June 10, 2025

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-1829-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 2026 Inpatient Rehabilitation Facility ("IRF") Prospective Payment System Proposed Rule* ("proposed rule"). Our comments focus on key provisions of the proposed rule—including the proposed FY 2026 payment update, administrative burden reduction, proposed changes to the IRF Quality Reporting 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.

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. Overview

The proposed rule would provide physicians and others paid under the Medicare physician fee schedule a modest payment increase of 2.8% for IRFs in FY 2026. Similar to the other proposed post-acute care payment rules, CMS also includes a broad request for information ("RFI") on how to reduce administrative burden for providers participating in the Medicare program. For the Quality Reporting Program ("QRP"), CMS is proposing to remove two measures related to COVID-19 vaccination requirements beginning with the FY 2026 (CY 2024) and FY 2028 (CY 2026) IRF QRP, respectively. CMS is also proposing to remove four social determinants of

health ("SDOH") patient assessment data elements to reduce administrative burden beginning October 1, 2025. Finally, the agency is proposing to amend its reconsideration policy and process through which IRFs can appeal IRF QRP payment penalties and also includes four separate RFIs on the IRF QRP in general.

II. Proposed FY 2026 IRF Payment Update

CMS is proposing to increase payments to IRFs by 2.8%, a modest increase from the 2.5% increase finalized for FY 2025. This change is due to several factors, including an annual market basket update, a downward productivity adjustment, budget neutrality adjustments related to case-mix group ("CMG") weights and labor/wage changes, and adjustments to the outlier case threshold. CMS estimates that the changes and updates outlined in the proposed rule would result in a net increase of $295 million in payments to the IRF industry overall.

CPR supports this proposed 2.8% payment update for FY 2026. While we typically do not weigh-in on payment levels for services, this inflationary update does assist IRFs in meeting the needs of patients and generally improves access to care. We had hoped for a more substantial update given persistent inflationary pressures and rising operational costs in the post-acute care sector, especially increased costs generated by staffing shortages, but we recognize and appreciate any increase that meaningfully assists IRFs continue to deliver high-quality, intensive rehabilitation services to Medicare beneficiaries with complex medical and functional needs. We encourage CMS to finalize this proposal in the final rule and to continue to monitor the financial sustainability of IRFs going forward, particularly considering ongoing workforce challenges and patient acuity trends.

III. Request for Information on Reducing Administrative Burden

To comply with President Trump's Executive Order 14192 entitled, "Unleashing Prosperity Through Deregulation of the Medicare Program," CMS is seeking public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

CPR is happy to share the following approach for the Trump Administration's consideration:

Discontinuation of the IRF Review Choice Demonstration

CPR recommends the discontinuation of the ongoing IRF Review Choice Demonstration ("RCD"). The IRF RCD is currently being implemented in Alabama and Pennsylvania, and will soon expand to Texas and then California, eventually covering over half of the IRFs across the country. The RCD was initiated as a demonstration project to test whether 100% claim review processes could reduce improper payments and improve compliance with Medicare coverage criteria for inpatient rehabilitation hospital services. However, CPR and its member organizations have repeatedly raised concerns about the duplicative, burdensome, and disruptive nature of the demonstration's design.

The IRF RCD imposes significant documentation and operational requirements on IRFs—often requiring staff to dedicate valuable time to resubmitting already-reviewed records for a second or third time. To date, there is a paucity of publicly available evidence that the program has significantly improved compliance or reduced improper payments in a manner that justifies the burden created by the program. In fact, CMS reports that over 90% of patient admission

decisions reviewed under the RCD to date have been affirmed. Additionally, IRFs are already subject to extensive oversight through medical reviews, audits, and the Targeted Probe and Educate ("TPE") program administered by CMS. The RCD adds yet another layer of review—often duplicative of existing processes—without demonstrating added value or improvements in beneficiary outcomes.

CPR also wishes to note that the RCD may inadvertently discourage appropriate admissions or delay transitions for patients who require intensive rehabilitation services, especially when acute care hospitals refer for admission individuals with complex needs. This is due to fear of claim denials and delays in transitioning from acute care to IRF care while additional documents are submitted and reviewed by RCD contractors. Despite repeated calls from the provider community and CPR in previous letters, CMS has not provided regular or detailed data on the demonstration's outcomes, nor has the agency meaningfully engaged stakeholders on whether the demonstration should be continued, modified, or ended altogether.

Accordingly, CPR urges CMS to immediately discontinue the IRF RCD in Alabama and Pennsylvania and prohibit further expansion to Texas and California. Instead, CMS should refocus resources on improving education and transparency around medical necessity documentation and engage with IRF stakeholders in developing sustainable oversight mechanisms that protect program integrity without undermining access to medically necessary care.

IV. IRF Quality Reporting Program

Proposed QRP Measures and Items to be Modified and Removed

CMS is proposing to remove two measures from the IRF QRP. First, beginning with the FY 2026 ("CY 2024") IRF QRP, CMS proposes to remove the "COVID-19 Vaccination Coverage among Healthcare Personnel ("HCP")" measure from the IRF QRP. Currently, IRFs are required to report data at least one week each month for covered personnel, which include employees, volunteers, and others. **CPR supports the proposed removal of this measure.**

As the COVID-19 pandemic has evolved, the widespread availability of vaccines, improved treatments, and declining rates of severe illness have significantly reduced the need for ongoing mandatory reporting of healthcare personnel vaccination rates. The continued collection of this measure imposes administrative burdens without providing actionable, patient-specific insights that directly enhance clinical care or patient outcomes. In addition, infection prevention protocols have matured beyond reliance on vaccination status alone. **While CPR fully recognizes and supports vaccination protocols generally, we believe that removing this measure appropriately reflects the current stage of pandemic recovery while reducing provider burden and allowing for IRFs to focus on broader quality improvement efforts.**

The second IRF QRP measure proposed for removal, the "COVID-19 Vaccine Percent of Patients/Residents Who Are Up to Date" measure, would be eliminated beginning with the FY 2028 ("CY 2026") IRF QRP. If finalized, this item will become voluntary and IRFs will no longer be required to collect or submit Patient/Resident COVID-19 vaccine data beginning with patients discharged on or after October 1, 2025. **CPR also supports the removal of this measure.**

Patients admitted to IRFs remain, by definition, among the most medically complex and vulnerable individuals in the Medicare program. However, the necessity for COVID-19 vaccine reporting as a federally mandated quality measure has diminished. Clinical best practices now recognize COVID-19 as part of broader infection prevention strategies, integrated into standard patient care without the need for duplicative and burdensome reporting requirements. **CPR believes that allowing IRFs the flexibility to determine how to best support vaccination among their patient populations—without the administrative burden of mandatory reporting—better supports high-quality, patient-centered care.** We think that CMS' proposal strikes an appropriate balance between continued vigilance and reasonable streamlining of the IRF QRP and fully support the proposed removal of this measure.

Additionally, CMS is also proposing to remove four social determinants of health ("SDOH") Standardized Patient Assessment Data Elements ("SPADEs") that were recently finalized in last year's rule as a method to reduce burden associated with these items. Under this proposal, beginning with patients discharged on or after October 1, 2026, IRFs would not be required to collect and submit data for one item for Living Situation (R0310), two items for Food (R0320A and R0320B) and one item for Utilities (R0330). Beginning with the FY 2028 IRF QRP, these items will be removed from the IRF-Patient Assessment Instrument ("IRF-PAI") altogether. CPR fully supports and acknowledges the importance of SDOH in health care; however, we believe the IRF QRP should be streamlined to ensure that each data element collected provides meaningful value, especially in relation to the significant burden placed on providers. For these reasons, **CPR also supports this proposal, as written, and encourages CMS to finalize the removal of these items under the IRF QRP.**

The proposal to remove these items comes less than a year after CMS finalized their inclusion in the IRF QRP. While CPR fully believes that social determinants of health are important factors in measuring the quality of health services and determining whether populations in need are being well served, we believe the inclusion of these specific data elements in the IRF-PAI has introduced added complexity and administrative burden to the assessment process and there are questions as to the clear evidence that collecting these discrete items has led to measurable improvements in care transitions or outcomes in the IRF setting. CPR has heard from our member organizations that many IRFs already incorporate broader assessments of social needs into their individualized discharge planning processes. **CMS' proposal to remove these items will lessen burden while preserving clinical flexibility to address social risk factors in other ways that are tailored to the needs of specific patient populations.** Given the fact that every minute spent documenting care and answering quality questions is time spent away from patient care, CPR fully supports CMS' efforts to streamline the IRF QRP by removing these data elements that no longer offer sufficient value relative to the burdens they impose.

Proposed Updates to the CMS Reconsideration Policy for Contested QRP Penalties

CMS is proposing several changes to the reconsideration process for IRFs contesting an IRF QRP penalty finding. Currently, IRFs can be subject to a significant payment penalty—up to 2% of total Medicare payments for an entire fiscal year—for failure to comply with IRF QRP requirements. For many IRFs, this can amount to hundreds of thousands of dollars in penalties, posing serious threats to financial viability and patient access to care in that IRF's locale. This is not a minor administrative sanction; it is a dramatically disproportionate and punitive fine that

can have devastating operational consequences, particularly for smaller or rural IRFs as well as those that serve a safety net Medicare population.

Currently, the initial avenue available for IRFs to contest a QRP penalty is to file a reconsideration request with CMS. CMS then reviews the reconsideration request and either approves or denies it. If CMS denies the reconsideration request, the IRFs' only remaining recourse is to file a formal complaint with the Provider Reimbursement Review Board ("PRRB"), before pursuing judicial review in federal court. This process is extremely time-consuming, costly, and resource-intensive, requiring specialized legal counsel and significant administrative efforts that divert attention and resources away from direct patient care.

In light of these realities, CPR strongly opposes CMS' proposal to tighten the reconsideration standard by replacing "extenuating circumstances" with "extraordinary circumstances." The term "extenuating circumstances" has long provided an appropriately flexible standard that recognizes the complex and unpredictable environments in which IRFs operate. Replacing it with "extraordinary circumstances" would significantly raise the bar for relief, further constraining an already narrow and burdensome process.

CMS' proposal risks failing to account for real-world factors beyond the facility's control—such as cybersecurity incidents, natural disasters, public health emergencies, or abrupt staffing disruptions—that have become increasingly common. **Elevating the standard could render reconsideration functionally inaccessible for many providers, particularly those without robust legal and financial resources.** Without a reasonable and achievable opportunity to seek redress for good faith lapses or uncontrollable events, IRFs face the very real possibility of suffering severe financial penalties with no practical way to challenge them.

Moreover, CPR emphasizes that IRF QRP penalties are punitive and often grossly disproportionate to the magnitude and nature of the underlying reporting failure. In some cases, a minor clerical error or the inability to submit complete data for a handful of patients can trigger a penalty that amounts to hundreds of thousands of dollars—funds that could otherwise be invested in patient care, staffing, or quality improvement initiatives. **The QRP penalty structure lacks due process and operates as a blunt instrument, imposing uniform, severe financial consequences regardless of the specific circumstances or degree of noncompliance.** Given the severity of the penalties and the limited avenues for relief, it is imperative that the reconsideration process remain fair, accessible, and grounded in a standard that allows legitimate, good faith challenges to succeed where appropriate.

Given these reasons, CPR strongly encourages CMS to retain the current "extenuating circumstances" language in the IRF QRP reconsideration process. If CMS believes that the current standard is being applied too loosely, we recommend issuing sub-regulatory guidance that clarifies expectations and documentation requirements, rather than codifying a more rigid and potentially exclusionary reconsideration standard.

CMS is also proposing to modify its reconsideration policy to clarify that the agency will permit IRFs to request, and CMS to grant, an extension to file a request for reconsideration of a noncompliance determination if the IRF was affected by an extraordinary circumstance beyond the control of the IRF. **CPR supports this proposal as this clarification would add much-needed flexibility and acknowledges that some events—especially emergencies—can impair**

a provider's ability not only to meet reporting requirements, but also to engage in timely appeals.

However, CPR wishes to note that this positive development does not outweigh the harm that would result from adopting a stricter overall standard for reconsideration eligibility. We believe that the availability of deadline extensions should complement, not compensate for, a fair and accessible reconsideration process.

Requests for Information (RFIs) on the IRF QRP

The proposed rule includes four dedicated RFIs related to the IRF QRP and IRF-PAI (Patient Assessment Instrument). CPR is submitting comments in response to only one of these requests for feedback—the RFI on data submission deadlines for the IRF QRP.

RFI on Data Submission Deadlines for the IRF QRP

Overview of RFI

To reduce the potential burden the IRF QRP data submission timeframe places on IRFs, CMS is proposing to reduce the data submission deadline from 4.5 months to 45 days to improve the timeliness of public reporting by one quarter. CMS is requesting feedback on this potential future reduction of the IRF QRP data submission deadline. Specifically, CMS is requesting 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.

CPR Response

CPR appreciates CMS' desire to improve the timeliness and actionability of IRF QRP quality measures, and the speed of public reporting. However, we have concerns about the operational feasibility and unintended consequences of this potential shift. CPR responds to the specific questions raised in the RFI below.

1. Impact on Timeliness and Actionability of Measures

While more timely data reporting could theoretically enable faster quality improvement actions in IRFs, CPR cautions CMS that dramatically 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 think a more reasonable reduction would be from 4.5 months to 60-days following the end of each fiscal quarter.**

2. Impact on Public Display of Quality Information

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 being posted on Care Compare and other public-facing quality platforms.

****

We greatly appreciate your consideration of our comments on the *Fiscal Year 2026 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 on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitaiton Nurses
Brain Injury Association of America*
Child Neurology Foundation
Falling Forward Foundation*
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
RESNA
UDSMR/Netsmart
Untited Cerebral Palsy

Member of the CPR Coalition Steering Committee