Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2025

MEDICARE INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM – RULE SUMMARY

Overview and Resources

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) released the proposed federal fiscal year (FFY) 2026 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 here. 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, 2025 unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate update to be an increase of $295 million in aggregate payments to IRFs in FFY 2026 over FFY 2025.

Comments on this proposed rule are due to CMS by June 10, 2025 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1829-P."

Request for Information (RFI) – Deregulation

On Jan. 31, 2025, President Trump issued Executive Order (EO) 14192 'Unleashing Prosperity Through Deregulation,' which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other interested parties participating in the Medicare program. CMS has made available an RFI here. Submit all comments in response to this RFI through the provided weblink.

IRF Payment Rate

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the proposed IRF standard payment conversion factor for FFY 2026 compared to the rate currently in effect.

	Final FFY 2025	Proposed FFY 2026	Percent Change
IRF Standard Payment Conversion Factor	$18,907	$19,364	2.42%

The table below provides details of the proposed updates to the IRF payment rates for FFY 2026.

Proposed CY 2026 Update Factor Component	IRF Rate Updates
Market Basket (MB) Update	+3.4%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 Percentage Points (PPTs)

Wage Index/Labor-Related Share Budget Neutrality (BN)	-0.03%
Case-Mix Groups (CMG) and CMG Relative Weight Revisions BN	-0.15%
Net Rate Update	**+2.42%**

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

CMS is proposing to continue to use the most recent inpatient hospital wage index, the FFY 2026 pre-floor, pre-reclassified hospital wage index to adjust payments rates under the IRF PPS for FFY 2026. 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 is proposing an increase to the labor-related share of the standard rate from 74.4% for FFY 2025 to 74.5% for 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.

Eight facilities designated as rural in FFY 2024 became urban in FFY 2025 as a result of the adopted Core Based Statistical Area (CBSA) delineations, resulting in a loss of the 14.9% rural adjustment to these facilities. To mitigate the impacts of this loss, CMS adopted that those eight IRF providers will be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers received two-thirds of the rural adjustment in FFY 2025, will receive one-third of the rural adjustment in FFY 2026, and will receive no rural adjustment in FFY 2027. For the IRF providers changing from urban to rural status, there is no phase-in. For FFY 2026, CMS is continuing with the second year of the phase-in for IRFs changing from rural to urban status.

CMS is proposing a wage index and labor-related share budget neutrality factor of 0.9997 for FFY 2026 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.

A complete list of the proposed wage indexes for payment in FFY 2026 is available here.

Case-Mix Group Relative Weight Updates

CMS assigns IRF discharges into case-mix groups 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 is proposing updates to these factors for FFY 2026 using FFY 2024 IRF claims data and FFY 2023 IRF cost report data (or most current available). To compensate for the CMG weights changes, CMS is proposing to use a FFY 2026 case-mix budget neutrality factor of 0.9985.

CMS did not propose any changes to the CMG categories or definitions. Using the claims data, CMS' analysis shows that 99.2% of IRF cases are in CMGs and tiers that would experience less than a +/-5% change in its CMG relative weight as a result of the updates. The proposed FFY 2025 CMG payments weights and ALOS values are provided in Table 2.

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. To meet this target for FFY 2026, CMS is proposing an outlier threshold value of $11,971, a 0.6% decrease compared to the current threshold of $12,043, based on FFY 2024 claims data.

Updates to the IRF Cost-to-Charge Ratio (CCR) Ceiling

CMS applies a ceiling to IRF's 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 are not available for IRFs.

CMS is proposing to continue to set 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 2026. If an individual IRF's CCR exceeds this ceiling for FFY 2026, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is proposing a national average CCR of 0.467 for rural IRFs and 0.398 for urban IRFs.

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 2.0 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 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 - Post Acute Care 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+
COVID-19 Vaccination Coverage among Healthcare Personnel ***(proposed to be removed FFY 2026)***		FFY 2023+
Discharge Function Score Measure		FFY 2025+
COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date ***(proposed to be removed FFY 2028)***		FFY 2026+

CMS is proposing to remove the four social determinants of health (SDOH) items that were added with the FFY 2025 IRF final rule from the IRF-Patient Assessment Instrument (PAI) beginning with the FFY 2028 IRF QRP:

- Living Situation – What is your living situation today?
- Food – Within the past 12 months, you worried that your food would run out before you got money to buy more.
- Food – Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
- Utilities – In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

CMS is also proposing the following measure removals due to the costs associated with the measures outweighing the benefit of continued use in the program:

- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (effective FFY 2026)
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (effective FFY 2028)

In addition, CMS is proposing to end the public display of these two measures after the September 2025 Care Compare refresh.

Finally, CMS is looking to amend its reconsideration policy and process request by:

- Proposing to replace the term "extenuating circumstances" with "extraordinary circumstances," including an explanation of the term's meaning, to align with the Extraordinary Circumstances Exception (ECE) policy.

- Proposing that the IRF must submit its request for an extension to file a reconsideration request to CMS via email no later than 30 calendar days from the date of the written notification of noncompliance.
- Proposing that IRFs would be notified by CMS of its final decision in writing by way of an email from CMS; and
- Proposing to modify the policy to state that CMS will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the IRF was in full compliance with the IRF QRP requirements for the applicable program year.

RFI – Quality Measure Concepts Under Consideration for Future Years

CMS is seeking input on the importance, relevance, appropriateness, and applicability of the following concepts under consideration for SNF QRP measures in future rulemaking: Interoperability, Well-being, Nutrition, and Delirium. CMS states that it will prioritize evidence-based outcome measures.

RFI – Potential Future Revisions Under Consideration for the IRF-PAI

In order to reduce burden and streamline data collection for IRFs, CMS is seeking comment on:

- How can CMS increase clarity around the definition of an unplanned discharge and which items would be required for unplanned discharges? How would IRFs recommend CMS implement skip patterns for certain items depending on how an IRF patient is discharged?
- Should CMS consider a pediatric IRF-PAI assessment to reduce burden, streamline the assessment process, and focus on age-appropriate assessment items for the pediatric population?
- Are there other ways to revise the IRF-PAI to reduce burden and streamline data collection in IRFs?

RFI – Potential Revision of the Final Data Submission Deadline Period from 4.5 Months to 45 days

In order to reduce the lag time between the data collection period and public reporting of measures under the IRF QRP, CMS is seeking input on a potential future reduction of the IRF QRP data submission deadline from 4.5 months to 45 days. Specifically, CMS is looking for comment on:

- How this potential change could improve the timeliness and actionability of IRF QRP quality measures;
- How this potential change could improve public display of quality information; and
- How this potential change could impact IRF workflows or require updates to systems.

RFI – Advancing Digital Quality Measurement in the IRF QRP

In order to improve healthcare quality data by promoting the adoption of interoperable health information technology (IT) using Fast Healthcare Interoperability Resources® (FHIR®) standards, CMS is seeking comment on the current state of health IT use.

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