



June 1, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1845-P
PO Box 8016
Baltimore, MD 21244-8016

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

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2027 and Updates to the IRF Quality Reporting Program Proposed Rule (CMS-1845-P)

Dear Administrator Oz:

The National Association of Rehabilitation Providers & Agencies (“NARA”) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services’ (“CMS”) Fiscal Year 2027 Inpatient Rehabilitation Facility (“IRF”) Prospective Payment System Proposed Rule and updates to the IRF Quality Reporting Program (“proposed rule”).

NARA represents rehabilitation providers and agencies across the continuum of care, including providers delivering physical therapy, occupational therapy, speech-language pathology, and other rehabilitation services in inpatient rehabilitation, skilled nursing facilities, outpatient settings, home health, pediatrics, health systems, and community-based care. NARA’s members are deeply committed to ensuring that Medicare beneficiaries have timely access to medically necessary rehabilitation services that improve function, prevent avoidable decline, support safe discharge, and reduce unnecessary hospitalizations and institutional care.

NARA’s comments focus on the proposed IRF coverage and documentation changes, the proposed revisions to the IRF Quality Reporting Program, and CMS’s request for information regarding potential future modifications to the IRF PPS methodology. Across these proposals, NARA urges CMS to preserve beneficiary access to intensive rehabilitation services, avoid policies that increase administrative burden without improving care, and maintain the important clinical and regulatory distinctions between IRFs and other post-acute care settings.

CMS proposes three modifications to the IRF coverage criteria at 42 C.F.R. § 412.622: clarifications of when therapy services must be initiated; documentation of functional status in the pre-admission screening; and timelines for interdisciplinary meetings. NARA appreciates CMS’s stated objective of ensuring that beneficiaries receive timely, coordinated, and medically

necessary rehabilitation care. However, the proposed changes raise significant concerns for our members, especially regarding operational feasibility, clinical appropriateness, documentation burden, and potential misuse in contractor medical review.

1) Commencement of Therapy Services

CMS proposes to clarify that therapy services must be initiated within the first 36 hours after midnight on the day of the patient's admission and that both therapy evaluations and therapy treatment sessions may count toward this initiation requirement. IRFs are designed and staffed to provide intensive, coordinated rehabilitation services, and NARA supports the underlying goal of ensuring that Medicare beneficiaries admitted to IRFs receive timely access to medically necessary rehabilitation services. NARA members recognize the importance of initiating therapy promptly after admission because early engagement in therapy is clinically important and is often central to achieving meaningful functional recovery, supporting safe discharge planning, and preventing avoidable complications.

However, NARA urges CMS to clarify that the 36-hour initiation requirement applies to therapy services ordered by the rehabilitation physician **at or after admission**, and does not apply to therapies merely identified in the pre-admission screening ("PAS"). The PAS is a preliminary screening tool used to assess whether the patient is appropriate for IRF-level care. Per CMS IOM 100-2, Chapter 1, Section 110.1.1, the PAS must be conducted by licensed or certified clinician(s), and must be completed before admission, based on available information from the referring setting. As a result, the PAS may not reflect the most current clinical picture once the patient arrives at the IRF. By contrast, the rehabilitation physician's orders and individualized plan of care are based on the patient's actual condition at admission, direct clinical judgment, updated medical information, and interdisciplinary input. These rehabilitation physician-directed decisions should be the basis for determining whether therapy services have been initiated timely. We believe that if therapy needs listed in the PAS were tied to compliance, it would improperly elevate a PAS document into a binding clinical directive, which is not the equivalent of physician orders.

NARA is also concerned that an overly rigid application of the 36-hour standard could create a significant risk of denial in clinically appropriate cases. Specifically, patients admitted to IRFs are medically complex and may experience changes in status, fatigue, diagnostic updates, medical instability, or other clinical circumstances that appropriately affect the timing, type, or intensity of therapy initiation. CMS should ensure that any finalized policy recognizes the need for clinical judgment upon IRF admission, rather than penalizing providers when therapy timing is modified based on patient safety, medical necessity, or physician-directed care planning.

Moreover, NARA is further concerned that CMS contractors may effectively begin enforcing a restrictive interpretation of this proposed policy before final rulemaking is complete. In fact, providers in IRF Review Choice Demonstration states have already experienced increased scrutiny and adverse determinations related to documentation and timing requirements. NARA urges CMS to ensure that any change to the therapy initiation standard is implemented only after final rulemaking, clear sub-regulatory guidance, provider education, and consistent instructions to Medicare Administrative Contractors and review contractors.

2) Current Functional Status in the Pre-Admission Screening

CMS proposes to require that the patient's current functional status be included as a required element of the pre-admission screening. NARA agrees that understanding a patient's current function is clinically important and recognizes that many IRFs already include this information in the PAS as a matter of routine practice. However, NARA is concerned that codifying this requirement without clear parameters will increase documentation burden and create new opportunities for inappropriate claim denials. While the proposal may appear modest, any new required element in the PAS becomes a potential technical compliance issue in medical review. Without specific guidance, contractors may apply inconsistent standards regarding the level of detail, format, terminology, or source documentation needed to satisfy the requirement.

NARA is particularly concerned that contractors may compare functional information in the PAS against post-admission Section GG functional scores and treat any difference as evidence of inconsistency, inaccuracy, or lack of medical necessity. Such comparisons would be clinically inappropriate. The PAS and Section GG assessments serve different purposes, are completed at different points in time, and are often based on different sources of information.

The PAS is a pre-admission screening tool completed 48 hours prior to the IRF admission. It is commonly based on information from the acute care hospital, referral documentation, medical records, and communication with referring providers. Its purpose is to determine whether the patient is *appropriate* for IRF admission. It is not intended to be a comprehensive, standardized rehabilitation assessment.

By contrast, physical therapy and occupational therapy evaluations are completed after admission in the IRF setting. These assessments are more standardized, discipline-specific, and based on direct assessment, observation, and clinical evaluation under rehabilitation conditions. If differences between the PAS functional descriptions and Section GG scores coded on the Admission IRF-Patient Assessment Instrument (PAI) are found, they may be explained by changes in medical condition, different methods of assessment, variation in the time of day the assessment occurs, patient fatigue,

medication effects, environmental differences, or the fact that a more detailed evaluation is performed by rehabilitation clinicians than those who may perform the PAS.

CMS should not finalize this proposal as written. If CMS proceeds, it should delay implementation until the agency issues detailed guidance defining what constitutes sufficient current functional status documentation in the PAS. If CMS finalizes this proposal without guardrails, the result may be an increased risk of denial, followed by increased administrative burden to IRFs to appeal those decisions, and subsequent documentation practices designed primarily to avoid perceived inconsistencies rather than accurately reflecting the patient's condition. This would undermine both clinical care and program integrity.

3) Timelines for Interdisciplinary Team Meetings

CMS proposes to require the initial interdisciplinary team (IDT) meeting within the first four days of admission rather than within the first seven days. CMS states that this proposal would better align the IDT meeting with development of the individualized plan of care. CMS should not finalize the proposed change requiring the initial IDT meeting to occur by day 4 of admission. While NARA supports timely interdisciplinary care planning, the current 7-day timeframe better supports meaningful, patient-centered care planning by allowing the clinical team sufficient time to complete evaluations, assess medical and functional status, determine therapy tolerance, identify discharge barriers, and establish realistic goals. Requiring the IDT meeting by day 4 risks turning the process into a compliance-driven documentation exercise rather than a clinically meaningful discussion. CMS should not impose a shorter timeframe without evidence that the current 7-day requirement is causing patient harm or that a 4-day requirement would improve outcomes.

The proposal would also increase administrative burden at a time when rehabilitation providers are already managing significant workforce constraints, rising labor costs, documentation demands, payer scrutiny, and contractor review activity. CMS has repeatedly emphasized the importance of reducing unnecessary regulatory burden. This proposal moves in the opposite direction by imposing an additional timing requirement without clear evidence that it will improve patient outcomes, quality, safety, or discharge planning.¹

NARA has significant questions regarding the operational uncertainty created by the proposal. As written, the proposed rule appears to include inconsistencies in how the "fourth day" would be calculated across the preamble, proposed regulatory text, and accompanying diagram. For example, the preamble discussion and diagram suggest that if a patient is admitted on "Day Zero," such as a Tuesday, the initial team conference could

¹ <https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/>

occur by “Day Four,” which would appear to allow the conference to be held on Saturday, assuming Wednesday is “Day 1,” Thursday is “Day 2,” and Friday is “Day 3.” However, in CMS’s own patient example, CMS indicates that Friday would be the latest permissible date for the team conference. Given the level of audit scrutiny and oversight associated with team conference timing and documentation, CMS must clearly define the applicable timeframe and provide consistent guidance, training, and education to all stakeholders. IRF stakeholders also need clarification as to whether this “Day Zero” methodology would apply to other IRF reporting and documentation requirements, including the individualized overall plan of care.

CMS should withdraw the proposal to require the initial IDT meeting within four days of admission. If CMS proceeds, the agency should delay implementation for at least one year, provide clear operational guidance, align contractor review instructions, and ensure that providers are not subject to technical denials when the record demonstrates active interdisciplinary collaboration and physician-directed care.

IRF Quality Reporting Program

CMS proposes to reduce the IRF Quality Reporting Program (“QRP”) data submission and corrections deadline for the IRF-PAI assessment and CDC NHSN date to no later than the 15th day of the second month after the end of the calendar quarter from 4.5 months after the end of each quarter. NARA supports the goal of timely, meaningful, and transparent quality data. Patients, families, providers, and policymakers benefit from accurate information regarding quality and outcomes. We urge CMS to proceed cautiously. A shorter reporting window may improve the timeliness of public reporting, but only if the data remains complete, accurate, and reliable. NARA supports AMRPA’s recommendation of the submission deadline being two full months from the end of a quarter with the first day of the month being set as the data submission deadline.

IRF FY 2027 Proposed Payment Updates

NARA appreciates CMS’s proposed FY 2027 updates to the IRF PPS payment system and supports finalizing the proposed payment-related updates. Stable and adequate Medicare payment is essential to preserving beneficiary access to intensive inpatient rehabilitation services, particularly as IRFs continue to manage sustained labor cost pressures, workforce shortages, inflationary operating expenses, and increasing administrative requirements.

IRFs provide a distinct, hospital-level rehabilitation benefit for medically complex Medicare beneficiaries who require intensive therapy, rehabilitation physician oversight, interdisciplinary care coordination, and nursing and medical management. Payment policy must continue to recognize the specialized staffing, infrastructure, regulatory obligations, and clinical resources necessary to furnish this level of care. While NARA supports the proposed FY 2027 estimated 2.8% payment increase, we urge CMS to continue monitoring whether annual payment updates adequately reflect the real-world cost pressures facing IRFs, including wage growth, recruitment

and retention challenges, supply and technology costs, documentation demands, and payer-related administrative burden.

Rural-to-Urban Phase-Out Policy

NARA also supports CMS's proposal to continue application of the previously adopted phase-out policy for IRFs that were reclassified from rural to urban in FY 2025. Abrupt changes in geographic classification can create significant financial instability for affected providers, particularly where facilities continue to serve rural or underserved populations despite reclassification. A continued phase-out policy is appropriate to mitigate sudden payment disruption and protect beneficiary access to IRF services in communities where rehabilitation capacity may already be limited.

Wage Index Methodology

NARA further supports CMS's proposed FY 2027 wage index methodology. Accurate wage index adjustments are critical to ensuring that IRF payments appropriately account for geographic variation in labor costs. At the same time, NARA urges CMS to carefully evaluate any future alternative data sources or methodologies before adopting an IRF-specific wage index. Any future changes should be transparent, data-driven, and subject to robust stakeholder review to ensure that they do not unintentionally destabilize providers, worsen geographic inequities, or reduce access to IRF care in high-cost labor markets, rural-adjacent communities, or underserved areas.

Outlier Threshold Update

Finally, NARA supports CMS's proposed FY 2027 outlier threshold update and urges the agency to continue monitoring whether outlier payments remain adequate for the most medically complex IRF cases. Outlier payments are an important safeguard for beneficiaries whose clinical needs require substantially higher resources than typical cases. These patients may present with multiple comorbidities, complex neurological or orthopedic conditions, significant functional impairments, medical instability, or other circumstances requiring intensive interdisciplinary intervention. CMS should ensure that the outlier methodology continues to protect access for these high-need beneficiaries and does not create disincentives for IRFs to admit clinically complex patients who appropriately require inpatient rehabilitation.

IRF PPS and QRP Requests for Information

CMS requests stakeholder feedback regarding potential future changes to the IRF PPS, including possible updates to how primary diagnoses and comorbidities are used to classify patients by case-mix. CMS indicates that such updates could build on selected elements of the Skilled Nursing Facility ("SNF") Patient-Driven Payment Model ("PDPM"). NARA strongly opposes any effort to redesign the IRF PPS using a PDPM-style framework or to otherwise blur the distinction between IRFs and SNFs.

IRFs and SNFs are distinct provider types serving different patient populations under different statutory, regulatory, clinical, staffing, and payment frameworks. IRFs provide hospital-level rehabilitation for medically complex patients who require intensive rehabilitation therapy, close

rehabilitation physician supervision, interdisciplinary care, and an individualized rehabilitation plan of care. SNFs provide an important but different level of post-acute care with different staffing requirements, physician involvement, therapy intensity, and regulatory obligations.

The IRF benefit is intentionally structured around intensive rehabilitation and functional recovery. Current IRF payment policy reflects rehabilitation impairment categories, functional status, interdisciplinary care needs, and the unique resource requirements associated with hospital-level rehabilitation. A PDPM-style methodology, developed for SNFs, is not an appropriate model for IRFs.

NARA is concerned that aligning IRF payment concepts with SNF payment concepts could become a stepping stone toward site-neutral post-acute care payment policy. NARA has consistently opposed site-neutral payment proposals that fail to recognize the substantial differences in patient acuity, regulatory requirements, staffing models, physician involvement, therapy intensity, infrastructure, and clinical capabilities across settings. IRFs incur different costs because they provide a different level of care. Payment policy must reflect those differences.

CMS has not demonstrated that the current IRF PPS fails to support access, fails to reflect resource use, or requires a fundamental redesign modeled on a different provider setting. Modernization, by itself, is not sufficient justification for restructuring a payment system that supports access to specialized, medically necessary inpatient rehabilitation care.

CMS should abandon any effort to model the IRF PPS on the SNF PDPM framework. Any future refinements to the IRF PPS should be narrowly tailored, evidence-based, clinically grounded, and developed specifically for the IRF patient population and statutory benefit. CMS should preserve and reinforce the distinct role of IRFs within the Medicare post-acute care continuum.

RFI: Advance Care Planning IRF QRP Measure

NARA urges CMS not to implement this measure concept as presented in the proposed rule. While NARA supports meaningful patient-centered care planning and recognizes the importance of honoring patient preferences, the measure concept as described lacks sufficient specificity, raises significant operational concerns, and does not appear well tailored to the IRF setting.

First, CMS has not provided sufficient measure specifications or clarity regarding the intended outcome the measure is designed to achieve. It is unclear whether the measure would assess documentation of advance directives, patient goals, surrogate decision-maker identification, end-of-life preferences, shared decision-making, or broader care planning discussions. Without clear specifications, providers cannot meaningfully evaluate the measure's relevance, feasibility, burden, or potential unintended consequences. CMS should not advance a new quality reporting measure without first defining the measure numerator, denominator, exclusions, data sources, timing requirements, and intended quality objective.

Second, NARA is concerned that this concept could become a process-based “checkbox” measure with limited clinical meaning. If the measure simply requires documentation that a discussion occurred or that a form was reviewed, it may add reporting burden without improving patient care, patient autonomy, or rehabilitation outcomes. Quality measures should drive meaningful improvements in care delivery and patient outcomes, not create additional documentation obligations that primarily serve compliance purposes.

Third, the concept has limited applicability in the IRF setting. IRFs generally serve patients who are medically stable enough to participate in intensive rehabilitation and whose care is focused on functional recovery, discharge planning, and return to the community. IRF stays are also typically short, leaving limited time for adding new standardized reporting requirements that may not be directly connected to the patient’s rehabilitation goals or immediate clinical needs. While advance care planning may be highly relevant in certain clinical circumstances, it is not uniformly applicable to all IRF patients in the same way as measures focused on function, safety, discharge outcomes, or care transitions.

Finally, NARA is concerned that the measure may be duplicative of existing accreditation standards and provider obligations. Accreditation organizations such as The Joint Commission and CARF already address advance directives, patient rights, patient preferences, informed decision-making, and care planning expectations. Adding a separate IRF QRP measure risks layering an additional federal reporting requirement on top of existing standards without demonstrating a clear gap in care or a measurable improvement in outcomes.

For these reasons, NARA recommends that CMS not move forward with the Advance Care Planning IRF QRP measure concept. If CMS continues to explore this area in future rulemaking, the agency should first engage stakeholders, provide detailed measure specifications, assess overlap with existing accreditation and regulatory requirements, evaluate burden in short-stay rehabilitation settings, and ensure that any future measure is directly tied to meaningful patient-centered outcomes rather than documentation completion.

Conclusion

NARA appreciates CMS’s continued attention to rehabilitation policy and the opportunity to comment on the FY 2027 IRF PPS proposed rule. NARA supports policies that promote timely access to medically necessary rehabilitation services, improve functional outcomes, reduce avoidable administrative burden, and preserve the integrity of the IRF benefit.

In summary, NARA urges CMS to:

1. Clarify that the 36-hour therapy initiation requirement applies to physician-ordered therapies at or after admission, not therapies merely listed in the PAS;
2. Avoid finalizing the proposed PAS current functional status requirement unless CMS provides clear guardrails to prevent inappropriate contractor denials;

3. Phase in the proposal to require the initial IDT meeting within four days of admission and include a well-defined exception process;
4. Proceed cautiously with any reduction in IRF QRP data submission timelines and ensure that data accuracy is not sacrificed for speed; and
5. Reject any PDPM-style redesign of the IRF PPS and preserve the distinct clinical, regulatory, and payment framework for inpatient rehabilitation hospitals.

NARA looks forward to continued collaboration with CMS to ensure that Medicare beneficiaries have access to the full continuum of rehabilitation services needed to restore function, support independence, and improve quality of life. Should you have any questions regarding our comments, please contact Christie Covington, NARA Executive Director, at christie.covington@naranet.org.

Respectfully submitted,

A handwritten signature in black ink that reads "Christopher Carlin". The signature is written in a cursive style with a large initial "C".

Christopher Carlin, MBA, OTR/L
President of the Board, National Association of Rehabilitation Providers and Agencies