

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

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On April 2, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2027 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 2.4 percent,
- update case mix group (CMG) weights and average length of stay values based on FY 2025 IRF claims and FY 2024 cost report data,
- maintain the current wage adjustment methodology, including a 5 percent cap on decreases, finalize the phase-out of the rural adjustment, and apply a budget-neutral wage adjustment factor of 1.0033,
- update outlier and cost-to-charge ratio (CCR) policies, including lowering the outlier threshold to \$8,689 and updating CCRs (0.461 rural / 0.386 urban) with a 1.54 ceiling,
- revise IRF coverage and care coordination requirements,
- update the IRF Quality Reporting Program (QRP) by shortening data submission timelines (beginning FY 2029), and
- maintain and refine broader payment and delivery policies, including signaling future wage index reform and alignment across post-acute care settings.

The proposed rule also includes two requests for information (RFIs): one on potential IRF PPS payment reform, including diagnosis-based classification and revised comorbidity scoring, and another on advanced care planning measures in the IRF QRP.

Additionally, CMS proposes updates to the DMEPOS Competitive Bidding Program, including increasing bid surety bond requirements to \$100,000 for Remote Item Delivery (RID) models while maintaining \$50,000 for traditional competitions.

**This proposed rule is scheduled to be published in the *Federal Register* on April 6, 2026, and comments are due by June 1, 2026.**



## CMS PROPOSES A 2.4 PERCENT MARKET BASKET UPDATE FOR FY 2027

*Pages 22-26*

For FY 2027, CMS proposes to update IRF PPS payment rates as required by law,<sup>1</sup> using a market basket percentage increase that reflects changes in the cost of goods and services typically used in IRFs.

Based on the 2021-based IRF market basket and IHS Global Inc.'s (IGI's) fourth quarter 2025 forecast, CMS projects a 3.2 percent market basket increase. After applying the required productivity adjustment of 0.8 percentage points, the proposed net payment update is 2.4 percent for FY 2027.

CMS also proposes to maintain the IRF labor-related share at 74.5 percent, based on the 2021-based market basket and IGI's latest forecast. This includes 70.8 percent for operating costs and 3.7 percent for capital-related costs that vary with local wages, reflecting the portion of payments adjusted for geographic wage differences.

**While the proposed market basket update is 2.4 percent, CMS estimates that total IRF payments will increase by approximately 2.8 percent in FY 2027 after accounting for other policy changes, primarily an increase in outlier payments.**

## CMS PROPOSES UPDATES TO CMG WEIGHTS AND ALOS VALUES

*Pages 14-21*

CMS proposes updates to CMG relative weights and average length of stay (ALOS) under the IRF PPS for FY 2027 to better align payments with patient resource needs. The updates are based on FY 2025 claims and FY 2024 cost report data, using CMS's existing methodology, with potential incorporation of newer data in the final rule.

CMS maintains budget neutrality by applying a 0.9990 adjustment factor, resulting in no change to total aggregate payments but redistributing payments across CMGs and tiers. CMS estimates that 99.4 percent of cases will see less than a 5 percent change in relative weights.

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<sup>1</sup> Section 1886(j) of the Social Security Act

ALOS changes are minimal and do not reflect meaningful shifts in length-of-stay patterns.

## CMS PROPOSES FY 2027 WAGE INDEX AND PAYMENT UPDATES, ENTERS FINAL STRETCH OF RURAL ADJUSTMENT PHASE-OUT

*Pages 27-39*

For FY 2027, CMS proposes to maintain its current wage index methodology (CBSA-based, using FY 2024 data), including the 5 percent cap on year-over-year decreases and use of statewide or regional proxies where data are unavailable. FY 2027 represents the final year of the rural adjustment phase-out for IRFs reclassified from rural to urban, eliminating the remaining 14.9 percent adjustment.

To maintain budget neutrality, CMS proposes a 1.0033 wage adjustment factor, alongside a 2.4 percent net payment update (3.2 percent market basket minus 0.8 percentage point productivity adjustment). CMS also proposes to lower the outlier threshold to \$8,689 to maintain outlier payments at approximately 3.0 percent of total payments, and to update CCRs to 0.461 (rural) and 0.386 (urban), maintaining a 1.54 ceiling with national averages applied where needed.

CMS also signals interest in future wage index reform, seeking comment on the potential 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.

**Proposed policy changes will likely result in localized payment shifts, particularly for rural providers and high-cost cases, as CMS continues to refine payment accuracy within a budget-neutral framework.**

## CMS PROPOSES UPDATES TO IRF COVERAGE REQUIREMENTS AND CARE COORDINATION POLICIES

*Pages 44-51*

For FY 2027, CMS proposes several updates to IRF coverage and documentation requirements to improve care coordination and ensure compliance with medical necessity criteria. CMS clarifies that all required therapy disciplines must be initiated within 36 hours of admission, rather than just one therapy, and failure to meet this requirement would render the IRF stay not reasonable and necessary for Medicare coverage.

CMS also proposes to enhance preadmission screening requirements by requiring documentation of the patient's current functional status, in addition to prior functional status, to better inform care planning and expected outcomes.

In addition, CMS proposes to require that the initial interdisciplinary team (IDT) meeting occur no later than Day 4 of admission, aligning with plan of care development timelines and promoting earlier care coordination. Subsequent IDT meetings would continue on a weekly cadence (every 7 days from the prior meeting). CMS indicates this change is intended to improve interdisciplinary communication, reduce care gaps, and support better patient outcomes.

**These proposals introduce more prescriptive coverage and documentation standards, increasing compliance expectations and potential audit risk for IRFs.**

## **CMS PROPOSES IRF QUALITY REPORTING PROGRAM (QRP) UPDATES AND SEEKS INPUT ON FUTURE MEASURES**

*Pages 58-65*

For FY 2027, CMS proposes updates to the IRF Quality Reporting Program (QRP), including revised data submission timelines beginning with the FY 2029 program year to improve the timeliness of public reporting. Specifically, CMS proposes shortening the current 4.5-month submission window to require data submission by the 15th day of the second month following each calendar quarter (approximately 45 days). CMS estimates this change would accelerate public reporting by up to three months with minimal provider burden.

These revised timelines would apply to both IRF-Patient Assessment Instrument (PAI) assessment data and CDC NHSN data, while maintaining the existing submission deadline for influenza vaccination reporting.

CMS also seeks stakeholder input through an RFI on future quality measure concepts, with a focus on advanced care planning and person-centered care, as well as broader opportunities to enhance measure relevance and usefulness for quality improvement.

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

## CMS REQUESTS INPUT ON FUTURE IRF PAYMENT REFORM AND MODERNIZATION

*Pages 52-57*

CMS is seeking stakeholder input on potential reforms to the IRF PPS to better align payments with patient characteristics, clinical complexity, and resource use, while improving consistency with other post-acute care payment systems.

CMS is considering replacing the current multi-step 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 to assign patients into a revised set of clinical categories aligned with models such as the Skilled Nursing Facility Patient-Driven Payment Model (PDPM). This approach is intended to improve payment accuracy, transparency, and alignment with clinical care.

CMS is also exploring a new comorbidity scoring methodology, similar to the PDPM Non-Therapy Ancillary (NTA) model, which would assign weighted scores based on the number and severity of comorbidities and group patients into broader comorbidity score bins rather than the current tiered structure.

CMS indicates these potential reforms are intended to address observed differences in profitability across patient groups, reduce incentives for selective admissions, and better reflect patient severity. CMS invites public comment on these potential changes and future direction of IRF payment policy.

**This RFI signals a potential structural redesign of the IRF PPS, with movement toward diagnosis-driven and more standardized payment methodologies across post-acute care settings**

## CMS PROPOSES UPDATES TO DMEPOS COMPETITIVE BIDDING PROGRAM BID SURETY BOND REQUIREMENTS

*Pages 66-69*

CMS proposes updates to bid surety bond requirements under the DMEPOS Competitive Bidding Program (CBP) to support implementation of Remote Item Delivery (RID) competitive bidding models. For traditional (non-RID) competitions, CMS would maintain the existing \$50,000 bid surety bond requirement.

For RID competitive bidding areas—expected to be nationwide or large regional markets—CMS proposes requiring a \$100,000 bid surety bond, reflecting the broader geographic scope and increased supplier responsibility. CMS also proposes that only one bond would be required per bidder for all RID bids within a round, regardless of the number of areas bid.

CMS indicates these changes are intended to discourage non-serious bids, ensure supplier capacity, and support more efficient, large-scale competitive bidding structures. CMS invites public comment on these proposals.

**The proposal is likely to increase financial and operational thresholds for participation, favoring larger suppliers and supporting consolidation in the DMEPOS market.**

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