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CMS Releases FY 2026 IRF PPS Proposed Rule: 2.6% Payment Increase, Quality Reporting Changes, and Solicitation of Feedback on Future Quality Measures

On April 11, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2026 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule. CMS released a fact sheet accompanying the rule.

In this rule, CMS proposes 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, clarifying the reconsideration process by defining "extraordinary circumstances," and requiring clear documentation for deadline extension requests.

The proposed rule also includes four requests for information on future enhancements to the IRF QRP and provides stakeholders the opportunity to respond to the Trump administration's request for information on deregulation[1] as it applies to the IRF PPS.

This proposed rule is scheduled to be published in the *Federal Register* on April 30, 2025, and comments are due by June 10, 2025.

[1] EO 14192, Unleashing Prosperity Through Deregulation

CMS PROPOSES 2.6% INCREASE IN IRF PAYMENTS FOR FY 2026

For FY 2026, CMS proposes to update IRF PPS payment rates as required by law,[2] using a market basket percentage increase that reflects changes in the cost of goods and services typically used in IRFs. This update is based on a recently rebased market basket, which uses 2021 as the base year. The projected market basket increase is 3.4%, based on economic forecasts from IHS Global Inc. (IGI). After applying the required productivity adjustment, calculated as a 10-year moving average of total factor productivity growth across the private nonfarm business sector, the adjusted update is reduced by 0.8 percentage points, resulting in a proposed net payment update of 2.6% for FY 2026.

Despite the Medicare Payment Advisory Commission (MedPAC) recommending a 7% reduction to IRF PPS payments for FY 2026, CMS does not have the statutory authority to apply a different update factor beyond the methodology described above. As a result, the proposed increase remains at 2.6%.

Additionally, CMS proposes revising 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 proposes a labor-related share of 74.5% for FY 2026. This includes 70.8% for operating costs and 3.7% for capital-related costs that vary with local wages.

Finally, CMS proposes to update the outlier threshold to maintain outlier payments at 3.0% of total payments. In total, CMS estimates that the proposed technical rate setting changes will result in an estimated increase in IRF payments of $295 million for FY 2026.

CMS invites public comment on proposed payment updates.

CMS PROPOSES UPDATES TO CMG WEIGHTS AND ALOS VALUES

In this proposed 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.

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

The updates are based on FY 2024 IRF claims and FY 2023 cost report data, with more recent data to be incorporated if available before finalization. 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. This process adjusts for comorbidities, estimates case-level costs, calculates updated CMG weights, and normalizes them to match the FY 2025 average.

To ensure budget neutrality, CMS applies a factor of 0.9985 to the payment rate after wage adjustments. CMS estimates that 99.2% of IRF cases will experience less than a 5% change. Only 0.6% of cases will see increases of 5–15%, and 0.2% will see decreases in that range, with negligible changes beyond those levels. ALOS updates are minimal and show no major shifts in stay patterns.

CMS invites public comment on these proposed CMG and ALOS updates for FY 2026.

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

For FY 2026, CMS proposes to maintain 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 will continue to reflect core-based statistical area (CBSA) delineations and use pre-reclassification and pre-floor hospital wage index data from FY 2022 cost reports. 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.

To ensure budget neutrality, CMS proposes a wage adjustment factor of 0.9997. This is applied after adjusting the standard payment rate for the labor-related share (74.5%) and wage index. Combined with the 2.6% market basket update, the FY 2026 IRF standard payment conversion factor would increase from $18,907 to $19,364.

CMS also proposes updates to the cost-to-charge ratio (CCR) values used to estimate IRF costs. For FY 2026, the proposed national average CCRs are 0.467 for rural IRFs and 0.398 for urban IRFs, based on FY 2023 cost reports. A CCR ceiling of 1.54 is proposed; if an IRF's CCR exceeds this threshold, CMS would apply the applicable national average (urban or

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

rural) instead. These updates aim to ensure accuracy in cost estimation and maintain consistency with past methodologies.

CMS invites public comment on all proposed wage and payment adjustments for FY 2026.

CMS PROPOSES STREAMLINING IRF QUALITY REPORTING: ELIMINATES COVID-19 MEASURES, SDOH ITEMS, AND CLARIFIES RECONSIDERATION POLICY

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).

CMS proposes several updates to the IRF-QRP to reduce administrative burden and improve clarity in policy implementation. First, CMS proposes removing two COVID-19 vaccination measures. The Healthcare Personnel (HCP) Vaccination Coverage measure would be eliminated starting in FY 2026 due to the end of the Public Health Emergency and the reduced severity of COVID-19, which diminishes the benefit of continued data collection relative to provider burden. Similarly, the Patient/Resident Vaccination Status measure would be phased out starting with patients discharged on or after October 1, 2025, and officially removed from the IRF-PAI by October 2026, due to similar concerns about burden and declining COVID-19 risk.

Additionally, CMS proposes to remove four standardized Social Determinants of Health (SDOH) patient assessment items from the FY 2028 IRF QRP. CMS cites provider burden and current limitations in data interoperability as reasons for removal, noting that future advancements in health IT may reduce barriers to collecting this information.

CMS also seeks to clarify and update the IRF QRP reconsideration process. Notably, the agency proposes to replace the term "extenuating circumstances" with "extraordinary circumstances" to align with established policies and provide more specific guidance for requesting deadline extensions due to events beyond a provider's control. IRFs would have 30 days from the noncompliance notification date to request an extension, with clearly defined documentation requirements. CMS further proposes codifying that it will only grant reconsideration requests if an IRF demonstrates full compliance with QRP requirements, including any granted exceptions or extensions.

Public comment is invited on all proposed changes.

CMS SEEKS FEEDBACK ON FUTURE IRF QRP ENHANCEMENTS

1. Quality Measure Concepts Under Consideration (Interoperability, Well-Being, Nutrition, Delirium):
CMS is requesting feedback on four new measure concepts for future inclusion in the IRF Quality Reporting Program (QRP). These include (1) interoperability, focusing on data exchange capabilities between health IT systems; (2) well-being, addressing comprehensive physical and mental health indicators such as emotional wellness and life satisfaction; (3) nutrition, considering assessments and tools that evaluate diet, physical activity, and other factors that support nutritional status; and (4) delirium, aimed at identifying and managing acute changes in cognitive function that can lead to poor outcomes in post-acute care. CMS seeks stakeholder input on the relevance and feasibility of these topics in the IRF setting.

2. Potential Revisions to the IRF-PAI (Patient Assessment Instrument):
CMS is exploring ways to streamline the IRF-PAI to reduce provider burden and improve data collection efficiency. The agency is specifically seeking input on whether to create skip patterns based on discharge type (e.g., unplanned, expired), which would align IRF processes with other post-acute care settings. Additionally, CMS is considering the development of a pediatric-specific IRF-PAI to ensure age-appropriate assessments. Stakeholder feedback will help shape future enhancements to the instrument.

3. Proposal to Shorten the Data Submission Deadline from 4.5 Months to 45 Days:
To improve the timeliness of public reporting, CMS is evaluating whether to shorten the IRF QRP data submission deadline from 135 days to 45 days following each quarterly reporting period. This change could reduce the overall lag between data collection and public reporting by up to three months. Feedback is requested on the potential benefits for consumers and providers, as well as any operational challenges that may arise.

4. Advancing Digital Quality Measurement (dQM) Using FHIR® Technology:
CMS is gathering input on the adoption of Fast Healthcare Interoperability Resources (FHIR®)-based APIs for quality data submission in the IRF QRP. The agency is interested in understanding current health IT capabilities across IRFs, including use of certified electronic health records, methods of data exchange, and barriers to interoperability. CMS also seeks information on how facilities are managing privacy, security, and workflow integration, and whether providers are ready to transition to standardized, digital reporting formats. Responses will inform future planning around digital quality measurement initiatives.

CMS INVITES COMMENT ON DEREGULATION PER RECENT EXECUTIVE ORDER

On January 31, 2025, President Trump signed Executive Order 14192,[4] 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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[4] EO 14192, Unleashing Prosperity Through Deregulation