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FY 2027 IRF PPS Final Rule Signals Modest Growth and Broader Payment Reform Direction

On July 30, 2026, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2027 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 2.3 percent;
- Update Case-Mix Group (CMG) relative weights and average length of stay (ALOS) values;
- Maintain the current wage index methodology while updating the labor-related share, outlier threshold, and cost-to-charge ratio (CCR) policies;
- Revise IRF coverage requirements and care coordination policies, including the 36-hour therapy initiation and interdisciplinary team (IDT) meeting requirements;
- Update the IRF Quality Reporting Program (QRP) by shortening data submission timelines (beginning FY 2029);
- Update the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) bid surety bond requirements for Remote Item Delivery (RID) CBPs.

The final rule also discusses two Requests for Information (RFIs) included in the proposed rule: one on potential IRF PPS payment reform, including diagnosis-based patient classification and revised comorbidity scoring methodologies, and another on future IRF QRP quality measure concepts, including Advance Care Planning (ACP). CMS states it may take the stakeholder feedback received into consideration in future rulemaking.

This final rule is scheduled to be published in the *Federal Register* on August 3, 2026.

CMS FINALIZES FY 2027 IRF PAYMENT RATE UPDATE OF 2.3 PERCENT AND CASE-MIX REFINEMENTS

FINALIZED WITH MODIFICATION

Pages 14-34[1]

For FY 2027, CMS finalizes an update to the IRF PPS payment rates as required by law,[2] using the 2021-based IRF market basket, which reflects changes in the cost of goods and services typically used by IRFs. Based on **IHS Global Inc.'s second quarter 2026 forecast**, CMS finalizes a 3.2 percent market basket increase. After applying the required **0.9 percentage point productivity adjustment,**[3] **the final payment update is 2.3 percent.**[4]

CMS also finalizes updates to CMG relative weights and ALOS values using FY 2025 claims and FY 2024 cost report data.[5] CMS maintains its existing methodology and applies a 0.9990 budget neutrality adjustment, resulting in no change to total aggregate payments while redistributing payments across CMGs and comorbidity tiers. CMS estimates that 99.4 percent of cases will experience less than a 5 percent change in CMG relative weights, and that ALOS changes are minimal and do not reflect meaningful shifts in utilization patterns.

CMS estimates that the payment update will result in a $340 million increase in IRF payments compared to FY 2026. The impact on individual facilities will vary based on patient mix and other payment adjustments.

CMS FINALIZES FY 2027 WAGE INDEX AND OTHER PAYMENT ADJUSTMENTS

FINALIZED WITH MODIFICATION

Pages 34-61

For FY 2027, CMS finalizes its existing Core-Based Statistical Area (CBSA)-based wage index methodology, including the 5 percent cap on year-over-year wage index decreases and continued use of statewide or regional proxies where local wage data are unavailable. CMS also finalizes a **74.3 percent labor-related share,**[6] consisting of **70.6 percent for operating costs**[7] and 3.7 percent for capital-related costs subject to geographic wage adjustment. FY 2027 also marks the final year of the three-year phase-out of the rural adjustment for IRFs

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[1] All page numbers listed are from the unpublished final rule.
[2] Section 1886(j) of the Social Security Act
[3] **Proposed:** 0.8 percentage points; updated based on more recent data.
[4] **Proposed:** 2.4 percent; updated based on more recent data.
[5] See table 2 on pages 16-20 of the unpublished final rule for the final CMG relative weights and ALOS values.
[6] **Proposed:** 74.5 percent; updated based on more recent data.
[7] **Proposed:** 70.8 percent; updated based on more recent data.

reclassified from rural to urban under the revised CBSA delineations. Affected IRFs will receive the full FY 2027 urban wage index without the former 14.9 percent adjustment. IRFs that remain classified as rural will maintain the full 14.9 percent rural adjustment.

To maintain budget neutrality, CMS finalizes a **wage adjustment factor of 1.0036.**[8] CMS also finalizes lowering the **high-cost outlier threshold to $8,857**[9] to maintain outlier payments at approximately 3.0 percent of total IRF PPS payments and updates the CCRs to **0.465 for rural IRFs**[10] and 0.386 for urban IRFs while maintaining a 1.56 national ceiling with national average CCRs applied where needed.

In the proposed rule, CMS signaled interest in future wage index reform and sought comment on the use of alternative data sources (e.g., Bureau of Labor Statistics occupation-level wage data or IRF-specific approaches) to better reflect geographic variation in labor costs. The agency states it may take this feedback into consideration if it develops an IRF-specific wage index in the future.

While CMS largely maintains its existing payment methodology, the updated payment parameters will affect FY 2027 payments differently across IRFs based on geographic labor costs and the volume of high-cost cases.

CMS FINALIZES UPDATES TO IRF COVERAGE REQUIREMENTS AND CARE COORDINATION POLICIES

36-Hour Initiation Requirement

FINALIZED AS PROPOSED

Pages 62-68

For FY 2027, CMS finalizes revisions to the IRF coverage requirements, clarifying that all therapy treatments and/or therapy evaluations ordered at admission must be initiated within 36 hours after midnight on the day of admission, rather than only one required therapy. CMS also clarifies that the requirement applies only to therapies ordered at admission and that therapies ordered after the initial 36-hour period are not subject to the requirement. An IRF claim that does not meet this coverage requirement may not be considered reasonable and necessary for Medicare coverage.

Preadmission Screening Documentation

NOT FINALIZED

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[8] **Proposed:** 1.0033; reflecting the updated labor-related share of 74.3 percent.
[9] **Proposed:** $8,689; updated based on more recent data.
[10] **Proposed:** 0.461; updated based on more recent data.

Pages 68-70

CMS does not finalize its proposal to require documentation of a patient's current functional status in the PAS after commenters requested greater clarity regarding documentation expectations and compliance requirements. The agency states it will pursue additional policy specificity and may consider feedback in future rulemaking.

Initial Interdisciplinary Team Meeting Requirements

FINALIZED WITH MODIFICATION

Pages 70-83

IDT meetings are meetings in which a patient's IRF care team reviews rehabilitation progress, recommends therapy changes, and updates the plan of care. Under current policy,[11] IDT meetings must occur at least weekly, which CMS notes has been interpreted to permit the initial meeting as late as seven days after admission. To promote earlier care coordination, CMS proposed requiring the initial IDT meeting to occur on or before the fourth day from midnight on the day of admission, but commenters raised concerns about operational challenges, particularly for weekend admissions and staffing constraints.

In response, CMS finalizes a modified policy requiring the initial IDT meeting to occur within four days of admission, rather than four days from midnight on the date of admission. CMS states this revision provides greater implementation flexibility while still promoting earlier interdisciplinary care planning. CMS also finalizes its proposal requiring subsequent IDT meetings within seven days of the previous meeting and revises the definition of "week" to mean seven consecutive calendar days.

These policies clarify existing IRF coverage requirements while providing flexibility for IDT meeting timing. CMS's decision not to finalize the PAS proposal suggests it may revisit the policy with greater specificity in future rulemaking.

CMS FINALIZES IRF QRP DATA SUBMISSION UPDATES AND DISCUSSES FUTURE QUALITY MEASURE CONCEPTS

For FY 2027, CMS finalizes revisions to the IRF QRP data submission requirements but does not change the public display of quality measure data. CMS also summarizes stakeholder feedback on future quality measure concepts without finalizing any new measures.

Revised Data Submission Timelines Beginning FY 2029

FINALIZED AS PROPOSED

Pages 94-110

[11] § 412.622(a)(5)

CMS finalizes its proposal to shorten the IRF QRP data submission deadline beginning with the FY 2029 IRF QRP. Under the revised policy, IRFs must submit and correct IRF Patient Assessment Instrument and applicable Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) quality reporting data by the 15th day of the second month after the end of each calendar quarter (approximately 45 days), replacing the current 4.5-month submission timeframe. CMS retains the existing weekend and federal holiday extension policy and the submission deadline for influenza vaccination reporting.

In response to comments requesting longer submission windows and additional flexibility, CMS states that a 45-day deadline will reduce the current nine-month lag between data collection and public reporting by three months. The agency notes that most IRFs already submit data within this timeframe and expects the revised deadline to improve the timeliness of quality information without increasing reporting burden.

Request for Feedback on Future Quality Measure Concepts

Pages 94-98

CMS sought feedback on developing an ACP quality measure for the IRF QRP, as well as on other future measure concepts. Commenters expressed mixed views, with some supporting an ACP measure to promote person-centered care and others raising concerns about its applicability in the IRF setting, documentation burden, and duplication of existing requirements. CMS states it may consider this feedback as it develops future measures.

CMS is prioritizing more timely, actionable quality data while signaling a broader shift toward outcome-oriented, person-centered measurement.

CMS CONTINUES TO EVALUATE FUTURE IRF PAYMENT REFORM AND MODERNIZATION

Pages 84-93

In the proposed rule, CMS requested stakeholder feedback on potential reforms to modernize the IRF PPS and better align payments with patient characteristics, clinical complexity, and resource use. In this final rule, CMS summarizes stakeholder comments and states that it will continue to evaluate these concepts before pursuing future rulemaking.

- **Patient Clinical Classification:** CMS continues to evaluate replacing the current multi-step patient classification system (ICD-10 to Impairment Group Code (IGC) to Rehabilitation Impairment Code (RIC) to CMG) with a more direct, diagnosis-based approach using ICD-10-CM codes. While commenters generally supported improving payment accuracy, many raised concerns about the methodology, reliance on SNF Patient-Driven Payment Model (PDPM)-based clinical categories, potential payment impacts, and implementation.

- **Comorbidity Adjustment Methodology:** CMS also continues to evaluate replacing the current three-tier comorbidity adjustment with a weighted scoring methodology modeled after the SNF PDPM Non-Therapy Ancillary (NTA) component. Stakeholders generally supported better recognizing patient complexity, but many expressed concerns about the methodology, transparency, and potential impacts on payment accuracy and beneficiary access.

CMS has not adopted any payment reforms but remains interested in modernizing the IRF PPS. Future proposals are likely to be informed by further evaluation of the potential effects on payment accuracy, beneficiary access, and provider behavior.

CMS FINALIZES UPDATES TO DMEPOS COMPETITIVE BIDDING PROGRAM BID SURETY BOND REQUIREMENTS

FINALIZED AS PROPOSED

Pages 111-115

CMS finalizes updates to the DMEPOS CBP bid surety bond requirements to support implementation of Remote Item Delivery (RID) competitive bidding programs. RID CBPs allow contract suppliers to furnish certain DMEPOS items to Medicare beneficiaries across large regional or nationwide competitive bidding areas through remote delivery. For future non-RID competitions, CMS maintains the existing $50,000 bid surety bond requirement.

For RID CBPs, CMS finalizes requiring a $100,000 bid surety bond, reflecting the broader geographic scope and supplier responsibility associated with regional or nationwide competitions. CMS also finalizes requiring only one $100,000 bid surety bond per bidding entity for all RID bids submitted in a competition round, regardless of the number of RID competitive bidding areas. In addition, CMS finalizes revising the regulatory text to replace the term "bid bond value" with "bid surety bond amount."

The final policy increases the financial commitment required for participation in RID CBPs. CMS expects the revised structure to support larger regional or nationwide RID competitions with less administrative burden for suppliers.

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