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CMS Finalizes 2.6% Payment Increase and Quality Reporting Changes in the FY 2026 Inpatient Rehabilitation Facility Final Rule

On August 1, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2026 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) final rule. CMS released a fact sheet accompanying the rule.

In this rule, CMS finalizes policies to:

- increase IRF payment rates by 2.6 percent,
- update case mix group (CMG) weights and average length of stay values based on FY 2024 IRF claims and FY 2023 cost report data,
- maintain the current wage adjustment methodology and update cost-to-charge ratios for IRFs,
- continue the phased reduction of the rural adjustment for IRFs reclassified from rural to urban, and
- update the IRF Quality Reporting Program (IRF QRP) for FY 2026 and beyond, by removing two COVID-19 vaccination measures, phasing out four Social Determinants of Health assessment items by FY 2028, and by clarifying the reconsideration process by defining qualifying circumstances and accompanying documentation requirements for deadline extension requests.

The final rule also summarizes feedback received in response to requests for information on future enhancements to the IRF QRP and reiterates the opportunity to respond to the Trump administration's request for information on deregulation[1] as it applies to the IRF PPS.

Finalized payment updates are effective for discharges occurring on or after October 1, 2025 through September 30, 2026.

This final rule is scheduled to be published in the *Federal Register* on August 5, 2025.

[1] EO 14192, Unleashing Prosperity Through Deregulation

CMS FINALIZES 2.6% INCREASE IN IRF PAYMENTS FOR FY 2026

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For FY 2026, CMS increases IRF PPS payment rates by 2.6 percent,[2] which includes a market basket percentage of 3.3 percent to changes in the cost of goods and services typically used in IRFs. This update also includes a 0.7 percentage point productivity adjustment (down from a proposed 0.8 percentage point adjustment).

Additionally, CMS revises the labor-related share for IRFs, which determines the portion of payment rates adjusted for regional wage differences. This share is calculated by identifying cost categories influenced by local labor markets, such as wages, benefits, and labor-related services. Based on the 2021-based IRF market basket and IGI's fourth quarter 2024 forecast, CMS finalizes a labor-related share of 74.4% for FY 2026. This includes 70.7% for operating costs and 3.7% for capital-related costs that vary with local wages.

Finally, CMS updates the outlier threshold to maintain outlier payments at 3.0% of total payments, or an amount of $10,062 in FY 2026.

CMS UPDATES TO CASE-MIX GROUP WEIGHTS AND AVERAGE LENGTH OF STAY VALUES

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In this final rule, CMS updates the Case-Mix Group (CMG) relative weights and Average Length of Stay (ALOS) values under the IRF PPS to better align payments with the relative resource needs of each CMG. For example, a CMG with a weight of 2 represents twice the average cost of a CMG with a weight of 1, supporting more accurate payments based on clinical complexity and resource use.

For FY 2026, CMS uses FY 2024 IRF claims data and FY 2023 IRF cost report data to update CMG relative weights and ALOS values. CMS continues to use its standard methodology, including cost-to-charge ratios from IRF units within acute care hospitals and hospital-specific relative value methods, to adjust for comorbidities and estimate case-level costs.

[2] Section 1886(j) of the Social Security Act

CMS PROPOSES FY 2026 WAGE INDEX AND PAYMENT UPDATES, CONTINUES RURAL ADJUSTMENT PHASE-OUT

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For FY 2026, CMS maintains its existing wage adjustment methodology for inpatient rehabilitation facilities (IRFs) as required by law,[3] which requires wage-related costs to be adjusted based on regional differences in hospital wage levels. These updates reflect core-based statistical area (CBSA) delineations and use pre-reclassification and pre-floor hospital wage index data from FY 2022 cost report data. A 5% cap on year-over-year wage index decreases, established in FY 2023, will remain in effect. Where no hospital wage data are available (such as in certain rural or urban regions) CMS will apply statewide or regional averages as proxies.

Additionally, CMS will continue the second year of a three-year phase-out of the rural adjustment for IRFs that transitioned from rural to urban status due to updated CBSA delineations, allowing affected facilities to receive one-third of the original rural adjustment in FY 2026. CMS clarifies that this policy does not apply to urban IRFs transitioning to rural status and notes that they will receive the full rural adjustment.

To ensure budget neutrality, CMS applies a wage adjustment factor of 0.9997 in FY 2026. Combined with the 3.3% market basket update, the FY 2026 IRF standard payment conversion factor increases from $18,907 to $19,371.

Finally, CMS updates the cost-to-charge ratio (CCR) values used to estimate IRF costs. For FY 2026, the national average CCRs are 0.398 for urban and 0.463 for rural IRFs.

CMS FINALIZES CHANGES TO IRF QUALITY REPORTING: ELIMINATES COVID-19 MEASURES, SDOH ITEMS, AND CLARIFIES RECONSIDERATION POLICY

Pages 58-88

The IRF QRP requires that IRFs submit required quality data or be subject to a 2.0 percentage point reduction in their Annual Increase Factor (AIF). Measures are publicly reported by CMS on the Care Compare website. All IRFs are required to report standardized patient assessment data as part of the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP). This data is collected via the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI).

[3] Section 1886(j)(6) of the Social Security Act

CMS finalizes several updates to the IRF-QRP to reduce administrative burden and improve clarity in policy implementation. First, CMS removes two COVID-19 vaccination measures:

- **The Healthcare Personnel (HCP) Vaccination Coverage** measure beginning in FY 2026, and,
- **The Patient/Resident Vaccination Status** measure beginning in FY 2028. IRFs would not be required to collect and submit this measure data to CMS for patients discharged on or after October 1, 2025. CMS also clarifies that IRFs wo do not report this data for quarter four of 2025 will not be penalized for the FY 2027 Annual Increase Factor Determination.

Additionally, CMS finalizes its proposal to remove four standardized Social Determinants of Health (SDOH) patient assessment items from the FY 2028 IRF QRP, citing provider burden and current limitations in data interoperability as reasons for removal.

In this final rule, CMS amends the IRF QRP Reconsideration policy to allow IRFs to request an extension for filing reconsideration requests due to events beyond a provider's control. Additionally, the agency clarifies that upon review of reconsideration requests, initial findings of noncompliance can be reversed if the IRF can provide proof of compliance with all QRP requirements during the reporting period, or if the IRF can provide a valid excuse for non-compliance.

CMS SUMMARIZES STAKEHOLDER FEEDBACK ON FUTURE IRF QRP ENHANCEMENTS

Pages 89-94

In the proposed rule, CMS issued four RFIs on future measure concepts for the IRF QRP including interoperability, well-being, nutrition and delirium. In the final rule, CMS provides a summary of stakeholder feedback received in comments.

Interoperability
Commenters were divided on an interoperability measure for IRFs. Supporters emphasized its role in care coordination and urged standards-based, clinically meaningful approaches. Others raised concerns about limited CMS support for IRF IT systems and differences in EHRs across settings.

Well-Being
Commenters offered varied input on a well-being measure for IRFs. Some supported its inclusion and suggested using person-centered or palliative care measures, aligning with HR 6110,[4] or focusing on patient independence. Others raised concerns about the broad nature

[4] HR 6110: Access to Inpatient Rehabilitation Therapy Act of 2023

of well-being, potential redundancy with existing measures, and added provider burden. Several urged CMS to validate any new measure and ensure feasibility within the IRF setting.

Nutrition
Commenters offered mixed feedback on a potential nutrition measure. Supporters emphasized its role in improving rehabilitation outcomes and recommended individualized plans and collaboration with nurses. Others urged CMS to avoid duplication, suggesting nutrition may be better addressed through IRF-PAI assessments rather than a standalone quality measure.

Delirium
Some commenters supported a delirium measure and recommended nonpharmacologic approaches, use of standardized tools, and collaboration with nurses. Others raised concerns about burden and redundancy, noting that delirium data is already collected via the IRF-PAI and that its prevalence in IRFs is low. Several urged CMS to ensure the measure is evidence-based and endorsed before implementation.

CMS ACKNOWLEDGES COMMENTS ON ADDITIONAL IRF QRP REQUESTS FOR INFORMATION

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CMS also summarized stakeholder feedback on RFIs from the proposed rule relevant to (1) revisions to the IRF-Patient Assessment Instrument (IRF-PAI), (2) a proposal to shorten the data submission deadline from 4.5 months to 45 days, (3) advancing digital quality measurement (dQM) using FHIR® technology, and (4) public display of COVID-19 vaccine measures.

IRF-PAI Revisions
CMS sought feedback on simplifying the IRF-PAI to reduce burden, including using skip logic for unplanned discharges and possibly developing a pediatric version. Commenters supported burden reduction but requested clarity on discharge definitions and input from providers before final changes.

Shortening Submission Deadline
CMS requested input on reducing the IRF QRP data submission window from 4.5 months to 45 days. Some commenters supported faster reporting, but most raised concerns about data quality, staff burden, and system readiness. Suggestions included phased implementation or alternative timelines.

Digital Quality Measurement
CMS requested feedback on transitioning to digital quality measures using FHIR®.

Commenters generally supported the shift but emphasized the need for technical support, funding, phased rollout, and accommodations for small and rural IRFs.

Public Display of COVID-19 Vaccine Measures
CMS finalized plans to end public reporting of HCP and patient COVID-19 vaccination rates after the September 2025 Care Compare refresh.

CMS REITERATES OPPORTUNITY TO COMMENT ON DEREGULATION PER RECENT EXECUTIVE ORDER

On January 31, 2025, President Trump signed Executive Order 14192,[5] Unleashing Prosperity Through Deregulation, directing federal agencies to reduce regulatory costs and administrative burdens. In response, CMS is seeking public input on ways to streamline Medicare regulations and ease compliance for providers, beneficiaries, and other stakeholders. Comments can be submitted through the RFI portal at: https://www.cms.gov/medicare-regulatory-relief-rfi.

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[5] EO 14192, Unleashing Prosperity Through Deregulation