DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1829–P]

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: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2026. As required by statute, this proposed rule includes the proposed 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 proposed rule includes updates to the IRF Quality Reporting Program (QRP).

DATES: To be assured consideration, comments must be received at one of the addresses provided below by June 10, 2025.

ADDRESSES: In commenting, please refer to file code CMS–1829–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1829–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1829–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Patricia Taft, (410) 786–4561, 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.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

Deregulation Request for Information (RFI): On January 31, 2025, President Trump issued Executive Order (E.O.) 14192 ''Unleashing Prosperity Through Deregulation,'' which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program. CMS has made available a Request for Information (RFI) at: *https://www.cms.gov/medicare-regulatory-relief-rfi.* Please submit all comments in response to this request for information through the provided weblink.

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 proposed 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 Kia Burwell at (410) 786–7816.

I. Executive Summary

A. Purpose

This proposed rule proposes to update the prospective payment rates for IRFs for 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 proposed rule includes the classification and weighting factors for the IRF PPS's case-mix groups (CMGs), a description of the methodologies and data used in computing the prospective payment rates for FY 2026.

For the IRF QRP, this rule proposes 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 propose to remove four Standardized Patient Assessment Data Elements under the Social Determinant of Health (SDOH) category with the FY2028 IRF QRP. We also propose to amend our reconsideration policy as described in section VII.D of this proposed rule. Finally, we include Requests for Information (RFIs) on four separate considerations: (1) future measure concepts for the IRF QRP in section

VII.E of this proposed rule; (2) potential revisions to the IRF-Patient Assessment Instrument (PAI) as described in section VII.F of this 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 this proposed rule; and (4) advancing digital quality measurement in IRFs as described in section V11.H of this proposed rule.

B. Summary of Major Provisions

In this proposed 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 IV.

For the IRF QRP, this rule proposes to remove two quality measures, remove four SDOH items and amend our reconsideration policy. We also include 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 proposed rule is an estimated $295 million increase in payments from the Federal Government to IRFs during FY 2026.
FY 2026 IRF QRP changes	The overall economic impact of this proposed 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 proposed 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 FY 2002 through FY 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 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 public health emergency. (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 proposed 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 V.B. of this proposed 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 Medicare Advantage (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

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

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, enacted on 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 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 Proposed Rule

The proposed updates to the IRF prospective payment rates for FY 2026 are 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 IV.
- 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 V.
- 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 V.
- Describe the calculation of the IRF standard payment conversion factor for FY 2026, as discussed in section V.
- 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 proposed 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.
- 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. Proposed 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 proposed rule, we propose to 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 proposing to use the FY 2024 IRF claims

and FY 2023 IRF cost report data (CMS Form 2552–10, OMB No 0938–0050). These are the most current and complete data available at this time. 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. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, we will use such data to determine the FY 2026 CMG relative weights and ALOS values in the final rule.

We are proposing 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 proposed 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 proposing to update 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 proposed rule, we discuss the proposed use of the existing methodology to calculate the proposed standard payment conversion factor for FY 2026.

In Table 2, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the proposed 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—PROPOSED 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	0.9697	0.8587	0.7788	0.7385	8	10	9	8
0102	Stroke M >=63.50 and M <72.50	1.2343	1.0930	0.9913	0.9400	11	11	11	10
0103	Stroke M >=50.50 and M <63.50	1.5845	1.4032	1.2726	1.2067	14	15	13	13
0104	Stroke M >=41.50 and M <50.50	2.0235	1.7919	1.6252	1.5410	16	17	16	16
0105	Stroke M <41.50 and A >=84.50	2.5170	2.2288	2.0214	1.9168	23	21	20	19
0106	Stroke M <41.50 and A <84.50	2.8396	2.5145	2.2805	2.1625	24	24	22	22
0201	Traumatic brain injury M >=73.50	1.0683	0.8491	0.7764	0.7290	10	9	8	9
0202	Traumatic brain injury M >=61.50 and M <73.50.	1.3868	1.1023	1.0080	0.9464	12	11	11	10
0203	Traumatic brain injury M >=49.50 and M <61.50.	1.7260	1.3718	1.2544	1.1778	14	14	13	12
0204	Traumatic brain injury M >=35.50 and M <49.50.	2.1262	1.6899	1.5453	1.4510	17	17	15	15
0205	Traumatic brain injury M <35.50	2.7176	2.1599	1.9751	1.8545	28	22	19	18
0301	Non-traumatic brain injury M >=65.50.	1.1966	0.9469	0.8820	0.8266	10	10	9	9
0302	Non-traumatic brain injury M >=52.50 and M <65.50.	1.5479	1.2249	1.1409	1.0693	12	12	11	11
0303	Non-traumatic brain injury M >=42.50 and M <52.50.	1.8292	1.4474	1.3482	1.2637	14	14	13	13
0304	Non-traumatic brain injury M <42.50 and A >=78.50.	2.1701	1.7172	1.5995	1.4992	18	17	16	15
0305	Non-traumatic brain injury M <42.50 and A <78.50.	2.3748	1.8791	1.7503	1.6405	19	19	17	16
0401	Traumatic spinal cord injury M >=56.50.	1.3893	1.1118	1.0829	0.9772	12	12	11	11
0402	Traumatic spinal cord injury M >=47.50 and M <56.50.	1.7371	1.3901	1.3540	1.2219	15	14	14	13
0403	Traumatic spinal cord injury M >=41.50 and M <47.50.	1.9959	1.5972	1.5558	1.4039	17	15	16	15
0404	Traumatic spinal cord injury M <31.50 and A <61.50.	3.2642	2.6122	2.5444	2.2960	23	33	25	21

TABLE 2—PROPOSED 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
0405	Traumatic spinal cord injury M >=31.50 and M <41.50.	2.5786	2.0635	2.0100	1.8138	20	20	21	19
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50.	3.3730	2.6993	2.6292	2.3726	24	28	26	24
0407	Traumatic spinal cord injury M <24.50 and A >=61.50.	4.6155	3.6936	3.5977	3.2466	42	36	33	33
0501	Non-traumatic spinal cord injury M >=60.50.	1.3013	1.0014	0.9327	0.8596	11	10	10	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50.	1.6192	1.2460	1.1605	1.0696	14	13	12	12
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50.	1.8350	1.4121	1.3152	1.2122	16	14	14	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50.	2.1952	1.6893	1.5734	1.4501	18	16	16	15
0505	Non-traumatic spinal cord injury M <39.50.	3.1079	2.3916	2.2276	2.0530	26	23	22	20
0601	Neurological M >=64.50	1.3092	0.9912	0.9334	0.8387	10	10	9	9
0602	Neurological M >=52.50 and M <64.50.	1.6292	1.2335	1.1617	1.0437	13	12	11	11
0603	Neurological M >=43.50 and M <52.50.	1.9373	1.4668	1.3813	1.2411	15	14	13	13
0604	Neurological M <43.50	2.4500	1.8549	1.7469	1.5695	20	17	16	16
0701	Fracture of lower extremity M >=61.50.	1.2309	0.9798	0.9312	0.8505	11	11	10	9
0702	Fracture of lower extremity M >=52.50 and M <61.50.	1.5228	1.2122	1.1520	1.0521	13	13	12	11
0703	Fracture of lower extremity M >=41.50 and M <52.50.	1.8663	1.4856	1.4119	1.2894	16	15	14	14
0704	Fracture of lower extremity M <41.50.	2.3035	1.8336	1.7426	1.5915	18	18	17	16
0801	Replacement of lower-extremity joint M >=63.50.	1.1814	0.9934	0.8854	0.8298	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50.	1.3501	1.1352	1.0118	0.9483	10	10	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50.	1.4822	1.2462	1.1107	1.0410	13	12	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50.	1.6840	1.4159	1.2620	1.1828	14	14	12	12
0805	Replacement of lower-extremity joint M <42.50.	2.0966	1.7629	1.5712	1.4726	17	17	15	15
0901	Other orthopedic M >=63.50	1.2391	0.9373	0.8841	0.8068	11	10	9	9
0902	Other orthopedic M >=51.50 and M <63.50.	1.5778	1.1935	1.1257	1.0273	13	12	12	11
0903	Other orthopedic M >=44.50 and M <51.50.	1.8712	1.4154	1.3350	1.2183	15	14	13	13
0904	Other orthopedic M <44.5	2.2545	1.7053	1.6085	1.4679	18	17	16	15
1001	Amputation lower extremity M >=64.50.	1.2283	1.0151	0.9237	0.8570	11	10	10	9
1002	Amputation lower extremity M >=55.50 and M <64.50.	1.4982	1.2381	1.1266	1.0453	13	13	12	11
1003	Amputation lower extremity M >=47.50 and M <55.50.	1.7827	1.4733	1.3406	1.2438	15	17	14	13
1004	Amputation lower extremity M <47.50.	2.3697	1.9584	1.7821	1.6534	19	19	17	17
1101	Amputation non-lower extremity M >=58.50.	1.3293	1.2612	1.0830	0.9374	12	12	11	10
1102	Amputation non-lower extremity M >=52.50 and M <58.50.	1.5509	1.4714	1.2635	1.0937	13	13	13	11
1103	Amputation non-lower extremity M <52.50.	1.9297	1.8308	1.5721	1.3608	16	17	15	13
1201	Osteoarthritis M >=61.50	1.3393	1.0444	0.9380	0.8731	11	10	9	10
1202	Osteoarthritis M >=49.50 and M <61.50.	1.5730	1.2267	1.1018	1.0255	13	12	12	11
1203	Osteoarthritis M <49.50 and A >=74.50.	2.1102	1.6457	1.4780	1.3758	16	16	15	14
1204	Osteoarthritis M <49.50 and A <74.50.	2.1650	1.6884	1.5164	1.4115	16	16	15	15
1301	Rheumatoid other arthritis M >=62.50.	1.2479	1.0037	0.9191	0.8373	10	10	10	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50.	1.5219	1.2241	1.1210	1.0212	12	12	11	10
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50.	1.7556	1.4121	1.2931	1.1780	13	14	13	12

TABLE 2—PROPOSED 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
1304	Rheumatoid other arthritis M <44.50 and A >=64.50.	2.2654	1.8222	1.6686	1.5201	16	17	16	15
1305	Rheumatoid other arthritis M <51.50 and A <64.50.	2.2620	1.8194	1.6661	1.5178	17	18	16	14
1401	Cardiac M >=68.50	1.1169	0.8993	0.8304	0.7637	10	9	9	8
1402	Cardiac M >=55.50 and M <68.50	1.4255	1.1478	1.0599	0.9747	12	12	11	10
1403	Cardiac M >=45.50 and M <55.50	1.7248	1.3888	1.2824	1.1793	14	14	13	12
1404	Cardiac M <45.50	2.1509	1.7319	1.5992	1.4706	18	17	15	15
1501	Pulmonary M >=68.50	1.3026	1.0482	0.9827	0.9427	10	10	9	9
1502	Pulmonary M >=56.50 and M <68.50.	1.5938	1.2826	1.2024	1.1534	12	12	11	11
1503	Pulmonary M >=45.50 and M <56.50.	1.8650	1.5008	1.4070	1.3497	15	14	13	13
1504	Pulmonary M <45.50	2.3356	1.8795	1.7620	1.6903	20	16	16	15
1601	Pain syndrome M >=65.50	1.0664	0.9423	0.8581	0.7820	9	10	9	9
1602	Pain syndrome M >=58.50 and M <65.50.	1.2816	1.1325	1.0313	0.9398	11	12	11	10
1603	Pain syndrome M >=43.50 and M <58.50.	1.5549	1.3739	1.2511	1.1401	13	14	13	12
1604	Pain syndrome M <43.50	2.0297	1.7935	1.6332	1.4883	14	19	16	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50.	1.3155	1.0444	0.9710	0.8933	12	10	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50.	1.6171	1.2839	1.1937	1.0982	13	13	12	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50.	1.9018	1.5099	1.4039	1.2915	15	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50.	2.1914	1.7398	1.6177	1.4882	18	17	16	15
1705	Major multiple trauma without brain or spinal cord injury M <36.50.	2.5452	2.0207	1.8788	1.7284	19	19	18	17
1801	Major multiple trauma with brain or spinal cord injury M >=67.50.	1.1158	0.9175	0.8393	0.7885	11	10	9	9
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50.	1.4226	1.1697	1.0701	1.0053	14	13	11	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50.	1.7727	1.4576	1.3333	1.2526	17	15	14	13
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50.	2.0721	1.7037	1.5585	1.4642	19	17	15	16
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50.	2.4800	2.0391	1.8654	1.7524	23	20	18	18
1806	Major multiple trauma with brain or spinal cord injury M <30.50.	3.5400	2.9107	2.6627	2.5014	35	28	27	24
1901	Guillain-Barré M >=66.50	1.3483	0.9457	0.8276	0.8220	11	10	9	9
1902	Guillain-Barré M >=51.50 and M <66.50.	1.9581	1.3734	1.2018	1.1937	15	14	13	13
1903	Guillain-Barré M >=38.50 and M <51.50.	2.7789	1.9491	1.7057	1.6942	20	18	17	18
1904	Guillain-Barré M <38.50	4.2665	2.9925	2.6187	2.6010	37	30	26	25
2001	Miscellaneous M >=66.50	1.1903	0.9543	0.8870	0.8121	10	10	9	9
2002	Miscellaneous M >=55.50 and M <66.50.	1.4763	1.1836	1.1001	1.0073	12	12	11	11
2003	Miscellaneous M >=46.50 and M <55.50.	1.7355	1.3914	1.2933	1.1841	14	13	13	12
2004	Miscellaneous M <46.50 and A >=77.50.	2.1138	1.6947	1.5752	1.4423	17	16	15	15
2005	Miscellaneous M <46.50 and A <77.50.	2.2095	1.7714	1.6465	1.5075	18	17	16	15
2101	Burns M >=52.50	1.5477	1.3171	1.0109	0.9722	14	13	10	11
2102	Burns M <52.50	2.4762	2.1072	1.6173	1.5554	19	18	16	16
5001	Short-stay cases, length of stay is 3 days or fewer.	0.0000	0.0000	0.0000	0.1756	0	0	0	3
5101	Expired, orthopedic, length of stay is 13 days or fewer.	0.0000	0.0000	0.0000	0.8544	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more.	0.0000	0.0000	0.0000	2.0471	0	0	0	20
5103	Expired, not orthopedic, length of stay is 15 days or fewer.	0.0000	0.0000	0.0000	0.9085	0	0	0	8
5104	Expired, not orthopedic, length of stay is 16 days or more.	0.0000	0.0000	0.0000	2.1866	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 proposed 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 propose to 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 proposed CMG relative weight revisions. However, the proposed 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	85	0.0
Increased by between 5% and 15%	2,490	0.6
Changed by less than 5%	434,616	99.2
Decreased by between 5% and 15%	791	0.2
Decreased by 15% or more	9	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 proposed revisions for FY 2026. The proposed 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 invite public comment on our proposed updates to the CMG relative weights and ALOS values for FY 2026.

V. Proposed 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, in this proposed rule, we are updating 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).

In FY 2016, we finalized the use of a 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs (80 FR 47049 through 47068). In FY 2020, we finalized a rebased and revised IRF market basket to reflect a 2016 base year. The FY 2020 IRF PPS final rule (84 FR 39071 through 39086) contains a complete discussion of the development of the 2016-based IRF market basket. 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. Proposed FY 2026 Market Basket Update and Productivity Adjustment

1. Proposed FY 2026 Market Basket Update

For FY 2026 (that is, beginning October 1, 2025, and ending September 30, 2026), we are proposing 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 are proposing to use the same methodology described in the FY 2025 IRF PPS final rule (89 FR 64285 through 64286).

Consistent with historical practice, we are proposing to estimate the market basket update for the IRF PPS for FY 2026 based on IHS Global Inc.'s (IGI's) 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 is projected to be 3.4 percent. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the market basket percentage increase or productivity adjustment), we will use such data, if appropriate, to determine the FY 2026 IRF market basket update in the final rule.

2. Proposed 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) 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.

Using IGI's fourth quarter 2024 forecast, the 10-year moving average growth of TFP for FY 2026 is projected to be 0.8 percent. In accordance with section 1886(j)(3)(C) of the Act, we are proposing to base the FY 2026 IRF market basket percentage increase, on IGI's fourth quarter 2024 forecast of the 2021-based IRF market basket. We are proposing 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 is 2.6 percent (3.4 percent market basket percentage increase reduced by the 0.8 percentage point productivity adjustment). Furthermore, we are proposing that if more recent data subsequently become available after the publication of the proposed rule and before the publication of the 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 the final rule.

For FY 2026, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 7 percent.[3] As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is proposing to update the IRF PPS payment rates for FY 2026 by the proposed IRF market basket update of 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 invite public comment on our proposals for the FY 2026 market basket percentage increase and productivity adjustment.

C. Proposed 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 are proposing 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 are proposing 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 is 70.8 percent. We are proposing 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 are proposing 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 are proposing 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 are proposing that if more recent data subsequently become available after publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the labor-related share), we will use such data, if appropriate, to determine the FY 2026 IRF labor-related share in the final rule.

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

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

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

	FY 2026 proposed labor-related share [1]	FY 2025 final labor-related share [2]
Wages and Salaries	49.5	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	70.8	70.7
Labor-related portion of Capital-Related (46%)	3.7	3.7
Total Labor-Related Share	74.5	74.4

[1] Based on the 2021-based IRF market basket relative importance, IGI's 4th quarter 2024 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.

We invite public comment on the proposed labor-related share for FY 2026.

D. Proposed 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 propose 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 propose to 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, GA.

We invite public comment on 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 inpatient PPS (IPPS) 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. 1301 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. 2001 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 which 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 Three-Year Phase Out of the Rural Adjustment

For FY 2026, CMS is continuing the three-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.

4. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the proposed payment rates set forth in this proposed rule, we multiply the unadjusted Federal payment rate for IRFs by the proposed FY 2026 labor-related share based on the 2021-based IRF market basket relative importance (74.5 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 V.C. of this proposed 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 proposed labor-related share of 74.5 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 0.9997.

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 proposed FY 2026 standard payment conversion factor.

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

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

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

To calculate the proposed IRF standard payment conversion factor for FY 2026, as illustrated in Table 5, we begin by applying the proposed 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 proposed 2.6 percent IRF market basket update for FY 2026 to the standard payment conversion factor for FY 2025 of $18,907 yields a proposed FY 2026 standard payment amount of $19,399. Then, we apply the proposed 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 0.9997, which results in a proposed IRF standard payment amount of $19,393. We next apply the proposed budget neutrality factor for the CMG relative weights of 0.9985, which results in the proposed IRF standard payment conversion factor of $19,364 for FY 2026.

We invite public comment on the proposed FY 2026 IRF standard payment conversion factor.

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

Explanation for adjustment	Calculations
FY 2025 IRF Standard Payment Conversion Factor	$18,907
Proposed Market Basket Update for FY 2026 of 2.6 percent*	× 1.026
Proposed Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	× 0.9997
Proposed Budget Neutrality Factor for the Revisions to the CMG Relative Weights	× 0.9985
Proposed FY 2026 Standard Payment Conversion Factor	= $19,364

*Reflects a FY 2026 3.4 percent IRF market basket percentage increase reduced by 0.8 percentage point for the proposed productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We then apply the proposed CMG relative weights described in section V.E of this proposed rule to the FY 2026 proposed standard payment conversion factor ($19,364), to determine the proposed unadjusted IRF prospective payment rates for FY 2026. The proposed unadjusted IRF prospective payment rates for FY 2026 are shown in Table 6.

TABLE 6—FY 2026 IRF PPS PROPOSED PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$18,777.27	$16,627.87	$15,080.68	$14,300.31
0102	23,900.99	21,164.85	19,195.53	18,202.16
0103	30,682.26	27,171.56	24,642.63	23,366.54
0104	39,183.05	34,698.35	31,470.37	29,839.92
0105	48,739.19	43,158.48	39,142.39	37,116.92
0106	54,986.01	48,690.78	44,159.60	41,874.65
0201	20,686.56	16,441.97	15,034.21	14,116.36
0202	26,854.00	21,344.94	19,518.91	18,326.09
0203	33,422.26	26,563.54	24,290.20	22,806.92
0204	41,171.74	32,723.22	29,923.19	28,097.16
0205	52,623.61	41,824.30	38,245.84	35,910.54
0301	23,170.96	18,335.77	17,079.05	16,006.28
0302	29,973.54	23,718.96	22,092.39	20,705.93
0303	35,420.63	28,027.45	26,106.54	24,470.29
0304	42,021.82	33,251.86	30,972.72	29,030.51
0305	45,985.63	36,386.89	33,892.81	31,766.64
0401	26,902.41	21,528.90	20,969.28	18,922.50
0402	33,637.20	26,917.90	26,218.86	23,660.87
0403	38,648.61	30,928.18	30,126.51	27,185.12
0404	63,207.97	50,582.64	49,269.76	44,459.74
0405	49,932.01	39,957.61	38,921.64	35,122.42
0406	65,314.77	52,269.25	50,911.83	45,943.03
0407	89,374.54	71,522.87	69,665.86	62,867.16
0501	25,198.37	19,391.11	18,060.80	16,645.29
0502	31,354.19	24,127.54	22,471.92	20,711.73
0503	35,532.94	27,343.90	25,467.53	23,473.04
0504	42,507.85	32,711.61	30,467.32	28,079.74
0505	60,181.38	46,310.94	43,135.25	39,754.29
0601	25,351.35	19,193.60	18,074.36	16,240.59
0602	31,547.83	23,885.49	22,495.16	20,210.21
0603	37,513.88	28,403.12	26,747.49	24,032.66
0604	47,441.80	35,918.28	33,826.97	30,391.80
0701	23,835.15	18,972.85	18,031.76	16,469.08
0702	29,487.50	23,473.04	22,307.33	20,372.86
0703	36,139.03	28,767.16	27,340.03	24,967.94
0704	44,604.97	35,505.83	33,743.71	30,817.81

TABLE 6—FY 2026 IRF PPS PROPOSED PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0801	22,876.63	19,236.20	17,144.89	16,068.25
0802	26,143.34	21,982.01	19,592.50	18,362.88
0803	28,701.32	24,131.42	21,507.59	20,157.92
0804	32,608.98	27,417.49	24,437.37	22,903.74
0805	40,598.56	34,136.80	30,424.72	28,515.43
0901	23,993.93	18,149.88	17,119.71	15,622.88
0902	30,552.52	23,110.93	21,798.05	19,892.64
0903	36,233.92	27,407.81	25,850.94	23,591.16
0904	43,656.14	33,021.43	31,146.99	28,424.42
1001	23,784.80	19,656.40	17,886.53	16,594.95
1002	29,011.14	23,974.57	21,815.48	20,241.19
1003	34,520.20	28,528.98	25,959.38	24,084.94
1004	45,886.87	37,922.46	34,508.58	32,016.44
1101	25,740.57	24,421.88	20,971.21	18,151.81
1102	30,031.63	28,492.19	24,466.41	21,178.41
1103	37,366.71	35,451.61	30,442.14	26,350.53
1201	25,934.21	20,223.76	18,163.43	16,906.71
1202	30,459.57	23,753.82	21,335.26	19,857.78
1203	40,861.91	31,867.33	28,619.99	26,640.99
1204	41,923.06	32,694.18	29,363.57	27,332.29
1301	24,164.34	19,435.65	17,797.45	16,213.48
1302	29,470.07	23,703.47	21,707.04	19,774.52
1303	33,995.44	27,343.90	25,039.59	22,810.79
1304	43,867.21	35,285.08	32,310.77	29,435.22
1305	43,801.37	35,230.86	32,262.36	29,390.68
1401	21,627.65	17,414.05	16,079.87	14,788.29
1402	27,603.38	22,226.00	20,523.90	18,874.09
1403	33,399.03	26,892.72	24,832.39	22,835.97
1404	41,650.03	33,536.51	30,966.91	28,476.70
1501	25,223.55	20,297.34	19,029.00	18,254.44
1502	30,862.34	24,836.27	23,283.27	22,334.44
1503	36,113.86	29,061.49	27,245.15	26,135.59
1504	45,226.56	36,394.64	34,119.37	32,730.97
1601	20,649.77	18,246.70	16,616.25	15,142.65
1602	24,816.90	21,929.73	19,970.09	18,198.29
1603	30,109.08	26,604.20	24,226.30	22,076.90
1604	39,303.11	34,729.33	31,625.28	28,819.44
1701	25,473.34	20,223.76	18,802.44	17,297.86
1702	31,313.52	24,861.44	23,114.81	21,265.54
1703	36,826.46	29,237.70	27,185.12	25,008.61
1704	42,434.27	33,689.49	31,325.14	28,817.50
1705	49,285.25	39,128.83	36,381.08	33,468.74
1801	21,606.35	17,766.47	16,252.21	15,268.51
1802	27,547.23	22,650.07	20,721.42	19,466.63
1803	34,326.56	28,224.97	25,818.02	24,255.35
1804	40,124.14	32,990.45	30,178.79	28,352.77
1805	48,022.72	39,485.13	36,121.61	33,933.47
1806	68,548.56	56,362.79	51,560.52	48,437.11
1901	26,108.48	18,312.53	16,025.65	15,917.21
1902	37,916.65	26,594.52	23,271.66	23,114.81
1903	53,810.62	37,742.37	33,029.17	32,806.49
1904	82,616.51	57,946.77	50,708.51	50,365.76
2001	23,048.97	18,479.07	17,175.87	15,725.50
2002	28,587.07	22,919.23	21,302.34	19,505.36
2003	33,606.22	26,943.07	25,043.46	22,928.91
2004	40,931.62	32,816.17	30,502.17	27,928.70
2005	42,784.76	34,301.39	31,882.83	29,191.23
2101	29,969.66	25,504.32	19,575.07	18,825.68
2102	47,949.14	40,803.82	31,317.40	30,118.77
5001	.....	.....	.....	3,400.32
5101	.....	.....	.....	16,544.60
5102	.....	.....	.....	39,640.04
5103	.....	.....	.....	17,592.19
5104	.....	.....	.....	42,341.32

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

Table 7 illustrates the methodology for adjusting the proposed prospective payments (as described in section V of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified as CMG 0104 (without comorbidities). The proposed 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 0.8568 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 0.9, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the proposed prospective payment, we begin by taking the proposed FY 2026 unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 6. Then, we multiply the proposed labor-related share for FY 2026 (74.5 percent) described in section V of this proposed rule by the unadjusted prospective payment rate. To determine the non-labor portion of the proposed prospective payment rate, we subtract the labor portion of the Federal payment from the proposed unadjusted prospective payment.

To compute the proposed wage-adjusted prospective payment, we multiply the labor portion of the proposed 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 proposed wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the proposed Federal payment.

Adjusting the proposed 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 PROPOSED FY 2026 IRF PROSPECTIVE PAYMENT

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		$29,839.92		$29,839.92
2	Labor-Related Share	×	0.745	×	0.745
3	Labor Portion of Payment	=	$22,230.74	=	$22,230.74
4	CBSA-Based Wage Index	×	0.8568	×	0.9000
5	Wage-Adjusted Amount	=	$19,047.30	=	$20,007.666
6	Non-Labor Amount	+	$7,609.18	+	$7,609.18
7	Wage-Adjusted Payment	=	$26,656.48	=	$27,616.85
8	Rural Adjustment	×	1.149	×	1.000
9	Wage- and Rural-Adjusted Payment	=	$30,628.29	=	$27,616.85
10	LIP Adjustment	×	1.0156	×	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	$31,106.09	=	$28,870.65
12	Wage- and Rural-Adjusted Payment		$30,628.29		$27,616.85
13	Teaching Status Adjustment	×	0	×	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,165.16
15	Wage-, Rural-, and LIP-Adjusted Payment	+	$31,106.09	+	$28,870.65
16	Total Adjusted Payment	=	$31,106.09	=	$31,035.81

Thus, the proposed adjusted payment for Facility A would be $31,106.09 and the proposed adjusted payment for Facility B would be $31,035.81.

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

A. Proposed 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 at 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 propose 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 propose 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, as we typically do, we will 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 invite public comment on the proposed update to the IRF outlier threshold for FY 2026.

B. Proposed 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 propose to apply a ceiling to IRFs' CCRs. Using that methodology, we propose 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 propose 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 propose 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 apply 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 proposed rule, we have 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 data from a previous FY's (that is, FY 2004 through FY 2022) settled cost report 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 proposed rule, we estimate a national average CCR of 0.467 for rural IRFs, and a national average CCR of 0.398 for urban IRFs.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we propose 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 proposed 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 propose that if more recent data become available after the publication of this proposed rule and before the publication of the 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 invite public comment on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2026.

II. 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 this proposed rule, we are proposing 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 are also proposing 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 propose to amend our reconsideration policy and process.

We are also seeking public comment on several Requests for Information (RFIs), specifically on: (1) future measure concepts for the IRF QRP in section VII.E of this proposed rule; (2) potential revisions to the IRF–PAI as described in section VII.F of this 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 this proposed rule; (4) advancing digital quality measurement in IRFs as described in section VII.H of this 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.
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 this proposed rule, we propose 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. Proposed 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 proposed rule for more details on this estimated burden calculation.

We propose 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.[4] 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.[5] 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 invite 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.

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

[5] 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.*

2. Proposed 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 this proposed rule, we propose 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 VII.A.2. of this proposed 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.[6] 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[7] 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 propose 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 propose 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 invite 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.

D. Proposal To Remove 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 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). 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 this proposed rule, we are proposing to remove these four standardized patient assessment data elements under the SDOH category 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 of data collection on health care providers. CMS has a goal to facilitate improved health care 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 exchanged can improve care coordination, efficiency, reduction in errors and patient experience. As health information technology (HIT) 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

[6] 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.*

[7] 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.*

quality measurement, while not imposing undue burden on essential health providers. Under our proposal, IRFs would not be required to collect and submit Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) beginning with the patients discharged on or after October 1, 2026, as previously finalized. Under our proposal, these items would not be required to meet the IRF QRP requirements beginning with the FY 2028 IRF QRP. 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. We refer readers to section VIII.A.3. of this proposed rule for more details on this estimated burden reduction.

We invite public comment 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.

E. Proposals To 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 CMS reducing 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 rulemakings, 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. Proposal To Allow 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 are proposing to remove the term ''extenuating circumstances'' as used currently in our reconsideration policy and replace it with ''extraordinary circumstances.'' Specifically, we propose 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 propose 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 propose 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 propose 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 propose 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 propose to codify this process at § 412.634(d)(6).

We further propose that 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. We propose 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 propose to codify this process at § 412.634(d)(7).

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

We invite comment 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).

3. Proposal To Update 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 propose 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 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, 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 propose to revise § 412.634(d)(5) to codify this modified policy in our regulation. The remainder of the text at § 412.634(d)(5) would remain the same. We note that we are considering proposing similar modifications across all post-acute care setting quality reporting programs to more closely align the reconsideration processes.

We invite 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).

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

We are seeking 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 2024 IRF PPS proposed rule (88 FR 21000 through 21003), 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 2024 IRF PPS final rule (88 FR 51036 and 51037) for a summary of the public comments we received in response to the RFI.

We are seeking input on four concepts for future measures for the IRF QRP.

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

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

1. Interoperability

We are seeking input on the quality measure concept of interoperability, focusing on information technology systems' readiness and capabilities in the IRF setting. Title XXX of the Public Health Service Act defines ''interoperability'' in part, and with respect to health information technology (IT), as health IT that enables the secure exchange of electronic health information with, and use of electronic

health information from, other health IT without requiring special efforts by the user.[8] The definition further states that interoperability of health IT allows for complete, including by providers and patients, access, exchange, and use of electronically accessible health information for authorized uses under applicable State or Federal Law.[9] We request input and comment 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. Please provide input on the relevant aspects of interoperability for the IRF setting.

2. Well-Being

We are seeking input on a quality measure concept of well-being for future quality measures. Well-being is a comprehensive approach to disease prevention and health promotion as it integrates mental, and physical health [10] [11] while emphasizing preventative care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting well-being of patients and their family members. We request input and comment on tools and measures that assess for overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, fulfillment, and self-care work. Please provide input on the relevant aspects of well-being for the IRF setting.

3. Nutrition

We are seeking input on a quality measure concept of nutrition for future quality measures. Assessment of an individual's nutritional status may include various strategies, guidelines, and practices designed to promote healthy eating habits and ensure individuals receive the necessary nutrients for maintaining health, growth, and overall well-being. This also includes aspects of health that support or mediate nutritional status, such as physical activity and sleep. In this context, preventable care plays a vital role by proactively addressing factors that may lead to poor nutritional status or related health issues. These efforts not only support optimal nutrition but also work to prevent conditions that could otherwise hinder an individual's health and nutritional needs. We request input and comment on tools and frameworks that promote healthy eating habits, exercise, nutrition, or physical activity for optimal health, well-being, and best care for all. Please provide input on the relevant aspects of nutrition for the IRF setting.

4. Delirium

Finally, we are seeking input on a quality measure concept of delirium for future quality measures. Delirium, often under-detected, is a common complication of illness or injury that leads to negative health outcomes like frailty, cognitive impairment, and functional decline. Post-acute care patients experiencing delirium symptoms are more likely to undergo rehospitalization, experience poor functional recovery outcomes, and have a higher 6-month mortality rate compared to patients without delirium.[12] We request input and comment 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. Please provide input on the relevant aspects of delirium for the IRF setting.

As we review new measure concepts, CMS will prioritize outcome measures that are evidenced-based.

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 Inpatient Rehabilitation Facility Patient Assessment Instrument (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 are seeking feedback on potential revisions to the IRF–PAI to reduce burden and streamline data collection for IRFs. Specifically, we are seeking 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?

We intend to use this input to inform our future IRF–PAI development efforts.

[8] Public Health Service Act, 42 U.S.C. 3000(9) (2025).

[9] Public Health Service Act, 42 U.S.C. 3000(9) (2025).

[10] Overall well-being. See more information at: *https://odphp.health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measures/overall-well-being-ohm-01.*

[11] Well-Being Measurement. See more information at: *https://www.va.gov/WHOLEHEALTH/professional-resources/well-being-measurement.asp.*

[12] Marcantonio, E.R., Kiely, D.K., Simon, S.E., John Orav, E., Jones, R.N., Murphy, K.M., & Bergmann, M.A. (2005). Outcomes of older people admitted to post-acute facilities with delirium. *Journal of the American Geriatrics Society, 53*(6), 963–969. *https://doi.org/10.1111/j.1532-5415.2005.53305.x.*

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

Sections 1886(j)(7)(E), and 1899B(f) and (g) of the Act require CMS to provide feedback to IRFs and to publicly report their performance on IRF quality measures specified under section 1899B(c)(1) of the Act and resource use and other measures specified under 1899B(d)(1) of the Act. More specifically, section 1899B(f)(1) of the Act requires the Secretary to provide confidential feedback reports to IRFs on their performance on the quality, resource use, and other measures specified under sections 1899B(c)(1) and (d)(1). Section 1899B(f)(2) provides that, to the extent feasible, the Secretary must make these confidential feedback reports available, not less frequently than on a quarterly basis, except in the case of measures reported on an annual basis, in which case confidential feedback reports may be made available annually. Additionally, sections 1886(j)(7)(E) and 1899B(g)(1) of the Act requires the Secretary to provide for the public reporting of each IRF's performance on the quality, resource use, and other measures specified under section 1899B(c)(1) and (d)(1) of the Act by establishing procedures for making the performance data available to the public. Section 1899B(g)(2) of the Act specifically requires that such procedures must ensure, through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act, that IRFs can review and submit corrections to the data and other information before it is made public.

Although sections 1899B(f) and (g) of the Act require the provision of confidential feedback reports and public reporting of IRF performance on measures, section 1886(j)(7)(C) of the Act provides the Secretary with discretion to prescribe the form and manner and the timeframes for IRFs to submit data as specified for reporting for the IRF QRP. Thus, in the FY 2016 IRF PPS final rule (80 FR 47122), we finalized that IRFs will have approximately 4.5 months (135 days) after each quarterly data collection period to complete their data submissions and make corrections to such data where necessary. We did not receive any comments on the 4.5-month data submission timeframe.

Public reporting of data collected under quality programs, such as the IRF QRP, is designed to provide consumers and their families with the most current information, so they can make quality-informed decisions about where to receive their care. In the process of implementing the public reporting for the quality reporting programs, we have identified that the time between when data on measures is collected and submitted to us and when that data are publicly reported (that is, approximately 9 months) may be too long to provide the most accurate and up to date information for the public. For example, we have heard from interested parties that the IRF QRP measure results are not useful for their quality improvement efforts due to the aged data and the delay in when they receive these reports.[13]

Currently, the largest contributing factor to the nine-month lag between the end of the data collection period and when measures are publicly reported is the 4.5-month timeframe for data submission. If the data submission timeframe was reduced from 4.5 months to 45 days, then the lag time between the end of the data collection period and public reporting of that data could be reduced by up to three months. This revised timeframe would result in more timely public reporting of data that may provide more value for consumers and families as they make decisions about where they may want to receive their care. Additionally, this timeframe provides IRFs with more recent data to use in their quality improvement activities.

An important consideration in reducing the data submission timeframe is the potential burden it may place on IRFs, which could lead to fewer assessments submitted within the shorter 45-day data submission timeframe. We conducted an analysis to evaluate the potential impact of reducing the timeframe by determining how many assessments are currently being submitted within 45 days. Using 2023 data, we identified that only 2.4 percent of all IRF–PAI assessments were submitted after the 45-day timeframe. Of those submissions, only two-thirds (or 1.6 percent of the total) were submitted between 45 days and 4.5 months and hence have potential to be impacted.[14] Because assessments are tied to payment, providers are likely to submit assessments close to the date of service and to close out medical records once the patient is discharged from service. On these bases, we believe reducing the IRF QRP data submission deadline from 4.5 months to 45 days would improve the timeliness of public reporting by one quarter, which could be beneficial to both consumers and IRFs with limited change in burden to IRFs.

We are requesting feedback on this potential future reduction of the IRF QRP data submission deadline from 4.5 months to 45 days that is under consideration. Specifically, we are requesting 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 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 are issuing 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 information technology (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,[15] 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:

[13] IRF Listening Session: Revising the Transmission Schedule for the IRF–PAI. Available in the Downloads section on the IRF QRP Measures Information web page: *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-measures-information.*

[14] Internal CMS analysis of FY 2023 IRF–PAI assessment data.

[15] ''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).

- Our intent 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 are considering 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 seek 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 are also seeking 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 this 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 seek 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 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 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 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? [16]
- Would your IRF and/or vendors be interested in participating in testing to explore options for transmission of assessments, for example testing the 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 to facilitate 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

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

success stories related to the implementation of these technologies.

We invite any feedback, suggestions, best practices, or success stories related to the implementation of these technologies and will use this input to inform our future dQM transition efforts.

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

We are not proposing any new policies regarding Form, Manner, and Timing of Data Submission Under the IRF QRP in this 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. Proposal To End the Public Display of COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

In the FY 2022 IRF PPS final rule (86 FR 42401), 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 section VII.C.1 of this proposed rule, we are proposing to remove the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure beginning with the FY 2026 IRF QRP. If finalized as proposed, an IRFs HCP COVID–19 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 will no longer display IRFs' HCP COVID–19 rates on the Care Compare tool at *Medicare.gov.*

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

3. Proposal To End the Public Display of Patient/Resident COVID–19 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 section VII.C.2, we are proposing to remove the Patient/Resident COVID–19 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. If finalized as proposed, we propose that the Patient/Resident COVID–19 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.

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

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day 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, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) 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 are soliciting 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 VII.E of this proposed rule, we are proposing to amend the IRF QRP reconsideration request policy and process. As we noted in the FY2016 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 IX.6b of this proposed rule. We welcome 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 VII.C.I of the proposed rule, we propose to remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19) measure, beginning with the FY 2026 IRF QRP.

We note 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)).[17] 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.[18] To account for overhead and fringe

[17] 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*).

[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.*

benefits, we have doubled the hourly 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 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.

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 VII.C.2 of this proposed rule, we propose 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.[19] 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 estimate 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 estimate 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 estimate the total cost will be decreased by $187.06 per IRF annually, or $218,116.15 for all IRFs annually.

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

In section VII.D of this proposed rule, we propose 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.[20] 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].

[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.*

[20] 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 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 estimate that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would decrease under this proposal. We estimate 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 estimate 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 invite 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.

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

Requirement	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed 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
Proposed 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

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 this proposed rule, is a decrease of 1.5 minutes or 0.025 hour of clinical staff time. We estimate 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 estimate the total cost for the proposed requirements of the FY 2028 IRF QRP will be decreased by $935.32 per IRF annually, or $1,089,642.75 for all IRFs annually. These amounts are detailed in Table 14.

TABLE 14—ESTIMATED CHANGE IN BURDEN ASSOCIATED WITH OMB CONTROL NUMBER 0938–0842

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
Proposed 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
Proposed removal of four standardized patient assessment data elements beginning with the FY 2028 IRF QRP	−10.67	−748.25	−12,446.00	−872,464.60

We invite public comments on the proposed information collection requirements.

IX. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would update 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 proposed rule would 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 proposed rule proposes to adopt 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).

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 proposed rule by comparing the estimated payments in FY 2026 with those in FY 2025. This analysis results in an estimated $295 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 proposed rule, if finalized as proposed, is expected to be an E.O. 14192 deregulatory action. We estimate that this rule would generate approximately $1 million in 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 health care 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 1,166 IRFs, of which approximately 47 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. As shown in Table 15, we estimate that the net revenue impact of the proposed rule on all IRFs is to increase estimated payments by approximately 2.8 percent. 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. We do not believe that this threshold will be reached by the requirements in this proposed rule. Therefore, the Secretary has certified that this proposed 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 15. 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 603 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 15, we estimate that the net revenue impact of this proposed rule on rural IRFs is to increase estimated payments by approximately 2.7 percent based on the data of the 131 rural units and 14 rural hospitals in our database of 1,166 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas between 1.6 percent and 5.7 percent. As a result, we anticipate that this proposed 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 proposed 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 proposed 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

We have estimated the impact of the proposed rule. This proposed rule updates the IRF PPS rates contained in the FY 2025 IRF PPS final rule (88 FR 50956). Specifically, this proposed rule proposes updates to the CMG relative weights and ALOS values, the wage index, and the outlier threshold for high-cost cases. This proposed rule would 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 proposed rule would be a net estimated increase of $295 million in payments to IRFs for FY 2026. The impact analysis in Table 15 of this proposed rule represents the projected effects of the proposed updates to IRF PPS payments for FY 2026 compared with the estimated IRF PPS payments in FY 2025. We determine 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 proposing to implement the standard annual revisions described in this proposed 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 $295 million.

This estimate is derived from the application of the proposed 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 $20 million increase in aggregate payments to IRFs due to the proposed update to the outlier threshold amount. We estimate that these proposed updates would result in a net increase in estimated payments of $295 million from FY 2025 to FY 2026.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 15. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 2.8 percent to 3.0 percent of total estimated payments for FY 2026, consistent with section 1886(j)(4) of the Act.
- The effects of the proposed 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 proposed 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 proposed 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 proposed estimated payments based on the FY 2026 payment changes relative to the estimated FY 2025 payments.

2. Description of Table 15

Table 15 shows the overall impact on the 1,166 IRFs included in the analysis.

The next 12 rows of Table 15 contain IRFs categorized according to their geographic location, designation 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 1,021 IRFs located in urban areas included in our analysis. Among these, there are 645 IRF units of hospitals located in urban areas and 376 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 518 for-profit IRFs. Among these, there are 479 IRFs in urban areas and 39 IRFs in rural areas. There are 553 non-profit IRFs. Among these, there are 466 urban IRFs and 87 rural IRFs. There are 95 government-owned IRFs. Among these, there are 76 urban IRFs and 19 rural IRFs.

The remaining four parts of Table 15 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 proposed rule to the facility categories listed are shown in the columns of Table 15. 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 three-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 proposed policies reflected in this proposed rule for FY 2026 to our estimated payments

per discharge in FY 2025 without the proposed policies.

The average estimated increase in payments for all IRFs is approximately 2.8 percent. This estimated net increase includes the effects of the proposed IRF market basket update for FY 2026 of 2.6 percent, which is based on a proposed IRF market basket percentage increase of 3.4 percent, less a proposed 0.8 percentage point productivity adjustment, as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.2 percent overall increase in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Since we are making the proposed updates to 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 proposed 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 15—PROPOSED 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	1,166	444,412	0.2	0.0	0.0	2.8
Urban unit	645	142,940	0.4	−0.2	0.0	2.8
Rural unit	131	17,940	0.3	−0.1	0.1	2.9
Urban hospital	376	276,551	0.1	0.1	0.0	2.8
Rural hospital	14	6,981	0.0	−0.4	0.0	2.2
Urban For-Profit	479	274,477	0.1	0.1	0.0	2.7
Rural For-Profit	39	10,654	0.1	−0.2	0.0	2.5
Urban Non-Profit	466	127,101	0.3	−0.1	0.0	2.9
Rural Non-Profit	87	12,421	0.3	−0.1	0.1	2.9
Urban Government	76	17,913	0.4	−0.2	0.1	2.8
Rural Government	19	1,846	0.2	−0.6	0.1	2.3
Urban	1,021	419,491	0.2	0.0	0.0	2.8
Rural	145	24,921	0.2	−0.2	0.1	2.7
Urban by region:						
Urban New England	30	15,406	0.1	1.7	0.1	4.6
Urban Middle Atlantic	113	42,457	0.2	0.4	0.0	3.2
Urban South Atlantic	188	99,882	0.2	0.2	0.0	2.9
Urban East North Central	165	50,096	0.2	0.4	0.0	3.3
Urban East South Central	56	28,860	0.1	0.6	0.0	3.3
Urban West North Central	79	25,162	0.2	0.5	0.0	3.3
Urban West South Central	210	95,229	0.1	−0.6	0.0	2.1
Urban Mountain	81	35,821	0.1	−0.6	0.0	2.2
Urban Pacific	99	26,578	0.5	−1.0	0.0	2.1
Rural by region:						
Rural New England	5	1,102	0.3	1.1	0.1	4.2
Rural Middle Atlantic	11	1,390	0.2	−1.2	0.1	1.7
Rural South Atlantic	17	6,370	0.1	−0.9	0.0	1.8
Rural East North Central	23	3,002	0.4	0.2	0.0	3.2
Rural East South Central	19	3,236	0.2	−1.2	0.1	1.6
Rural West North Central	19	2,273	0.3	0.2	0.1	3.3
Rural West South Central	44	6,953	0.2	0.5	0.1	3.4
Rural Mountain	5	321	0.2	2.6	0.2	5.7
Rural Pacific	2	274	1.0	0.5	0.3	4.4
Teaching status:						
Non-teaching	1,060	393,903	0.2	0.0	0.0	2.8
Resident to ADC less than 10%	58	35,281	0.2	−0.1	0.0	2.7
Resident to ADC 10%–19%	37	13,852	0.4	−0.4	0.0	2.7
Resident to ADC greater than 19%	11	1,376	0.5	1.3	0.0	4.4
Disproportionate share patient percentage (DSH PP):						
DSH PP = 0%	62	15,745	0.4	−0.4	0.0	2.5
DSH PP <5%	183	93,425	0.1	0.2	0.0	3.0
DSH PP 5%–10%	241	103,512	0.1	−0.1	0.0	2.6
DSH PP 10%–20%	402	152,880	0.2	0.0	0.0	2.8
DSH PP greater than 20%	278	78,850	0.3	−0.1	0.0	2.8

[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 2025 of 3.4 percent, reduced by 0.8 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 Proposed 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 15.

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 2.8 percent in FY 2025. Thus, we are adjusting the outlier threshold amount in this proposed rule from $12,043 in FY 2025 to $11,971 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 0.2 percentage point increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.8 percent to 3.0 percent. The impact of this update to the outlier threshold amount (as shown in column 4 of Table 15) is to increase estimated overall payments to IRFs by 0.2 percentage point.

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

In column 5 of Table 15, we present the effects of the proposed 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 proposed 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 proposed changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this proposed rule, we are proposing to update the FY 2026 labor-related share from 74.4 percent in FY 2025 to 74.5 percent in FY 2026.

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 proposed changes would have small distributional effects. For example, we estimate the largest increase in payments of 2.6 percent for rural IRFs in the Mountain region. We estimate the largest decrease in payments from the proposed update to the wage index and labor-related share to be a 1.2 percent decrease for rural IRFs in the Middle Atlantic and East South Central regions.

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

In column 6 of Table 15, we present the effects of the proposed budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these proposed 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 the proposed 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 VII.C.I of the proposed rule, we propose 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.[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)
Administrative Assistants	43–6013	$18.01	$18.01	$36.02

We estimate that the removal of this measure from the IRF QRP will results 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 VII.E of this proposed rule, we propose 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

[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.*

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 U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[22] To account for overhead and fringe benefits, we have 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)
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 VII.C.2 of the proposed rule, we propose 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 VII.D of this proposed rule, we propose 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.[23] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 18.

TABLE 18—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

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 19.

[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.*

[23] 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 19—ESTIMATED IRF QRP PROGRAM IMPACTS

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 invite public comments on the proposed effects on requirements.

D. Alternatives Considered

IRF PPS Updates

As noted previously in this proposed 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 propose to update the IRF prospective payments in this proposed rule by 2.6 percent (which equals the 3.4 percent IRF market basket percentage increase for FY 2026 reduced by a 0.8 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, short stay transfers to home health, 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 propose 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 propose 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 are proposing 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 this 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 this proposed rule. For each reviewer of the rule, the estimated cost is $387.84 (3 hours × $129.28). Therefore, we estimate 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 this proposed rule. Table 20 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for IRFs in our database.

TABLE 20—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	$295 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.

TABLE 20—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURE—Continued

	Category	Transfers
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 2.8 percent, compared with the estimated payments in FY 2025, as reflected in column 7 of Table 15.

IRF payments per discharge are estimated to increase by 2.8 percent in urban areas and 2.7 percent in rural areas, compared with estimated FY 2025 payments. Payments per discharge to rehabilitation units are estimated to increase 2.8 percent in urban areas and 2.9 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.8 percent in urban areas and 2.2 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this proposed rule. The largest payment increase is estimated to be 5.7 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.

Steph Carlton, Acting Administrator of the Centers for Medicare & Medicaid Services, approved this document on April 8, 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 proposes to amend 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; and

(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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