NARA
The National Association of Rehabilitation Providers and Agencies

June 10, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1829-P
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically at http://www.regulations.gov

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2026 and Updates to the IRF Quality Reporting Program Proposed Rule (CMS-1827-P)

Dear Administrator Oz:

The National Association of Rehabilitation Providers and Agencies (NARA) represents more than 90,000 practitioners of physical therapy, occupational therapy, and speech-language pathology through our member organizations. These providers deliver therapy services to Medicare and Medicaid beneficiaries across the United States in a wide range of care settings, including skilled nursing facilities, assisted living facilities, outpatient clinics, hospital inpatient and outpatient departments, beneficiaries' homes, and retirement communities.

As a member-driven organization, NARA is dedicated to ensuring access to care for beneficiaries and advancing the growth and business success of rehabilitation providers through education, support, and advocacy. Our diverse membership gives us a unique and comprehensive perspective on payment and quality programs affecting inpatient rehabilitation facilities. Below are our comments on the proposed rule:

Proposed Payment Structure

NARA supports the proposed 2.8% payment update for FY 2026. This inflationary adjustment will help inpatient rehabilitation facilities (IRFs) meet beneficiary needs and enhance access to care. Although we had hoped for a more significant increase given the ongoing inflationary pressures and rising operational costs particularly those driven by staffing shortages, we recognize and appreciate any adjustment that helps IRFs continue providing high-quality, intensive rehabilitation services to Medicare beneficiaries with complex medical and functional needs. We urge CMS to finalize this proposal in the final rule and to continue monitoring the financial viability of IRFs, especially considering persistent workforce challenges and evolving patient acuity trends.

Quality Reporting Program

NARA supports CMS's proposal to remove two measures from the IRF Quality Reporting Program (IRF QRP). First, CMS proposes to eliminate the "COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)" measure beginning with the FY 2026 (CY 2024) IRF QRP. Currently, IRFs must report data monthly for at least one week for covered employees, volunteers, and other personnel. As the COVID-19 pandemic has evolved with widespread vaccine availability, improved treatments, and reduced rates of severe illness the need for continued mandatory reporting of staff vaccination rates has declined. Moreover, the administrative burden of collecting this data no longer yields actionable, patient-specific insights to improve care or outcomes. Infection prevention strategies have also matured, extending beyond vaccination status alone. While NARA continues to support vaccination protocols, we believe this measure's removal reflects the current stage of pandemic recovery and allows IRFs to redirect efforts toward broader quality improvement initiatives.

The second measure CMS proposes to remove is the "COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date" measure, which would be phased out beginning with the FY 2028 (CY 2026) IRF QRP. If finalized, this measure would become voluntary, and IRFs would no longer be required to collect or submit COVID-19 vaccination data for patients discharged on or after October 1, 2025. While IRF patients remain among the most medically complex and vulnerable in the Medicare population, the value of federally mandated reporting for this specific vaccination measure has diminished. COVID-19 is now integrated into broader infection control practices, and duplicative reporting requirements risk diverting attention from direct patient care. NARA believes that allowing IRFs discretion in how they promote vaccination without federal reporting mandates supports more responsive, patient-centered care. CMS' proposal appropriately balances continued vigilance with the necessary streamlining of the IRF QRP.

Additionally, CMS proposes removing four Social Determinants of Health (SDOH) Standardized Patient Assessment Data Elements (SPADEs) that were finalized in last year's rule. Starting October 1, 2025, reporting on one item related to Living Situation (R0310), two items related to Food (R0320A and R0320B), and one related to Utilities (R0330) would become optional. These items would be fully removed from the IRF-Patient Assessment Instrument (IRF-PAI) beginning with the FY 2028 IRF QRP. NARA supports this proposal and urges CMS to finalize the removal as written.

Although social determinants of health are critical to patient outcomes, NARA believes these specific data elements have added unnecessary complexity and administrative burden to the assessment process—without clear evidence that they improve care transitions or outcomes in the IRF setting. Many IRFs already integrate broader social needs assessments into individualized discharge planning. Removing these SPADEs reduces burden while preserving flexibility for IRFs to address social risk factors in ways that are more tailored and clinically relevant. Given that time spent on documentation and reporting takes away from direct patient care, NARA strongly

supports CMS' efforts to streamline the IRF QRP by eliminating these items that no longer provide sufficient value relative to the effort required to collect them.

Proposed Changes in the IRF QRP Reconsideration Process

CMS is proposing several changes to the reconsideration process for IRFs challenging a penalty under the IRF QRP. Currently, IRFs that fail to meet QRP requirements face a substantial financial penalty of up to 2% of total Medicare payments for an entire fiscal year. For many facilities, especially smaller or rural IRFs and those serving safety-net populations, this can mean hundreds of thousands of dollars in lost revenue. These penalties are not minor administrative fines; they are punitive, disproportionate, and can seriously jeopardize an IRF's financial viability and its ability to serve beneficiaries in the community.

Under the existing process, IRFs may submit a reconsideration request to CMS if they believe a penalty was imposed in error or under mitigating circumstances. CMS then reviews and either approves or denies the request. If the reconsideration is denied, the IRF's only remaining recourse is to file an appeal with the Provider Reimbursement Review Board (PRRB), followed by potential judicial review in federal court. This escalation path is highly resource-intensive and costly, often requiring legal representation and significant administrative effort, which pulls focus away from patient care and clinical operations.

Given these challenges, NARA strongly opposes CMS' proposal to tighten the reconsideration standard by replacing the current "extenuating circumstances" threshold with a more restrictive "extraordinary circumstances" standard. The long-standing "extenuating circumstances" standard has provided necessary flexibility, acknowledging the unpredictable and complex environments in which IRFs operate. Replacing it with "extraordinary circumstances" would impose a much higher bar for relief, making it even more difficult for IRFs to contest penalties regardless of whether they acted in good faith or were impacted by events beyond their control.

CMS' proposal fails to adequately consider real-world disruptions such as natural disasters, cyberattacks, public health emergencies, or unexpected staffing crises that are increasingly common and can prevent facilities from complying with reporting requirements. Raising the standard for reconsideration could make relief effectively inaccessible for many providers, particularly those with limited legal or financial resources.

NARA also emphasizes that the penalties imposed under the IRF QRP are frequently disproportionate to the underlying infraction. In some cases, a minor clerical error or incomplete data for just a few patients can result in a penalty totaling hundreds of thousands of dollars funds that would be better directed toward patient care, workforce support, or quality improvement. The current penalty framework lacks nuance and due process, applying a uniform and severe financial consequence regardless of the scale or nature of noncompliance. Given the magnitude of these penalties, it is critical that IRFs retain access to a fair and attainable reconsideration process that accounts for legitimate and unintentional errors.

For these reasons, NARA urges CMS to retain the existing "extenuating circumstances" standard for IRF QRP reconsideration requests. If CMS believes the current standard is being applied too broadly, we recommend issuing sub-regulatory guidance to clarify expectations and documentation requirements, rather than codifying a narrower and more exclusionary threshold.

Separately, CMS is proposing to allow IRFs to request extensions for filing reconsideration requests when affected by extraordinary circumstances beyond their control. NARA supports this clarification, as it provides critical flexibility and recognizes that emergency events may not only impact reporting compliance but also a provider's ability to engage in timely appeals. However, NARA stresses that this proposed extension policy does not offset the harm of adopting a more restrictive reconsideration standard overall. Deadline flexibility should complement not replace a fair, accessible, and reasonable reconsideration process that allows providers to challenge penalties when they have acted in good faith and encountered legitimate obstacles.

RFI on Data Submission Deadlines for the IRF QRP

In this proposed rule, CMS is proposing to reduce the data submission deadline from 4.5 months to 45 days to improve timeliness of public reporting by one quarter. While NARA supports the reduction of data submission deadlines for improved public reporting, we are concerned that such a drastic change may undermine both completeness and accuracy of data. If IRFs are forced to prioritize speed over accuracy, there is a heightened risk of data errors, incomplete submissions, and diminished staff engagement in meaningful quality improvement efforts. NARA believes a more reasonable deadline reduction would be from 4.5 months to 60 days following the end of each fiscal quarter. We agree the patients and families deserve the most current and transparent data on provider quality, but we need to ensure it is accurate and meaningful. If IRFs are unable to complete internal reviews, verify coding accuracy, or ensure alignment with electronic health records prior to submission, the resulting data may be inaccurate or inconsistent potentially leading to the publication of misleading information on Care Compare and other public-facing quality reporting platforms.

Thank you again for the opportunity to provide input. Should you have any questions regarding our comments, please contact Christie Covington, NARA Executive Director, at christie.covington@naranet.org.

Respectfully submitted,

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President
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