

June 10, 2025

The Honorable Mehmet Oz
The Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-1829-P
PO Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

Re: CMS-1829-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program, Proposed Rule, Vol. 90, No. 82, Federal Register (April 30, 2025)

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) 2026 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS). Our comments focus primarily on CMS' proposed payment-related proposals and proposals for the IRF Quality Reporting Program (QRP).

I. RCPA's Response to CMS' Payment-Related Proposals

Proposed Payment Adjustment Factors & Payment Update for FY 2026

For fiscal year (FY) 2026, CMS proposes a 3.4% market basket update. While RCPA appreciates the update, it is inadequate and should be increased to reflect cost increases impacting inpatient rehabilitation facilities (IRFs), which includes dramatic increases associated with salary expenses and supply expenses.

Labor costs are one of the major pressures for IRFs, with many reporting that their labor costs have increased over the past several years with little signs of slowing. Many IRFs have been forced to limit admissions due to insufficient staffing, directly impacting Medicare beneficiary access to care. Labor costs are rising far beyond the rate of inflation while workforce shortages persist throughout the health care industry, even before consideration of the higher compensation required for the more extensively trained and specialized practitioners employed in IRFs.

Labor, however, is not the only part of the market basket that is more specialized (and expensive) for IRFs compared to other settings. Services commonly provided during an IRF stay, such as the use of advanced rehabilitation technologies and specialized drugs, may also outpace services offered in other hospital-level settings of care and are not fully captured in the generalized market basket.

RCPA urges CMS to consider all avenues to ensure that patient access to care is not threatened, and provide additional financial relief for rehabilitation hospitals and units. Such support would help address not only temporary fiscal pressures, but also the long-term inflationary challenges facing hospitals, and help provide much-needed stability in the field while avoiding disruptions in patient care.

Additionally, RCPA recommends that CMS consider all options to update IRF PPS payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions in access to IRF services for Medicare beneficiaries.

II. Response to CMS' Proposals for the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

Proposed Removal of the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure and Patients Beginning With the FY 2026 IRF QRP

CMS proposes to remove two measures from IRF QRP, beginning with the FY 2026 IRF QRP: the COVID-19 vaccination coverage among health care personnel (HCP) measure, and beginning with the FY 2028 IRF QRP, the COVID-19 vaccine: percent of patients/residents who are up-to-date measure.

RCPA supports the proposed removal of the COVID-19 vaccination coverage among HCP measure and the COVID-19 vaccine: percent of patients/residents who are up-to-date measure from the IRF QRP.

Recent Centers for Disease Control and Prevention (CDC) guidance indicates that the administrative and financial burdens of maintaining these measures now outweigh their clinical and public health benefits of its continued use in the program.

The proposal to remove the HCP COVID-19 measure is supported due to concerns that have been raised regarding inaccurate reporting and inconsistency with mandates.

Proposal To Remove Four Standardized Patient Assessment Data Elements Beginning With the FY 2028 IRF QRP

CMS proposes to remove four items as standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) category: one item for Living Situation (R0310); two items for Food (R0320A and R0320B); and one item for Utilities (R0330). CMS assessed the current SDOH elements as part of its effort to “balance the need for data collections requiring quality care and the burden of data collection on health care providers,” with the goal of ensuring that any collected data elements sufficiently contribute to the improvement of care, quality, and health outcomes. Based on its assessment, CMS proposes to remove these data elements, which RCPA supports.

RCPA does have some concerns with the utilization of some of these items for IRF patients, especially those with brain injury, which supports the removal. For example, the wording of the item (Living Situation) asks the patient to identify their living situation “today,” which for patients in an IRF following a traumatic injury or other serious medical event may be difficult to determine or recall. In these instances, the patient’s medical condition may prevent them from responding appropriately or may prohibit them from knowing whether they will be able to return to the living situation they had prior to the traumatic injury/event. In responding to this item, IRF patients may also need to take into consideration whether their existing living situation is appropriate for their continued use following their injury or illness (for example, whether their living situation can accommodate new wheelchair use).

RCPA Recommendations:

- CMS should finalize the removal of the four items as standardized patient assessment data elements under the social determinants of health (SDOH) category.
- CMS should evaluate the reliability and validity of any remaining or future SDOH items and their potential responses for the population of cases that are referred to IRFs and other post-acute care settings.
- CMS should consider reducing the timeframe – such as using a three-month period – for remaining or future SDOH assessments to provide more reliable, valid, and actionable information as part of any transition of care.
- CMS should exclude patients with cognitive deficits or patients under the age of 18 from any potential requirements for data collection on any remaining or future SDOH items.

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

CMS seeks input on the importance, relevance, appropriateness, and applicability of the following quality measure concepts under consideration for future years in the IRF QRP:

Interoperability

CMS requests feedback on approaches to assessing interoperability in the IRF setting; for instance, measures that address or evaluate the level of readiness for interoperable data exchange or measures that evaluate the ability of data systems to securely share information across the spectrum of care.

IRFs already report data on two measures related to interoperability:

- IRF QRP Measure #6: Transfer of Health (TOH) Information to the Provider–Post-Acute Care (PAC) [CMIT Measure ID #00728 (not endorsed)]
- IRF QRP Measure #7: Transfer of Health (TOH) Information to the Patient–Post-Acute Care (PAC) [CMIT Measure ID #00727 (not endorsed)]

These two measures are based upon IRF-PAI assessment data elements that ask, “At the time of discharge, did your facility provide the patient’s current reconciled medication list to the subsequent provider?” or, “At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver?” Current national average performance for IRFs on these measures is well above 90% (94.7% for TOH to Provider and 97.7% for TOH to Patient). The IRF-PAI also includes follow-up assessment data elements for the “Route of Current Reconciled Medication List Transmission,” with response options that include “Electronic Health Record” and “Health Information Exchange.” It may be possible to evaluate the level of readiness for interoperable data exchange based on the responses of these IRF-PAI assessment data elements.

While these quality measures and IRF-PAI assessment data elements may not capture all the available patient health information that may be securely shared across the spectrum of care, RCPA feels this could provide an initial indication of IRF readiness for interoperable data exchange that would not impose additional administrative burden or require additional costs to implement.

Well-Being

CMS requests feedback on tools and measures that assess overall health, happiness, and satisfaction in life, potentially including aspects of emotional well-being, social connections, purpose, fulfillment, and self-care work.

The primary goal of IRF care is to restore functional ability and return the patient back to their community setting; it would be difficult to determine whether any measurement of well-being would improve over the relatively short length of stay (an average of 13 days). RCPA recommends that CMS exercise caution with identifying tools and measures related to well-being, and collaborate directly with IRFs to ensure that development of tools and measures are appropriate, limit the amount of additional burden, and provide value for IRF patients, providers, and payers.

Nutrition

CMS requests feedback on tools and frameworks that promote healthy eating habits, exercise, nutrition, or physical activity for optimal health, well-being, and best care for all. A significant number of IRF patients have primary conditions or comorbidities such as diabetes, hypertension, obesity, heart disease, or cancers that can be related to poor nutrition. By providing both medical management and functional improvement under the supervision of a rehabilitation physician, the medical and therapeutic interventions being provided in an IRF are promoting healthy eating habits, exercise, nutrition, or physical activity for optimal health and well-being.

Delirium

CMS requests feedback on the applicability of measures that evaluate for the sudden, serious change in a person's mental state or altered state of consciousness that may be associated with underlying symptoms or conditions.

IRFs are already reporting data related to Delirium through the collection of the Signs and Symptoms of Delirium (from CAM[®]) IRF-PAI assessment data elements. However, as noted below, these IRF-PAI assessment data elements received support for removal from the IRF-PAI. Delirium is very complex and is difficult to measure, suggesting that the existing items may be insufficient to make any determination or diagnosis. Additionally, those diagnosed by a physician with Delirium or Altered Level of Consciousness would be identifiable by the ICD-10 codes utilized as etiologic diagnoses or comorbidities, suggesting that the CAM[®] items are duplicative and unnecessary.

RCPA recommends that CMS evaluate opportunities to utilize the ICD-10 codes included in the IRF-PAI as these specific diagnoses or comorbidities for the purpose of evaluating a patient for the sudden, serious change in a person's mental state or altered state of consciousness, and be removed from the IRF-PAI.

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

CMS requests feedback on potential revisions to the IRF-PAI to reduce burden and streamline data collection for IRFs. Specifically, CMS is seeking input on unplanned discharges; burdens involving pediatric IRF-PAI assessments; and removal of all-payer IRF-PAI standards.

Unplanned Discharges

RCPA opposes separating the submission of the IRF-PAI into multiple time points to accommodate the differentiation of different discharge types, such as planned or unplanned discharges or patient expiration. CMS should consider updating “skip logic” within the IRF-PAI for unplanned discharges and other cases identified as incomplete stays. This would not only be a more effective way to reduce burden, but it would also maintain consistency with data collection standards provided to other post-acute care providers such as Skilled Nursing Facilities (SNFs).

Burdens Involving Pediatric IRF-PAI Assessments

RCPA supports the consideration of a pediatric IRF-PAI assessment. An assessment such as this could reduce burden, streamline the assessment process, and focus on age appropriate assessment items, all of which appear consistent with the goal of this year's IRF PPS rulemaking. This would address existing concerns about completing current IRF-PAI assessments when the items have not been tested or validated for use on the younger population and do not measure age-appropriate clinical domains.

Removal of All-Payer IRF-PAI Standards

RCPA recommends that the requirement to collect and submit complete IRF-PAI assessments for patients from all payers (i.e., non-Medicare) be removed. In addition to the inappropriateness of collection of this information on pediatric, adolescent, and all other patients under the age of 18, CMS does not use any of the IRF-PAI information from non-Medicare patients for payment or IRF QRP quality measures and public reporting.

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

CMS requests feedback on potentially reducing the IRF QRP data submission deadline from 4.5 months to 45 days. RCPA appreciates CMS' consideration of ways to improve the timeliness of IRF QRP quality measures. By the time IRF QRP measures are publicly displayed on Care Compare, the information for IRF-PAI-based measures is between 9–21 months old, information for CDC NHSN measures is between 12–24 months old, and information for Claims-Based measures is between 18–42 months old.

While the data submission deadline for IRF-PAI and CDC NHSN data may be reduced to provide more timely and actionable information, the claims-based measures — which are the least timely of the measures — would not be impacted by this proposed change. While claims do not have a defined deadline, they are submitted within a relatively short timeframe following discharge in order to receive timely payment. However, finalization of claims data is not completed and available for use until at least 18 months following the end of a quarter. RCPA recommends that CMS reduce the timeframe for finalizing claims data to achieve its goal of timelier and more effective QRP public reporting.

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

CMS requests feedback on the current state of health information technology (IT) use, including electronic health records (EHRs), in IRFs. RCPA believes any imposition of new requirements for Digital Quality Measurement will require several interim but significant steps to be realized.

RCPA recommends that CMS consider providing funding or incentive opportunities to offer IRFs the opportunity to obtain the resources and technology necessary to facilitate the improved transfer or exchange of health information consistently and reliably throughout the patient's continuum of care.

Second, RCPA requests that CMS consider a phased implementation of any new requirements, so that IRFs and their health IT systems face reasonable expectations that can be accomplished within a mutually agreeable timeframe.

Finally, RCPA asks that CMS consider instituting rural or hardship exceptions or exemptions as part of any new Digital Quality Measurement standards. For example, CMS could offer the opportunity to apply for hardship exceptions similar to what is provided in the Medicare Promoting Interoperability Program.

Proposal To End the Public Display of COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure and Patient/Resident COVID-19 Measure

CMS proposes to end public display of the HCP COVID-19 vaccination coverage measure and patient/resident COVID-19 measures after the September 2025 Care Compare refresh on the Care Compare tool at Medicare.gov.

RCPA supports the proposal to end public display of these measures that are also proposed for removal from the IRF QRP. However, it is recommended that the public display of these measures end as soon as the measure is finalized for removal from the IRF QRP.

RCPA appreciates the opportunity to comment on this proposed rule. Questions about these comments may be made to [Melissa Dehoff](#), Director, Rehabilitation Services Divisions, at 717-364-3284.

Sincerely,

A handwritten signature in black ink, appearing to read 'Richard S. Edley', written in a cursive style.

Richard S. Edley, PhD
RCPA President and CEO