June 1, 2026

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2026 and Updates to the IRF Quality Reporting Program Proposed Rule (CMS-1845-P)

Dear Administrator Oz:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") *Fiscal Year 2027 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Proposed Rule* ("proposed rule"). Our comments focus on key provisions of the proposed rule—including proposed updates impacting IRF coverage and documentation, proposed changes to the IRF Quality Reporting Program, proposed updates to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Competitive Bidding Program, and responses to the various requests for information included in the proposed rule—with the goal of ensuring that Medicare beneficiaries continue to have access to the full range of medically necessary rehabilitation services, including those provided in inpatient rehabilitation hospitals.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently in need of the intensive level of rehabilitation care provided in inpatient rehabilitation facilities ("IRFs") and other settings of post-acute care ("PAC").

I. Proposed FY 2027 Updates Impacting Coverage and Documentation

CMS is proposing three modifications to the IRF coverage criteria that appear in Section 412.622 of the IRF regulations, codifying these new criteria as binding on IRF providers. The three proposed changes, along with CPR's responses to each, are provided below.

A. Commencement of Therapy Services

CMS is proposing to clarify that ALL therapy services must be *initiated* within the first 36 hours after midnight on the day of the patient's admission. Both therapy evaluations and actual therapy sessions count toward this initiation requirement. While CPR strongly supports CMS's stated goal of ensuring that Medicare beneficiaries admitted to IRFs receive timely access to all medically necessary therapy services, we have some concerns about this proposal that should be considered in final rulemaking. Prompt initiation of therapy is foundational to achieving optimal functional outcomes, and CPR is aligned with the agency's objective of beginning appropriate therapeutic interventions as soon as clinically feasible following admission. In practice, IRFs are already structured to deliver intensive, coordinated therapy shortly after admission, consistent with the statutory and regulatory framework governing the IRF benefit.

CPR supports CMS' therapy initiation proposal; however, at the same time, CMS's proposed regulation should apply the 36-hour requirement to **therapies ordered by the rehabilitation physician at or after admission**, rather than those merely identified in the pre-admission screening ("PAS"). The PAS is, by design, a preliminary assessment intended to determine whether the patient is an appropriate candidate for IRF care. It is conducted prior to admission and often based on evolving clinical information and assessments from professionals other than the treating rehabilitation physician. By contrast, the physician's orders reflect a more current, comprehensive, and clinically grounded evaluation of the patient's condition, incorporating updated diagnostic information, direct examination, and interdisciplinary input. As such, it is the physician-ordered therapies—not those listed in the PAS—that should govern compliance with the 36-hour initiation standard. The focus should be on ensuring that the full scope of ordered services is assessed based on the most accurate and contemporaneous clinical judgment.

More broadly, CPR emphasizes the importance of maintaining a clear and appropriate distinction between the PAS and the physician's plan of care during the IRF stay. Collapsing these two functions risks elevating a preliminary screening tool into a binding clinical directive, which is inconsistent with both regulatory intent and standard medical practice. Patients admitted to IRFs frequently present with complex and evolving conditions, and their therapy needs may change materially between the time of the PAS and the point at which the physician establishes the formal plan of care. CPR believes that CMS policy should reflect this clinical reality by ensuring that compliance standards are tied to dynamic, physician-directed decision-making, rather than pre-admission documentation.

Finally, CPR is concerned that CMS is effectively **operationalizing this proposed standard in advance of final rulemaking** through claim denials under the IRF Review Choice Demonstration. While CMS is still in the process of proposing and refining its interpretation of the therapy initiation requirement for future rulemaking, providers in demonstration states (AL, PA, TX, CA) are already experiencing adverse determinations based on a more restrictive reading of the standard. This creates a disconnect between formal policy development and on-the-ground enforcement, raising concerns about transparency, fairness, and due process. **CPR urges CMS to ensure that any changes to the therapy initiation standard are clearly**

articulated through notice-and-comment rulemaking and are not prematurely enforced through demonstration programs or contractor interpretation.

B. Current Functional Status in the Pre-Admission Screening

CMS is also proposing to explicitly require that the patient's *current* functional status be included among the required elements of the preadmission screening, which currently includes a requirement to detail the patient's prior level of function. While this proposed update will likely not constitute a major change in operations for most IRFs since many include this as standard information on their PAS documents, CPR does wish to impress on CMS that it does constitute a higher documentation burden than what is required under current regulations and raises numerous questions as to what constitutes compliance with this new requirement.

From a clinical perspective, it is important to know the patient's functional status upon admission. However, CPR notes that information on a patient's current functional status is already routinely captured as part of the PAS process. Accordingly, this proposal raises significant concerns regarding CMS contractors' level of scrutiny in assessing what information is recorded and whether it sufficiently describes a patient's current functional status. CPR is concerned that contractors may use discrepancies in current functional status between a patient's PAS documentation and a patient's post-admission Section GG functional scores. Absent clear guardrails, there is a serious risk that current functional status data collected in fundamentally different contexts could be inappropriately juxtaposed and used to deny claims for such admissions.

The PAS, by design, represents a limited and time-specific snapshot of the patient's condition, typically based on information from medical personnel in the referring acute care setting. It is intended to support determinations of medical necessity and appropriateness for IRF admission, not to serve as a comprehensive or standardized functional assessment. In contrast, admission assessments conducted within the IRF—particularly those using Section GG measures—are systematic, discipline-specific, and performed under controlled conditions by rehabilitation clinicians. The functional elements captured in the PAS often reflect only a subset of abilities most relevant to the referral decision, and therefore should not be viewed as clinically or statistically comparable to the more robust and standardized assessments conducted after admission.

Without explicit clarification from CMS, requiring more detailed functional status documentation in the PAS could create a pathway for inappropriate comparisons that do not account for differences in timing, methodology, clinical context, or the rehabilitation expertise of those rendering the assessments in the acute care setting. This, in turn, heightens the risk that contractors may interpret any variation between PAS documentation and admission GG scores as evidence of inconsistency or inaccuracy, potentially leading to claim denials or post-payment recoupments. Such an outcome would distort the clinical purpose of the PAS and introduce incentives for documentation practices that prioritize perceived alignment over accuracy.

These concerns are particularly salient in light of current enforcement dynamics under the IRF Review Choice Demonstration, where evolving interpretations of documentation standards have

already contributed to increased scrutiny and denial activity. Introducing additional, ambiguously defined documentation requirements without clear parameters for use would likely exacerbate these challenges.

For these reasons, CPR urges CMS not to finalize the proposal as written. At a minimum, **CMS should delay implementation until the agency provides detailed guidance specifying how PAS function status data will be defined, collected, and—critically—how it will and will not be used in medical review and program integrity activities.** Clear delineation between PAS documentation and post-admission assessment data is essential to ensure that policy changes do not inadvertently increase administrative burden or denial risk without improving patient care or program outcomes.

C. Timelines for Interdisciplinary Team Meetings

The proposed rule also calls for an acceleration of the timeframe for holding the initial interdisciplinary team ("IDT") meeting from within the first seven (7) days of admission to within the first four (4) days of admission. CMS justifies this change as an alignment of the timeframe for the plan of care and the interdisciplinary team meeting, designed to facilitate the required team input for the physician-developed plan of care.

CPR strongly opposes this proposal and believes that, at best, it fails to recognize the frequency, intensity, and clinical value of ongoing interdisciplinary collaboration that already occurs throughout a patient's stay—particularly in the critical early days following admission. In practice, rehabilitation physicians, therapists, and nursing staff engage in continuous communication through bedside discussions, therapy sessions, and real-time coordination with patients and their families. These interactions are dynamic and patient-specific, allowing the care team to respond immediately to changes in condition and treatment needs. Importantly, CMS's existing requirements surrounding the timely development and submission of the Individualized Plan of Care ("IPOC") already compel the type of "coordinated interdisciplinary care" described in the proposed rule, as they require meaningful input from multiple disciplines and physician oversight within a defined timeframe.

Against this backdrop, mandating a formal IDT meeting within an arbitrary four-day window is unlikely to generate new or more effective team collaboration. Instead, it risks displacing the more clinically relevant and flexible forms of communication that currently drive patient-centered care and deprives the IDT from assessing the patients' tolerance and response to the IPOC once it has been fully implemented. By emphasizing compliance with a scheduled meeting, the proposal may inadvertently limit informal but highly valuable interactions, such as bedside huddles and discussions with family members, which often provide the most immediate and actionable insights into patient needs. For all IRFs, the requirement would also divert clinician time away from direct patient care, as staff must coordinate, conduct, and document an additional meeting that may not meaningfully contribute to care planning or improve patient outcomes. In this sense, the policy risks becoming a procedural exercise, rather than a substantive improvement in the current process of interdisciplinary coordination.

CPR wishes to note that the proposal is also difficult to reconcile with broader Administration priorities aimed at reducing regulatory burden across federal healthcare programs. Requiring additional IDT meetings will add to the already extensive documentation obligations imposed on IRF clinical teams, increasing administrative workload and associated costs without a clear link to improved patient outcomes. At a time when providers are navigating workforce constraints and resource limitations, policies that expand compliance requirements without demonstrable clinical benefit warrant careful consideration.

Given these concerns, **CPR urges CMS to reconsider this proposal in the final rule and prefers that it be withdrawn. At a minimum, if CMS elects to proceed, the agency should delay implementation for at least one year to resolve definitional ambiguities, ensure alignment across all components of the rule, and provide sufficient education to providers and Medicare Administrative Contractors ("MACs").** With or without such steps, the proposal risks increasing administrative burden, disrupting effective clinical workflows, and failing to achieve its intended goal of enhancing coordinated interdisciplinary care.

II. IRF Quality Reporting Program

CMS is proposing to reduce the data submission deadline from 4.5 months to 45 days beginning with the FY 2029 IRF QRP. According to CMS, this shortened data submission timeframe would reduce the lag in public reporting by up to three months resulting in more timely reporting of data for consumers and their families. This proposed timeframe change would also allow IRFs to have earlier access to data in support of their quality measures. While CPR appreciates CMS' desire to improve the timeliness and actionability of IRF QRP quality measures, and the speed of public reporting, we have concerns about the operational feasibility and unintended consequences of this proposed shift.

While more timely data reporting could theoretically enable faster quality improvement actions in IRFs, CPR cautions CMS that compressing the submission window may undermine both data completeness and accuracy. If IRFs are forced to prioritize speed over validation, there is a risk of increased data errors, missing information, or reduced staff engagement with meaningful quality improvement work. CPR believes that any gains in timeliness would be negated if the data reported is less reliable or actionable due to submission pressures. **While CPR is overall supportive of reducing the IRF QRP data submission deadline, we believe CMS should proceed with caution.**

CPR agrees that patients and families deserve up-to-date, transparent information on provider quality. However, the value of publicly reported data depends not just on timeliness, but on accuracy and meaningful context. If IRFs are unable to complete internal reviews, ensure proper coding, or align with electronic health records before submission, the result could be misleading or inconsistent information on Care Compare and other public-facing platforms.

Reducing the IRF QRP data submission deadline from 4.5 months to 45 days represents a substantial operational shift. IRFs—particularly smaller or rural facilities—may lack the IT infrastructure or staffing capacity to meet this new timeline without significant investment in new systems, training, and process redesign. Additionally, it would also reduce flexibility for

facilities that experience staffing shortages, system outages, or future public health emergencies. **Given these reasons, CPR urges CMS to proceed with caution as it moves forward with this proposed data submission deadline reduction.** If CMS does proceed with this change, we strongly recommend that CMS conduct impact analyses with a representative sample of IRFs across diverse settings (e.g., rural, urban, nonprofit, for-profit) and allow for robust stakeholder engagement.

III. IRF PPS and QRP Requests for Information

CMS is requesting stakeholder feedback on potential enhancements to the IRF PPS, including updates to how primary diagnoses and comorbidities are used to classify patients by case-mix. These potential updates would build on selected elements of the case-mix classification methodology used in the Skilled Nursing Facility ("SNF") Patient-Driven Payment Model ("PDPM"), as implemented in the FY 2019 final rule. We respond to this request for stakeholder feedback below.

CPR strongly opposes CMS's exploration of a PDPM-style redesign of the IRF PPS. While CMS presents this request for information as a modernization effort intended to improve alignment across post-acute care systems, CPR is deeply concerned that the proposal represents a significant step toward eroding the longstanding statutory, clinical, and regulatory distinctions between IRFs and SNFs. Any movement toward convergence between the IRF PPS and the SNF PDPM threatens to undermine the integrity of the IRF benefit and could ultimately serve as the foundation for future site-neutral payment policies that are wholly inappropriate for these distinct settings of care.

IRFs and SNFs are fundamentally different provider types established under separate statutory authorities to serve different patient populations with different clinical needs. IRFs furnish intensive, hospital-level rehabilitation services to medically complex patients who require close physician supervision, coordinated interdisciplinary care, and intensive medical rehabilitation therapy delivered under a physician-directed plan of care. By contrast, SNFs provide a lower-acuity level of post-acute care with different staffing models, lower therapy intensity requirements, less frequent physician involvement, and substantially different regulatory obligations. While IRFs and SNFs play distinct roles in facilitating healing, recovery, and rehabilitation of certain Medicare patients, they should not be artificially melded together, thereby fundamentally undermining the specialized services provided in an IRF for some of the most vulnerable and complex Medicare patients. **These distinctions are embedded throughout the Medicare statute and implementing regulations and reflect Congress's clear intent that IRFs operate as a distinct and specialized benefit category within the Medicare program.**

The IRF benefit is governed by an extensive regulatory framework that has no parallel in the SNF setting, including the "60 percent rule," intensive therapy requirements, rehabilitation physician supervision standards, interdisciplinary team requirements, individualized plan of care obligations, and detailed medical necessity criteria.[1] These requirements recognize that IRFs serve patients with serious and often highly complex medical rehabilitation needs that cannot be

[1] 42 C.F.R. § 412.622

safely or effectively managed in less intensive post-acute settings. **Attempting to incorporate structural elements of the SNF PDPM methodology into the IRF PPS fundamentally ignores these differences and risks collapsing distinct levels of care into a payment framework that was never designed for hospital-level rehabilitation services.**

CPR is particularly troubled that CMS's request for information goes well beyond a conceptual discussion and instead outlines a detailed framework involving replacement of the current impairment group code and rehabilitation impairment category structure with a reduced set of clinical categories modeled substantially on the SNF PDPM system, coupled with expanded comorbidity scoring methodologies. Although CMS characterizes the effort as exploratory, the level of specificity in the discussion strongly suggests that the agency is already contemplating a significant restructuring of IRF payment policy.

A PDPM-style framework is fundamentally incompatible with the rehabilitative mission of IRFs. The current IRF PPS was intentionally designed around rehabilitation impairment categories, functional status, and interdisciplinary rehabilitation needs because rehabilitation intensity and functional recovery are central to the IRF benefit. In contrast, PDPM was developed for SNFs and reflects the operational realities and patient populations of that setting. Importing PDPM concepts into the IRF PPS risks shifting focus of IRF payment away from functional recovery and coordinated rehabilitation care and toward diagnosis coding and medical complexity scoring in a manner that undermines the entire purpose of inpatient hospital rehabilitation.

CPR is also deeply concerned that aligning IRF payment methodologies with SNF payment concepts could facilitate future efforts by CMS, the Medicare Payment Advisory Commission ("MedPAC"), or Congress to impose site-neutral payment policies across post-acute care settings. CPR has consistently opposed site-neutral payment proposals—including a proposed "unified post-acute care payment system"–that fail to account for meaningful differences in patient acuity, staffing requirements, infrastructure, regulatory obligations, and clinical capabilities. IRFs incur significantly different costs because they furnish a substantially different level of care. Any policy that incrementally weakens the distinction between IRFs and SNFs risks creating pressure for payment equalization that would threaten beneficiary access to intensive inpatient rehabilitation services, particularly for medically complex patients who depend on the specialized capabilities available only in the IRF setting.

Further, CMS has failed to articulate a compelling policy rationale for undertaking such a sweeping redesign of the IRF PPS. The agency references variability in profitability and interest in modernization, but it has not demonstrated that the current payment system fails to support beneficiary access, accurately reflect IRF resource utilization, or achieve the statutory objectives under the IRF benefit. Modernization alone is not a sufficient justification for fundamentally restructuring a payment system that supports care for some of Medicare's most medically complex rehabilitation patients.

For these reasons, CPR strongly urges CMS to abandon any effort to model the IRF PPS on the SNF PDPM framework. Any future refinements to the IRF payment system should be narrowly

tailored, clinically grounded, evidence-based, and developed specifically for the IRF patient population and statutory benefit category. **CMS should preserve and reinforce the distinct role of inpatient hospital rehabilitation within the continuum of care rather than pursue policies that blur the line between hospital-level rehabilitation and other lower-acuity post-acute services.**

****

We greatly appreciate your consideration of our comments on the *Fiscal Year 2027 Inpatient Rehabilitation Facility Prospective Payment System* proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Academy of Physical Medicine & Rehabilitation
American Association of People with Disabilities
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Child Neurology Foundation
Christopher & Dana Reeve Foundation*
Clinician Task Force
Disability Rights Education and Defense Fund (DREDF)
Falling Forward Foundation*
National Association for the Advancement of Orthotics and Prosthetics (NAAOP)
National Association of Rehabilitation Providers and Agencies
RESNA
United Spinal Association*

****Member of the CPR Coalition Steering Committee***