Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2025

MEDICARE IRF PPS FINAL RULE

Overview and Resources

On August 1, 2025, the Centers for Medicare & Medicaid Services (CMS) released the final federal fiscal year (FFY) 2026 payment rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the final rule and other resources related to the IRF PPS are available on the CMS website. An online version of the final rule is available here.

Program changes adopted by CMS will be effective for discharges on or after October 1, 2025, unless otherwise noted. CMS estimates the overall economic impact of the finalized payment rate update to be an increase of $340 million in aggregate payments to IRFs in FFY 2026 over FFY 2025.

IRF Payment Rate

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

	Final FFY 2025	Final FFY 2026	Percent Change
IRF Standard Payment Conversion Factor	$18,907	$19,371 (proposed at $19,364)	+2.45% (proposed at +2.42%)

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

Final CY 2026 Update Factor Component	IRF Rate Updates
Market Basket (MB) Update	+3.3% (proposed at +3.4%)
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.7 Percentage Points (PPTs) (proposed at -0.8 PPTs)
Wage Index/Labor-Related Share Budget Neutrality (BN)	+0.01% (proposed at -0.03%)
Case-Mix Groups (CMG) and CMG Relative Weight Revisions BN	-0.15% (as proposed)
	+2.45%

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

CMS will 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 adopting the labor-related share of the standard rate at 74.4% (proposed at 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 adopting a wage index and labor-related share budget neutrality factor of 1.0001 (proposed at 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 final 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 adopting 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 adopting a FFY 2026 case-mix budget neutrality factor of 0.9985 (as proposed).

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 experience less than a +/-5% change in its CMG relative weight as a result of the updates. The finalized FFY 2026 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 finalizing an outlier threshold value of $10,062 (proposed at

$11,971), a 16.45% 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 IRFs' 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 is not available for IRFs.

CMS will continue to set the national CCR ceiling at three standard deviations above the mean CCR and is therefore finalizing a national CCR ceiling of 1.54 (as proposed) 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 adopting a national average CCR of 0.463 (proposed at 0.467) for rural IRFs and 0.398 (as proposed) 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 PPT 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:

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 (PAC) 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 - PAC 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 ***(finalized 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 ***(finalized to be removed FFY 2028)***		FFY 2026+

CMS is adopting the removal of 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 finalizing the removal of the following measures:

- 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)

Additionally, CMS is adopting to end the public display of these two measures after the September 2025 Care Compare refresh.

Lastly, CMS is amending its reconsideration policy and process request by:

- Replacing the term "extenuating circumstances" with "extraordinary circumstances," including an explanation of the term's meaning, to align with the Extraordinary Circumstances Exception (ECE) policy;
- Adopting 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. This request must include:
    - The CCN for the IRF;
    - The business name of the IRF;
    - The business address of the IRF;
    - Certain contact information for the IRF's chief executive officer or designated personnel;
    - A statement of the reason for the request for the extension; and
    - Evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media.
- Adopting that IRFs would be notified by CMS of its final decision in writing by way of an email from CMS; and
- Finalizing a modification to 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 sought input on the importance, relevance, appropriateness, and applicability of the following concepts under consideration for IRF QRP measures in future rulemaking: Interoperability, Well-being, Nutrition, and Delirium. CMS will consider the input for future measure development efforts. A summary of the comments received can be found on the pages above.

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

In order to reduce the burden and streamline data collection for IRFs, CMS sought comments on the following:

- 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 sought input on a potential future reduction of the IRF QRP data submission deadline from 4.5 months to 45 days. Specifically, CMS sought comments 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 sought comments on the current state of health IT use.

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