



The Honorable Mehmet Oz  
Administrator, Centers for Medicare & Medicaid Services  
Hubert H. Humphrey  
200 Independence Avenue, SW, Room 445-G  
Washington, DC 20201

May 29, 2026

***Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program; CMS-1845-P***

Dear Dr. Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, including 12 rehabilitation hospitals, we appreciate the opportunity to comment on the Fiscal Year (FY) 2027 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Proposed Rule (April 6, 2026) (Proposed Rule).

Our comments focus on payment policies, proposed coverage requirements, and changes to the IRF Quality Reporting Program (QRP).

## **PAYMENT RATES**

### **MARKET BASKET UPDATE**

AzHHA is concerned that the proposed market basket update does not adequately reflect the cost structure of IRFs or the sustained financial pressure facing providers. CMS estimates that 74.5% of IRF costs are labor-related, making it difficult to achieve the productivity gains assumed under the Affordable Care Act (ACA). As a result, even small gaps between payment updates and labor cost growth have an outsized operational impact.

Rehabilitation hospitals rely on highly specialized clinical staff—many of whom remain in short supply—driving continued wage growth, reliance on contract labor, and rising recruitment and retention costs.

These pressures are especially severe in post-acute settings, where staffing flexibility is limited and patient acuity remains high, even as demand for rehabilitation services grows.

While aggregate margins may appear stable, this can mask the reality for many hospital-based IRFs operating on narrow margins with limited ability to absorb sustained cost increases. Over time, even modest shortfalls in annual updates compound, affecting staffing and service availability.

We recognize CMS is constrained by statute in calculating the annual update. However, we encourage the agency to continue evaluating whether the current methodology reflects real-time labor cost changes and to consider recommendations to Congress, as appropriate, to better align payment updates with providers' actual cost experience.

### **AREA WAGE INDEX**

Current IRF wage index policy creates a structural imbalance across provider types. IRFs rely on pre-reclassification IPPS wage index data, while many acute care hospitals in the same markets benefit from geographic reclassifications that increase their wage indices. This disparity contributes to declining wage indices in CBSAs where IRFs and hospitals compete for the same workforce.

We also have concerns with the development of an IRF-specific wage index. IRF labor costs are embedded within broader hospital cost centers, limiting the reliability of a standalone calculation. In addition, the Bureau of Labor Statistics data capture only wages and do not reflect the full cost of employment, including benefits.

The most direct and equitable approach is to continue using the pre-reclassification, pre-floor IPPS wage index while extending the same wage index policies available to IPPS hospitals—including geographic reclassification—to IRFs. This would promote parity across provider types within the same market.

If CMS moves forward with a new methodology, it should phase in changes over at least three years, maintain budget neutrality, and continue the 5% cap on year-over-year decreases.

### **OUTLIER THRESHOLD**

We appreciate CMS's proposal to decrease the high-cost outlier threshold from \$10,141 in FY 2026 to \$8,689 in FY 2027, which better aligns payments with current cost experience.

We also encourage CMS to adopt a multi-year averaging methodology when setting the threshold, consistent with other IRF adjustments, to reduce volatility. In addition, CMS should consider either capping individual IRF outlier payments at 10% of total IRF PPS revenues or reducing the 3% outlier pool and redistributing those funds through the base conversion factor. We note concerns raised by stakeholders that outlier payments may be heavily concentrated among a small number of providers, which underscores the importance of policies that promote stability and equitable distribution

## **REVISIONS TO COVERAGE CRITERIA**

### **INITIATION OF THERAPIES WITHIN 36 HOURS**

AzHHA has significant concerns with CMS's proposal to require that all therapies be initiated within 36 hours following midnight of the day of admission.

While we support timely initiation of rehabilitation services, the proposed standard is overly rigid and unclear. It is not clear whether "required therapy treatments and/or evaluations" refers only to therapies ordered at admission or to therapies that become clinically necessary during the stay, creating compliance risk.

IRF patients are medically complex and therapy needs often evolve. Certain needs—particularly speech-language pathology—may not be identified at admission and may appropriately emerge after the 36-hour window. A rigid standard could discourage ordering medically necessary services as needs change.

The proposal also does not reflect operational realities. Patient readiness varies, and weekend or off-hour admissions can make coordination across multiple disciplines challenging within a compressed timeframe.

We are concerned this requirement would increase denials without improving patient outcomes. CMS should not finalize the proposal as written. At a minimum, CMS should clarify that the requirement applies only to therapies ordered at admission and adopt a delayed implementation date of no earlier than October 1, 2028. As proposed, the policy may also discourage physicians from ordering medically necessary therapies when needs emerge after admission.

### **CURRENT FUNCTIONAL STATUS ON PREADMISSION SCREENING**

CMS proposes requiring documentation of a patient's "current functional status" in the preadmission screening. However, the proposal does not define the term or specify how it should be measured or reviewed, creating uncertainty for providers and contractors.

Acute care hospitals do not complete Section GG functional scores and are typically not positioned to do so. In addition, a patient's functional status may change between the acute assessment and IRF admission, potentially resulting in inaccurate or misleading documentation.

CMS should not finalize this proposal without clearly defining "current functional status," establishing standardized reporting expectations, and providing clear guidance on how compliance will be evaluated.

### **TIMING OF INITIAL INTERDISCIPLINARY TEAM (IDT) MEETING**

CMS proposes to require that the initial IDT meeting occur on or before the fourth day from midnight of admission.

This change is clinically counterproductive and operationally unnecessary. IRF teams already engage in ongoing communication about patient care, and the proposed requirement would further compress an already tight admission window.

Therapy evaluations must be completed within 36 hours, and the physician must finalize the individualized plan of care by Day 4. Meaningful IDT discussions depend on having enough time to observe patient progress in therapy. Requiring the meeting by Day 4 would limit its clinical value, as it would occur before sufficient data is available.

We oppose this proposal and urge CMS to maintain the current 7-day timeframe. If CMS proceeds, we recommend at least a one-year implementation delay.

### **IRF QUALITY REPORTING PROGRAM — DATA SUBMISSION TIMELINE**

AzHHA is concerned with CMS’s proposal to shorten the IRF QRP data submission timeline from 4.5 months to 45 days.

While we support improving the timeliness of quality data, this change would be challenging to operationalize. Data validation, aggregation, and submission processes involve multiple systems and staff, and compressed timelines increase the risk of reporting errors.

If finalized, CMS should take a more measured approach. At a minimum, we recommend a longer submission window—no less than 100 days—to ensure data completeness and accuracy while maintaining patient care operations.

### **CONCLUSION**

We appreciate CMS’s efforts to refine the IRF PPS and improve program integrity. However, we urge the agency to carefully consider the combined impact of payment updates and new operational requirements on providers’ ability to deliver high-quality rehabilitation care.

Thank you for the opportunity to comment. Please feel free to contact me with any questions.

Sincerely,



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