Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2026

MEDICARE IRF PPS PROPOSED RULE

Overview and Resources

On April 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released the proposed federal fiscal year (FFY) 2027 payment rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the proposed rule and other resources related to the IRF PPS are available on the CMS website.

An online version of the proposed rule is available here.

Program changes proposed by CMS would be effective for discharges on or after Oct. 1, 2026, unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate update to be an increase of $355 million in aggregate payments to IRFs in FFY 2027 over FFY 2026.

Comments on this proposed rule are due to CMS by June 1, 2026 and can be submitted electronically here by using the website's search feature to search for file code "CMS-1845-P."

IRF Payment Rate

The table below shows the FFY 2027 proposed IRF standard payment conversion factor, inclusive of budget neutrality adjustments, compared to the FFY 2026 rate that is currently in effect.

	Final FFY 2026	Proposed FFY 2027	Percent Change
IRF Standard Payment Conversion Factor	$19,371	$19,881	+2.63%

The table below provides details of the proposed updates to the IRF payment rates for FFY 2027.

Proposed FFY 2027 Update Factor Component	IRF Rate Updates
Market Basket (MB) Update	+3.2%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 Percentage Points (PPTs)
Wage Index/Labor-Related Share Budget Neutrality (BN)	+0.33%
Case-Mix Groups (CMG) and CMG Relative Weight Revisions BN	-0.10%
Net Rate Update	+2.63%

Wage Index, Labor-Related Share, and Revised CBSA Delineations

CMS proposed to continue using the FFY 2027 pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) wage index to adjust payments rates under the IRF PPS for FFY 2027. The wage index is applied to the labor-related portion of the IRF standard rate to adjust for differences in area wage levels.

Using the 2021-based market basket, CMS proposed the labor-related share of the standard rate at 74.5% for FFY 2027, an increase from 74.4% in FFY 2026.

CMS applies a 5% cap on any decrease to the IRF wage index, compared with the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IRF's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the IRF's capped wage index in the prior FFY. A new IRF is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IRF would not have a wage index in the prior FFY.

CMS proposed a wage index and labor-related share budget neutrality factor of 1.0033 for FFY 2027 to ensure that aggregate payments made under the IRF PPS are not greater or less than what would otherwise be made if wage adjustments had not changed. This budget neutrality factor also includes the impact of the 5% cap on IRF wage index decreases.

CMS is soliciting comments on creating an IRF-specific wage index using alternative data sources, such as Bureau of Labor Statistics data or IRF cost reports, for potential use in future years.

Case-Mix Group Relative Weight Updates

CMS assigns IRF discharges into case-mix groups (CMGs) that are reflective of the different resources required to provide care to IRF patients. Patients are first categorized into rehabilitation impairment categories based on the primary reason for rehabilitative care. Patients are further categorized into CMGs based upon their ability to perform activities of daily living or based on age and cognitive ability (motor score). Within each of the CMGs there are four tiers, each with a different relative weight that is determined based on comorbidities. Currently, there are 95 CMGs with four tiers, and five other CMGs that account for very short stays and patients who die in the IRF.

Each year, CMS updates the CMG relative weights and average lengths of stays (ALOS) with the most recent available data. CMS proposed updates to these factors for FFY 2027 using FFY 2025 IRF claims data and FFY 2024 IRF cost report data (or most current available). To compensate for the CMG weights changes, CMS proposed a FFY 2027 case-mix budget neutrality factor of 0.9990.

CMS did not propose any changes to the CMG categories or definitions. Using the claims data, CMS' analysis shows that 99.4% of IRF cases are in CMGs and tiers that experience less than a +/-5% change in its CMG relative weight as a result of the updates. The proposed FFY 2027 CMG payments weights and ALOS values are provided in Table 2 of the proposed rule.

Outlier Payments

Outlier payments were established under the IRF PPS to provide additional payments for extremely costly cases. Outlier payments are made if the estimated cost of the case exceeds the payment for the case plus an outlier threshold. Costs are determined by multiplying the facility's overall cost-to-charge ratio (CCR) by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost of the case and the outlier threshold.

CMS has established a target of 3% of total IRF PPS payments to be set aside for high-cost outliers. For FFY 2027 CMS proposed an outlier threshold value of $8,689, a 14.32% decrease compared to the current threshold of $10,141, based on FFY 2025 claims data.

Updates to the IRF CCR Ceiling

CMS applies a ceiling to IRFs' CCRs. If an individual IRF's CCR exceeds this ceiling, that CCR is replaced with the appropriate national average CCR for that FFY, either urban or rural. The national urban and

rural CCRs and the national CCR ceiling for IRFs are updated annually based on analysis of the most recent data that is available. The national urban and rural CCRs are applied when:

- New IRFs have not yet submitted their first Medicare cost report;
- IRFs overall CCR is in excess of the national CCR ceiling for the current FFY; and/or
- Accurate data to calculate an overall CCR is not available for IRFs.

CMS proposed to continue setting the national CCR ceiling at three standard deviations above the mean CCR and is therefore proposing a national CCR ceiling of 1.54 for FFY 2027. If an individual IRF's CCR exceeds this ceiling for FFY 2027, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS proposed a national average CCR of 0.461 for rural IRFs and 0.386 for urban IRFs.

Updates to the IRF Basis of Payment Requirements

For an IRF claim to be considered reasonable and necessary, a patient's intensive rehabilitation therapy program must consist of at least three hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day for at least five days a week and all therapies must begin within 36 hours from midnight of the day of admission to the IRF. To remediate ambiguous policy interpretation on whether one therapy or all therapies need to be initiated with 36 hours, CMS proposed revising § 416.622(a)(3)(ii) to require that all therapy treatments and/or therapy evaluations must begin no later than 36 hours after midnight of the day of admission.

Additionally, as part of § 412.622(a)(4)(i)(B)) IRFs are also required to document a preadmission screening that must *"include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination."* CMS proposed revising this policy to require that the patient's "current functional status" is documented in the preadmission screening to build a more complete picture of the rehabilitation trajectory and expected level of improvement while in the IRF.

Under the current Interdisciplinary Team (IDT) meeting policy IDT meetings must occur *"at least once per week throughout the duration of the patient's stay."* To enhance the development and execution of a patient's plan of care CMS proposed requiring the initial IDT meeting to occur on or before the fourth day from midnight on the date of the patient's admission. CMS is also proposing that a patient's subsequent IDT meetings occur weekly following the initial IDT meeting. Lastly, CMS proposed revising the definition of "week" to mean a period of seven consecutive calendar days.

Request for Information (RFI) – Future IRF Payment Reform

CMS is seeking input on future payment reforms to enhance and modernize the IRF payment structure to align with other post-acute care settings and evolving clinical practices. Specifically, these reforms include exploring alternatives to how primary diagnoses are mapped to clinical categories, and the potential use of comorbidity scores and score bins to categorize comorbidities.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP)

In the Calendar Year (CY) 2016 End-Stage Renal Disease PPS and DMEPOS final rule CMS finalized that a bidding entity may not submit a bid and be awarded a contract for competition unless it obtains a bid

surety bond in each competitive acquisition area in an amount of no less than $50,000 and no more than $100,000.

In the CY 2026 Home Health PPS final rule CMS outlined a plan to implement remote item delivery (RID) CBPs for certain items designated under the DMEPOS CBP. To discourage DMEPOS suppliers from submitting non-serious or disingenuous bids, CMS proposed requiring a single bid surety bond of $100,000 for all bids submitted by a bidding entity for RID competitions in a round of the DMEPOS CBP, rather than the current $50,000. For all non-RID competitions CMS proposed maintaining a bid surety bond amount of $50,000.

Updates to the IRF Quality Reporting Program (QRP)

CMS collects quality data from IRFs on measures that relate to three stated resource domains. IRFs that do not successfully participate in the IRF QRP are subject to a 2 percentage point reduction to the market basket update for the applicable year, as required by law.

The following table lists the previously finalized IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures		
IRF QRP Measures	**NQF #**	**Payment Determination Year**
National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138	FFY 2015+
Influenza Vaccination Coverage among Healthcare Personnel	#0431	FFY 2016+
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure	#1717	FFY 2017+
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674	FFY 2018+
IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	#2635	FFY 2018+
IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	#2636	FFY 2018+
Discharge to Community - Post Acute Care (PAC) IRF, with the added exclusion of patients with a hospice benefit in the 31-day post-discharge observation window		FFY 2020+
Medicare Spending Per Beneficiary - PAC IRF		FFY 2020+
Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRFs		FFY 2020+
Potentially Preventable Within Stay Readmission Measure for IRFs		FFY 2020+
Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based)		FFY 2020+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		FFY 2020+
Transfer of Health Information to the Provider-Post-Acute Care (PAC)		FFY 2022+
Transfer of Health Information to the Patient-PAC		FFY 2022+
Discharge Function Score Measure		FFY 2025+

Beginning with the FFY 2029 IRF QRP, CMS proposed revising both the IRF QRP Assessment Data Submission Deadline and the CDC NHSN Data Submission deadlines from the current 4.5-month deadline to approximately 45 days. Specifically, for both submission deadlines CMS proposed that IRFs complete their data submissions and any corrections, if necessary, no later than the day 15 of the second month after the end of the calendar quarter. If that day falls on a Friday, weekend, or Federal holiday, the deadline would be delayed until 11:59 p.m. EST on the next business day. Tables 12 and 13 in the

proposed rule detail the proposed data collection timeframes and data submission deadlines for the FFY 2029 payment determination.

RFI – IRF QRP Measure Concepts Under Consideration for Future Years

CMS is seeking input on the importance, relevance, appropriateness, and applicability of quality measure topic related to advanced care planning, a continuous process that supports people in understanding and communicating goals, values, and preferences regarding future medical decisions. CMS is also seeking input on the relevant aspects of advanced care planning and measures appropriate for the IRF setting.

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