.

RCPA greatly appreciates CMS' consideration of our comments related to IRF coverage, payment, and quality reporting program requirements. Questions about these comments may be made to Melissa Dehoff, Director, Rehabilitation Services Divisions, at 717-364-3284.

Sincerely,

Richard S. Edley, PhD
RCPA President and CEO