Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2027 and Updates to the IRF Quality Reporting Program
[CMS-1845-F]
Final Rule Summary

On August 3, 2026, the Centers for Medicare & Medicaid Services (CMS) published on the *Federal Register* website a final rule (CMS-1845-F) to update the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2027. Additionally, this rule includes updates for the IRF Quality Reporting Program (QRP). CMS finalizes proposals related to IRF therapy treatments or therapy evaluations, and interdisciplinary team meetings, but *did not finalize* a proposal related to documentation of functional status in the pre-admission screening. CMS also summarizes responses to two Requests for Information (RFIs) on alternative data sources for IRF PPS wage index and potential future IRF PPS payment reform. Finally, this rule includes changes to the DMEPOS Competitive Bidding Program. The IRF PPS Addenda, along with other supporting documents and tables referenced in this final rule, are available on the CMS website at CMS-1845-F.

CMS estimates that the Medicare IRF PPS payments in FY 2027 will be about $340 million higher than in FY 2026. CMS estimates that the changes related to IRF QRP will not result in any costs or savings to IRFs during FY 2027.

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I. Executive Summary

This final rule updates FY 2027 payments to inpatient rehabilitation facilities. In addition, this rule revises §412.622(a)(3)(ii) to require all therapy treatments and/or therapy evaluations begin no later than 36 hours from midnight on the day of admission (hereafter referred to as the 36-hour requirement); and finalizes requirements for the initial Interdisciplinary Team (IDT) by revising §412.622(a)(5) to require the initial meeting to occur on or before four days from the date the patient is admitted to align with the Plan of Care (POC) timeframe. CMS also summarizes the comments received in response to a Request for Information (RFI) on options to modernize and revise the primary diagnosis and comorbidity score methodology under the Skilled Nursing Facility Patient Driven Payment Model (PDPM) for the IRF PPS.

For the IRF Quality Reporting Program (QRP), this final rule revises the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. Finally, CMS provides summaries of the comments received in response to an RFI on future measure concepts for the IRF QRP.

For the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP), this rule finalizes a higher bid surety bond amount for a bidding entity submitting a bid in a Remote Item Delivery (RID) competitive bidding area.

CMS estimates that the Medicare IRF PPS payments in FY 2027 will be about $340 million higher than in FY 2026. CMS estimates that the proposal related to IRF QRP will not result in any costs or savings to IRFs during FY 2027.

II. Background

In this section of the final rule, CMS provides a brief overview of the IRF PPS, which applies to inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital. CMS reviews the applicable statutory authorities[1] and IRF PPS provisions which are further described in the FY 2002 through 2026 IRF PPS final rules.

CMS also summarizes provisions of the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) affecting the IRF PPS in FY 2012 and beyond, particularly focusing on the IRF Quality Reporting Program (QRP) that the agency implemented in 2014.

CMS has developed and made public a separate online document to provide detailed background information related to the regulatory and legislative provisions that have affected the IRF PPS over the years. The document also includes details related to claims submission and processing. The document may be found on the CMS website at: Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Regulatory and Legislative History.

III. Summary of Provisions of the Final Rule

Policy changes and updates to the IRF PPS for FY 2027 finalized in this rule include the following:

- Update the case-mix group (CMG) relative weights and average length of stay values for FY 2027 in a budget neutral manner,

- Update the IRF PPS payment rates for FY 2027 by the IRF market basket percentage increase, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act,

- Update the FY 2027 IRF PPS payment rates by the FY 2027 wage index, applying the final year of the phase-out of the rural adjustment for IRFs transitioning from rural to urban, and the labor-related share in a budget-neutral manner,

- Summarize public comments received on alternative data sources for the wage index,

- Describe the calculation of the IRF standard payment conversion factor for FY 2027,

- Update the outlier threshold amount for FY 2027,

- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2027,

[1] Including Section 1886(j) of the Social Security Act establishing the IRF PPS and conferring broad statutory authority on the Secretary to propose refinements to the IRF PPS.

- Require all therapy treatments and/or therapy evaluations to begin no later than 36-hours from midnight on the day of admission (§412.622(a)(3)(ii)),

- *Not* finalizing the proposal to require the patient's current functional status is documented in the preadmission screening (§412.622(a)(4)(i)(B)),

- Require the initial IDT meeting to occur on or before 4 days from the date the patient is admitted and align with the POC timeframe (§412.622(a)(5)(ii)), and

- Summarize public comments on the RFI on updating the IRF payment system to explore options to modernize the IRF PPS by leveraging the existing clinical classification and comorbidity score methodology used by the SNF PDPM to group patients by case mix.

This rule also changes the IRF QRP data submission deadlines for FY 2029.

Separately, with respect to the DMEPOS Competitive Bidding Program (CBP), the rule updates the bid surety bond requirement to require a higher bid surety bond amount for a bidding entity submitting a bid under a Remote Item Delivery competitive bidding program.

IV. Updates to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2027

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (*e.g.*, very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

In the proposed rule for FY 2027, CMS proposed updates to the CMG relative weights and average length of stay values for FY 2027 using FY 2025 IRF claims and FY 2024 IRF cost report data using the same methodology as it has in prior years. Changes to the CMG weights are budget neutral. CMS proposed a budget neutrality factor of 0.9990, which was unchanged in this final rule.

CMS notes that few commenters submitted feedback on the updates to the CMG relative weights and ALOS values, all in support of the proposed updates, and that commenters encouraged continued updates in the final rule, using most recent available data. **CMS thus finalizes its proposal to update the CMG relative weights and ALOS values for FY 2027** using the same methodologies that the agency has used to update the CMG relative weights and ALOS values for each FY since CMS implemented an update to the methodology in FY 2009.

Table 2 in the final rule displays the relative weights and length of stay values by CMG and comorbidity tier. Table 3 displays the distributional effect of changes in CMS weights across cases. As proposed for FY 2027, 99.4 percent of IRF cases are in CMGs for which the FY 2027 weight differs from the FY 2026 weight by less than 5 percent (either increase or decrease).

CMS indicates that the finalized changes in the average length of stay values from FY 2026 to FY 2027 are small and do not show any trends in IRF length of stay patterns.

Column 6 of Table 14 in the impact section of the final rule (reproduced in section XII of this summary) shows the distributional effects of the changes in the CMGs by type of facility.

V. FY 2027 IRF PPS Payment Update

A. Background

CMS is required by sections 1886(j)(3)(C)(i) and 1886(j)(3)(C)(ii)(I) of the Act to establish the IRF PPS update based on a market basket percentage increase less a productivity adjustment.

B. FY 2027 Market Basket Update and Productivity Adjustment

In the IRF PPS proposed rule for FY 2027, CMS proposed an update factor of 2.4 percent to the IRF PPS payment rates for FY 2027. Consistent with historical practice, CMS estimates the market basket update for the IRF PPS for FY 2027 based on the most recently available data at the time of rulemaking, which may result in differences between the proposed and final rules.

FY 2027 IRF PPS Update Factor	
IRF market basket	3.2%
Total factor productivity (TFP)	-0.9
Total	**2.3%**

The final update reflects IHS Global Insight's (IGI's) 2nd quarter 2026 forecast of the IRF market basket with historical data through the 1st quarter of 2026. The productivity offset is based on IGI's 2nd quarter 2026 forecast of the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity.[2] The market basket is unchanged from the proposed rule, and the productivity adjustment changed slightly from 0.8% to 0.9%, for a net update of 2.3 percent. The update factor will be 2.0 percentage points lower for IRFs that fail to meet IRF QRP requirements.

In its March 2026 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress should reduce the IRF PPS base payment rate by 7 percent for FY

[2] Productivity Home Page : U.S. Bureau of Labor Statistics.

2027.[3] By law, CMS must update IRFs rates by the market basket less productivity and cannot adopt MedPAC's recommendation.

Comments on the proposed market basket increase were characteristically mixed, with some supporting, and some opposing the proposed adjustment. Some commenters urged CMS to continue refining the IRF market basket to recognize the specialized costs that IRFs face. Several commenters expressed concerns about the productivity adjustment, both its magnitude, and its application in general.

After consideration of the public comments received, **CMS is finalizing a FY 2027 IRF productivity-adjusted market basket increase of 2.3 percent** based on the most recent data available. This reflects a 3.2 percent market basket percentage increase, less the 0.9 percentage point productivity adjustment required by law.

C. FY 2027 IRF Labor-Related Share

In the proposed rule, CMS proposed a total labor-related share of 74.5 percent for FY 2027, which was 0.1 percentage point higher than the FY 2026 labor share of 74.4 percent. Using IGI's 2nd quarter 2026 forecast data, **CMS now calculates, and finalizes, a labor-related share under the IRF PPS of 74.3 percent,** as shown in Table 4 below reproduced from the final rule:

Table 4: Proposed IRF Labor Related Share

	FY 2026	FY 2027*
Wages and Salaries	49.4	49.3
Employee Benefits	11.8	11.8
Professional Fees: Labor-related	5.5	5.5
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance and Repair Services	1.5	1.5
All Other: Labor-related Services	1.8	1.8
Subtotal	**70.7**	**70.6**
Labor-related portion of capital (46%)	3.7	3.7
Total Labor Related Share	**74.4**	**74.3**

* Based on the 2nd quarter 2026 IHS Global Inc. forecast of the 2021-based IRF market basket.

[3] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2026. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch9_MedPAC_Report_To_Congress_SEC.pdf

D. Wage Adjustment for FY 2027

1. FY 2027 Wage Index

In the IRF PPS proposed rule for FY 2027, CMS proposed to continue using the Office of Management and Budget's (OMB) core-based statistical areas (CBSAs) as the labor market areas for the IRF PPS and the FY 2027 pre-reclassification and pre-floor hospital IPPS wage indexes. In cases where there is a rural area without IPPS wage data but an IRF wage index needs to be assigned, CMS proposed to continue to use the average wage index from all contiguous CBSAs. For urban areas where there are no IPPS hospitals but an IRF wage index needs to be assigned, CMS proposed to use the urban area average for the state in which the IRF is located.[4] CMS proposed to continue applying a 5 percent cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline.[5] CMS also solicited comments on using alternative data sources such as BLS to construct an IRF-specific wage index for potential use in future years.

CMS indicates that most commenters supported its proposal to maintain the current IRF wage index methodology for FY 2027, although many commenters raised concerns about aspects of the current methodology, particularly CMS' use of the pre-reclassification, pre-floor IPPS wage index, arguing that this wage index puts IRFs at a competitive disadvantage in labor markets they share with acute-care IPPS hospitals. Some commenters urged CMS to be cautious in using other sources of wage data, or developing an IRF-specific wage index. Others (including MedPAC), however, supported the development of an IRF specific wage index, stating that a wage index calculated by using Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) data would improve the accuracy of geographic labor costs that IRFs incur. They remarked that this data is publicly available and would reduce administrative burden compared to cost report data.

After consideration of the comments received, CMS is finalizing the updates to the wage index as proposed for FY 2027.[6]

2. Final Year of the 3-Year Phase Out of the Rural Adjustment

As a result of some counties transitioning from a rural designation to an urban one under the 2023 OMB definitions adopted in FY 2025, eight IRFs would lose their rural status for purposes of the 14.9 percent rural payment adjustment. In the FY 2025 IRF PPS final rule, CMS adopted a policy to phase-out the rural adjustment for these IRFs over three-years (FY 2025, FY 2026, and FY 2027).

[4] For FY 2027, the only rural area without wage index data available is in North Dakota, and the only urban area without wage index data available is CBSA 25980, Hinesville Fort Stewart, GA.

[5] New IRFs would be paid the wage index for the area in which they are geographically located for their first full or partial FY with no cap applied.

[6] This includes continuing to use the revised OMB MSA delineations identified in OMB Bulletin No. 23-01, as discussed in the FY 2025 IRF PPS final rule (89 FR 64291 through 64304).

CMS indicates that commenters supported the agency's proposal to complete the final year of the rural-to-urban adjustment phase-out as previously adopted. Thus, **CMS is finalizing the final year of the 3-year budget-neutral phase-out of the rural adjustment for FY 2024 IRFs transitioning from rural to urban status in FY 2027 under the revised CBSA delineations as proposed**.

3. IRF Budget-Neutral Wage Adjustment Factor Methodology

To determine the FY 2027 IRB PPS wage index budget neutrality factor, CMS estimates aggregate IRF PPS payments using the FY 2026 labor-related share and wage index and then estimates aggregate payments using the proposed FY 2027 labor share and wage index. The ratio of the FY 2026 payments and the proposed FY 2027 payments is the proposed budget neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2027. In the IRF PPS proposed rule for FY 2027 CMS proposed a budget neutrality adjustment of 1.0033; using updated data, **CMS is finalizing a 2027 budget neutral wage adjustment factor of 1.0036. CMS did not receive any comments on its proposal.**

E. Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2027

Table 5 of the final rule (reproduced below) shows the calculations used to determine the FY 2027 IRF standard payment amount. In addition, Table 6 of the rule lists the FY 2027 final payment rates for each case-mix group (CMG).

Table 5: Calculations to Determine the FY 2027 IRF Standard Payment Conversion Factor	
Explanation for Adjustment	**Calculations**
Standard Payment Conversion Factor for FY 2026	$19,371
Market Basket Less Productivity	x 1.023
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0036
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9990
FY 2027 Standard Payment Conversion Factor	= $19,868

F. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 7 provides a detailed hypothetical example of how the IRF FY 2027 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRFs (one urban, teaching with a disproportionate share (DSH) percentage of 15 percent and one rural, non-teaching with a DSH percentage of 5 percent) using the applicable final rule wage index values and facility-level adjustment factors.

VI. Update to Payments for High-Cost Outliers under the IRF PPS for FY 2027

A. Update to the Outlier Threshold Amount for FY 2027

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF's overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF PPS, CMS' intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments. CMS proposed to continue this policy for FY 2027.

To update the IRF outlier threshold amount for FY 2027, CMS proposed to use FY 2025 claims data and the same methodology that has been used to set and update the outlier threshold since FY 2002 (66 FR 41362-41363). CMS estimates that IRF outlier payments are 2.6 percent of total IRF payments for FY 2026, and the agency needs to set the outlier threshold such to maintain estimated IRF outlier payments at the 3 percent of total IRF payments.

CMS indicates that commenters were "broadly supportive" of setting the outlier threshold to ensure that outlier payments represented 3 percent of total payments to IRFs, although some argued that Medicare should provide "greater compensation" for outlier cases. Other commenters expressed concern about the uneven distribution of outlier payments across providers, while others raised concerns about the year-over-year volatility in the outlier threshold under the IRF PPS.

After considering comments received and using the most recent available data, CMS is finalizing the outlier threshold amount of $8,857 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2027.

B. Update to the IRF Cost-to-Charge Ratio (CCR) Ceiling, and Urban/Rural Averages for FY 2027

CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining outlier payment amounts. The national urban and rural CCRs are applied in the following situations:

- new IRFs that have not yet submitted their first Medicare cost report;
- IRFs with an overall CCR that is more than the national CCR ceiling for FY 2025; and
- other IRFs for which accurate data to calculate an overall CCR are not available.

The national CCR ceiling for FY 2027 would continue to be set at three standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the national average CCR (either urban or rural).

CMS proposed national average cost weighted CCRs for FY 2027 of 0.386 for urban IRFs and 0.461 for rural IRFs. The proposed national CCR ceiling was 1.54. **Using updated FY 2024 cost report data, the urban CCR is 0.386, the rural CCR is 0.465, and the national CCR ceiling is 1.56.** If an individual IRF's CCR exceeds 1.56 for FY 2027, CMS would replace the IRF's CCR with the applicable urban or rural national average CCR.

CMS did not receive any comments on the proposed updates to the FY 2027 IRF CCR ceiling and urban/rural averages; therefore, **the agency is finalizing the FY 2027 CCR ceiling and urban/rural averages based on updated data**.

VII. Proposals to Revise the Basis of Payment Requirements

A. Initiation of Therapies No Later Than 36-Hours from Admission

Currently, in order for an IRF claim to be considered reasonable and necessary, the patient's intensive rehabilitation therapy program must consist of at least three hours of therapy per day at least five days per week. The "required therapy treatments and/or therapy evaluations for IRF patients must begin within 36 hours from midnight of the day of admission to the IRF" (42 CFR 412.622(a)(3)(ii)). CMS believes that subregulatory guidance the agency posted in 2010 may have created ambiguous policy interpretation as to whether only one therapy or all therapies must be initiated within 36 hours from the day of admission to the IRF. CMS therefore proposed to revise 42 CFR 412.622(a)(3)(ii) to state that "[a]ll required therapy treatments and/or therapy evaluations must begin no later than 36 hours from midnight the day of admission to the IRF." In the absence of compliance with this new requirement, if finalized, an IRF claim would not be considered reasonable and necessary (in accordance with section 1862(a)(1) of the Act).

CMS indicates the agency received many comments that supported its discussion of, and accompanying revision of the regulatory text regarding the 36-hour requirement, but most requested clarifications and/or certain considerations by CMS. "Many" commenters requested that CMS clearly differentiate in the policy whether the 36-hour requirement applies to therapies documented in the preadmission screening (PAS) or to therapies that are ordered by the rehabilitation physician following admission (such as after the patient's History and Physical). Similarly, many commenters also suggested that CMS consider the approach to implementation of this policy and provide for clinical flexibility. Other individual commenters sought specific clarifications.

After consideration of public comments, CMS is finalizing its proposed revision of the regulatory text for the 36-hour requirement **to require that all therapy treatments and/or therapy evaluations must begin no later than 36 hours from midnight on the day of admission**.

B. Updated Documentation of Current Functional Status in the Preadmission Screening (PAS)

Currently, under 42 CFR 412.622(a)(4)(i), in order for an IRF claim to be considered reasonable and necessary, IRFs are required to document a comprehensive preadmission screening to indicate that a patient meets the requirements for an IRF admission. The preadmission screening must include, among other things, "the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy." CMS believes that in order for the IRF to develop an appropriate plan of care for the patient, in addition to documentation of the patient's prior level of function, the IRF should also document the patient's current functional status in the preadmission screening. Therefore, in the proposed rule, CMS proposed to revise §412.622(a)(4)(i)(B) to additionally require that the patient's "current functional status" be documented in the patient's preadmission screening in their medical record at admission.

The majority of commenters opposed the proposal to require current functional status in the PAS in its current form because of potential clinical and compliance risks if finalized as proposed. They expressed that CMS should provide additional detail on functional data collection and compliance requirements in a future proposal. Commenters requested clarification on what type of assessment and level of detail would be required. In light of these comments, **CMS is not finalizing its proposal,** and indicates that the agency may take into consideration the public comments received to inform future rulemaking on this topic.[7]

C. Proposed Initial Interdisciplinary Team (IDT) Meeting

In order for an IRF claim to be considered reasonable and necessary, the IRF must fulfill several requirements specified at §412.622(a)(4) and (5). These include the development of a plan of care (POC) by a rehabilitation physician with input from an interdisciplinary team (IDT) within four days of the patient's admission to the IRF. Additionally, the IRF must document weekly interdisciplinary team meetings during which all members of a patient's IRF care team must review the patient's progress toward their rehabilitation goals, making recommendations for therapy changes to support discharge goals. CMS notes that prior guidance provided to IRFs says the initial IDT meeting may occur on day eight from the day of admission, which is not aligned with the current policy.

In the IRF PPS proposed rule for FY 2027, CMS expressed concern that under the current IDT policy, IRF patients may have only one IDT meeting occur prior to discharge, which raises concern about the level of coordinated interdisciplinary care a patient is receiving. Also, given the average length of stay in an IRF is typically between 12 to 14 days, for a patient who has their first IDT meeting on day seven, it is likely that the IDT meeting would focus on discharge planning rather than making timely updates to the patient's POC based on their progress. Therefore, CMS proposed to revise §412.622(a)(5)(ii) to specify that the first IDT meeting shall occur on or before the fourth day from midnight on the date the patient is admitted to implement appropriate treatment services; establish or review the patient's stated rehabilitation goals; and

[7] An aside, it is a rare occurrence under the current Administration for CMS to not finalize a policy once proposed.

identify any problems that could impede goals. The initial IDT would be in coordination with the development and timing of the patient's start of therapy (per the 36-hour rule) and the POC. Following the initial IDT meeting, CMS further proposed that a patient's subsequent IDT meetings occur weekly, and made several conforming technical proposals.

In the preamble, CMS provides Revised Figure 1 and Table 8 which provide examples of when IDT meetings occur based on the date the prior IDT was conducted. The Figure and Table are reproduced here:

REVISED FIGURE 1: Initial Interdisciplinary Team Meeting Policy in Effect for FY 2027

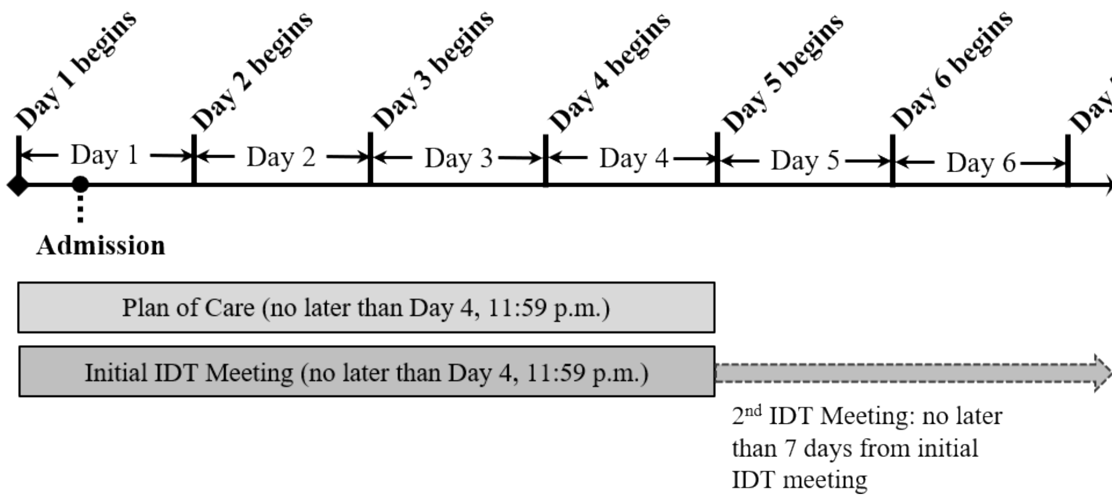

TABLE 8: Compliant and Non-Compliant IRF Patient Examples of IDT Timeline

Patient	Length of Stay	Initial IDT	IDT #2	IDT #3	Compliant?
A	4 days	Day 2	N/A	N/A	Yes
B	10 days	Day 4	Day 9	N/A	Yes
C	6 days	Day 2	Day 5	N/A	Yes
D	14 days	Day 2	Day 11	N/A	No – the initial IDT is compliant, but IDT #2 is non-compliant as there are more than 7 days between the initial IDT and IDT #2.
E	20 days	Day 4	Day 11	Day 19	No – IDT #3 is non-compliant as there have been more than 7 days since IDT #2. The initial IDT and IDT #2 are compliant.

F	16 days	Day 6	Day 13	N/A	No – the initial IDT is noncompliant as there were more than 4 days between admission and the initial IDT.

In the proposed rule, CMS provided a description of the simulation exercise it conducted to assess the impact of the proposed initial IDT policy on IRFs. Assuming the IDT meetings would be one hour in duration, IRFs that move from once to the twice weekly IDT meeting frequency would face an additional approximate cost of $399.06 per week.

CMS summarizes the comments the agency received in response to these proposals. Comments were wide-ranging, but judging from CMS' recap, there was little, if any, support for CMS's proposed changes to the IDT meetings timeline. Commenters who did not outright oppose the changes requested clarifications, suggested clearer definitions, or asked for flexibilities in how the new IDT meeting policies would be implemented. However, CMS indicates that "most" commenters expressed concerns about the proposed changes, arguing that the proposed timeline may disrupt IRFs' current care planning practices, and would impose substantial administrative burden on IRFs without demonstrable clinical benefit in return. These commenters

> "…remarked that the proposal contradicts CMS' goals of improved patient-centered care as the additional meetings would detract from time spent directly with patients. They stated that adding burden and procedural steps in an already tight initial timeframe is particularly concerning due to current staffing shortages and resource constraints that IRFs are facing, and could result in unintended consequences, claim denials, or reduce access for patients. Additionally, commenters remarked that the policy is not aligned with CMS' initiatives aimed at reducing burden in hospitals."

CMS' response to these comments clearly indicates that the agency disagrees, but the agency recognizes the concerns raised, and has thought through the benefits of the proposed changes in light of the increased cost and administrative burden. After consideration of public comments, **CMS is finalizing the 4-day IDT policy with a clarification.** CMS will revise §412.622(a)(5)(ii) as proposed to specify that the initial IDT meeting shall occur on or before the fourth day the patient is admitted to implement appropriate treatment services; establish or review the patient's stated rehabilitation goals; and identify any problems that could impede goals. Following the initial IDT meeting, CMS is finalizing that a patient's subsequent IDT meetings occur weekly (for example, within seven days from the prior IDT meeting). In addition to the revisions to §412.622(a)(5)(ii), CMS will redesignate paragraph (a)(5)(iii) as paragraph (a)(5)(iv) and add a new paragraph (a)(5)(iii) to clarify that the initial IDT meeting shall determine the cadence of patient's subsequent IDT meetings.

VIII. Request for Information Regarding Future IRF Payment Reform

CMS is exploring opportunities to modernize the IRF PPS to better reflect evolving clinical practice and align more closely with other post-acute care settings. This includes potential refinements to clinical categories and comorbidity groupings. In this section of the proposed rule, CMS provided an overview of the current IRF PPS patient classification system and requested input on future payment reforms to enhance and modernize the IRF payment structure.

A. Background

Under the IRF PPS, providers report an Impairment Group Code (IGC) in Item 21A of the IRF Patient Assessment Instrument (IRF-PAI)[8] to identify the primary reason the patient requires IRF care. Each IGC maps to a single Rehabilitation Impairment Category (RIC), which serves as the first level of classification in the payment system. The CMS grouper uses the RIC to assign the patient to a case mix group (CMG) based primarily on functional status at admission and, for certain CMGs, age. Functional status is a key predictor of resource use under the IRF PPS. From FY 2002 through FY 2019, CMG assignment relied on motor and cognitive scores derived from the FIM™ instrument.[9] In the FY 2019 final rule (83 FR 38514), CMS removed the FIM™ instrument and associated Function Modifiers and adopted IRF-PAI Quality Indicator items to reduce provider burden. Beginning in FY 2020, CMGs have been assigned using functional scores derived from these IRF-PAI assessment items.

CMGs are further refined to account for clinical complexity. Patients may be assigned to comorbidity tiers that adjust payment to reflect higher expected resource use. Additional payment adjustments apply for special circumstances, such as very short stays or death.

The IRF PPS currently includes 21 Rehabilitation Impairment Categories and 17 associated Impairment Group Codes, as established in the FY 2002 final rule (66 FR 41316). IGCs are represented by one- or two-digit codes, sometimes extended with decimals to identify more specific subgroups.

B. The Need for IRF Payment Reform

CMS believes refinements to the IRF clinical categories and comorbidity groupings are necessary to support continued payment reform under section 1886(j) of the Act, which would contribute to overall payment reform, and that the IRF PPS is updated to reflect changes in patient complexity and advances in rehabilitation care since its implementation in 2002. By adopting more standardized, diagnosis-based classification approaches across PAC settings,

[8] The IRF-PAI is the assessment instrument IRF providers use to collect patient assessment data for quality measure calculation and payment determination in accordance with the IRF QRP.

[9] The Functional Independence Measure (FIM) is a standardized assessment tool designed to evaluate an individual's level of disability and track changes in functional status over time. It specifically measures the degree of assistance required for performing activities of daily living, encompassing areas such as self-care, mobility, communication, and social cognition.

CMS aims to improve consistency, support care delivery reform, and position the IRF PPS for future payment reforms that better reflect patient complexity and value. CMS notes that these potential refinements would be similar to those used in other Medicare payment systems, including the Inpatient Psychiatric Facility (IPF) PPS and the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM). CMS also cites MedPAC analyses that support this need for refinement.[10]

In the proposed rule's request for information, CMS sought input on potential approaches to ensure that payments under a revised IRF PPS appropriately reflect underlying patient severity and costs, particularly in the event of systematic changes in coding or documentation that are not accompanied by corresponding changes in clinical complexity or resource utilization.

1. Potential Changes to IRF Patient Clinical Classification

The IRF PPS currently relies on 17 major category IGCs, comprising 85 specific IGCs, to classify each patient into one of 21 distinct Rehabilitation Impairment Categories (RICs). Under this framework, up to three ICD-10-CM etiologic diagnosis codes are mapped through a multistep process—from IGCs to RICs to CMGs—to determine payment. Over time, this layered classification approach has created opportunities for misalignment among the patient's primary reason for IRF admission, the clinical care delivered, and the resulting payment, particularly as diagnostic coding practices and patient complexity have evolved.

To address these limitations, CMS is considering modifying how primary diagnoses are mapped to clinical categories. Specifically, CMS has leveraged the existing clinical categories recently implemented under the SNF PDPM to develop a preliminary set of 15 IRF-specific clinical categories to reflect the primary reason for the IRF stay (see Table 9, reproduced from the preamble of the proposed rule). These proposed categories would modernize IRF patient classification by replacing the current mapping scheme with a comprehensive and exhaustive crosswalk from ICD-10-CM diagnosis codes directly to IRF PPS clinical categories.

CMS notes that these proposed clinical categories align with the 10 SNF PPS clinical categories and expand on the Acute Neurologic and Non-Surgical Orthopedic/Musculoskeletal categories, as they accounted for a high proportion of IRF stays and were too broad, which prompted additional breakdown to better reflect IRF case-mix and allow for a more tailored and meaningful distribution of IRF stays. CMS solicited public comments on the potential use of these clinical category assignments under the IRF PPS to classify a patient for payment purposes.

[10] See: MedPAC Reports to the Congress on Medicare Payment Policy, March 2023, March 2025, and March 2026.

TABLE 9: Potential IRF Clinical Categories

Potential IRF Clinical Categories
Acute Infections
Acute Neurologic - Brain/Cranial Nerve
Acute Neurologic - Peripheral Nerve/Muscle
Acute Neurologic - Spinal Cord
Cancer
Cardiovascular and Coagulations
Major Joint Replacement or Spinal Surgery
Medical Management
Non-Orthopedic Surgery
Non-Surgical Orthopedic/Musculoskeletal - Infection
Non-Surgical Orthopedic/Musculoskeletal - Injury
Non-Surgical Orthopedic/Musculoskeletal - Peripheral Nerve/Muscle
Non-Surgical Orthopedic/Musculoskeletal - Rheumatoid/Structural
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
Pulmonary

Select Comments: Several commenters expressed conditional support for CMS' efforts to improve payment accuracy and better reflect patient complexity, while emphasizing the need for additional analysis and interested party engagement before implementation. However, even these commenters still expressed many of the concerns described by commenters who unconditionally opposed the RFI on payment reform. Commenters expressed significant concerns regarding the underlying research, methodology, financial impact, and implementation approach. Many commenters disagreed with aligning IRF payment methodologies with SNF PDPM-based clinical categories, given the distinct population served by IRFs.

CMS indicates that it will continue to analyze the clinical category assignments, including its potential impacts on payment accuracy, beneficiary access, and provider behavior, and will consider interested party feedback as the agency assesses potential future refinements to the IRF clinical categories.

2. Potential Changes to IRF PPS Comorbidities

Drawing on the comorbidity scoring methodology used by the SNF PDPM Non-Therapy Ancillary (NTA) component, CMS developed a preliminary comorbidity scoring and binning approach for the IRF PPS accounting for both the severity and the number of comorbid conditions. Under this framework, CMS identifies comorbidities associated with higher IRF costs using multiple sources, including Hierarchical Condition Categories (HCCs), Prescription HCCs (RxHCCs), IRF-PAI items, and selected custom conditions. Each comorbidity would contribute to a weighted score reflecting its relative impact on resource use, similar to the methodology applied under the SNF PDPM NTA system.

As shown in Table 10 (reproduced from the preamble), comorbidity scores would then be grouped into one of 6 comorbidity score bins: a comorbidity score of 0, 1, 2, 3, 4-5, and 6 or higher. Each bin groups IRF stays by corresponding comorbidity score based on estimated similarities in costs. CMS believes that these scoring and grouping refinements would align spending and value through improved accuracy while also aligning IRF PPS more closely with other PAC payment systems. In the proposed rule, CMS solicited public comments on the potential use of comorbidity scores and score bins under the IRF PPS to categorize comorbidities for payment purposes.

TABLE 10: Potential Comorbidity Score Bins

Potential Bins	Potential Comorbidity Score in Each Bin
Bin 1	Comorbidity Score of 0
Bin 2	Comorbidity Score of 1
Bin 3	Comorbidity Score of 2
Bin 4	Comorbidity Score of 3
Bin 5	Comorbidity Score of 4 or 5
Bin 6	Comorbidity Score of 6+

<u>Select Comments</u>: CMS indicates that comments on the alternative to the IRF comorbidity scoring methodology were mixed, with limited support for the concept of modernization and substantial concern about the specific approach the agency described in the proposed rule. Many commenters expressed concern that the alternative scoring system could underrecognize important comorbidity burdens. Several commenters further expressed that aligning IRF payment methodologies too closely with SNF payment systems could blur distinctions between the two settings and potentially support future site-neutral payment policies. They stated that IRFs serve patients with substantially higher acuity, staffing requirements, and rehabilitation intensity, and that a payment model derived from SNF methodologies may fail to capture those differences.

As with its discussion of potential changes to IRF patient clinical classifications (above), CMS indicates that it will continue to analyze the alternative comorbidity scoring approach, including its potential impacts on payment accuracy, beneficiary access, and provider behavior, and will consider interested party feedback as the agency assesses potential future refinements to the IRF comorbidity adjustment methodology.

IX. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

A. Background and Statutory Authority

The IRF QRP is authorized under section 1886(j)(7) of the Act. The program is applicable to freestanding IRFs and to inpatient rehabilitation units of hospitals or critical access hospitals (CAHs). By statute, a facility that does not submit data in accordance with the IRF QRP requirements for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. FY 2014 was the first IRF PPS rate year in which the IRF QRP affected payments.[11]

The IRF standardized patient assessment instrument (IRF-PAI) is used for data collection and reporting and includes standardized patient assessment data elements (SPADEs) that are interoperable and common across post-acute care (PAC) providers. Measures remain in the IRF QRP until they are removed, suspended, or replaced. Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect other categories of data through the IRF-PAI.

In the final rule, CMS finalizes revisions to the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. CMS also summarizes comments received in response to its RFI on future measure concepts.

B. General Considerations Used for the Selection of Measures for the IRF QRP

Details on factors used to evaluate whether a measure should be removed from the IRF QRP are under 42 CFR §412.634(b)(2) and details on considerations CMS uses for selecting quality, resource use, and other measures can be found in the FY 2016 IRF PPS final rule (80 FR 47083 through 47084). The table below (Table 11 reproduced from the final rule with minor modifications) shows the current measures for the IRF QRP.

Quality Measures Currently Adopted for the IRF QRP

Short Name	Measure Name & Data Source
IRF-PAI Assessment-Based Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients

[11] A detailed legislative and regulatory history is available for download from the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS. Additional information about the program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting.

Short Name	Measure Name & Data Source
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC IRF QRP
TOH-Provider	Transfer of Health Information to the Provider–PAC Measure
TOH-Patient	Transfer of Health Information to the Patient–PAC Measure
DC Function	Discharge Function Score Measure
National Healthcare Safety Network (NHSN)	
CAUTI	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
CDI	NHSN Facility-wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

C. IRF QRP Measure Concepts Under Consideration for Future Years - RFI

In the FY 2027 IRF PPS proposed rule, CMS sought input on the importance, relevance, appropriateness, and applicability of quality measure concepts related to advance care planning (ACP), and specifically relevant aspects of advance care planning and measures appropriate for the IRF setting. The agency stated it would prioritize evidence-based outcome measures that promote person-centered care practices.

In the final rule, CMS summarizes comments received. Many commenters expressed support for an ACP measure, including because such a measure could reduce avoidable conflict during transitions and help ensure that rehabilitation plans reflect patient priorities. Some commenters made recommendations for measure specifications and development, including caregiver involvement in the measure framework. Several commenters did not support an ACP measure for the IRF QRP including because of concerns about the limited applicability of such a measure in the IRF setting. CMS does not respond to comments but says it may take feedback into consideration for future measure development efforts.

D. Form, Manner, and Timing of Data Submission Under the IRF QRP: Proposal to Revise IRF QRP Data Submission Deadlines Beginning with FY 2029 IRF QRP

Background. CMS is statutorily required to provide feedback to IRFs and to publicly report their performance on IRF quality measures specified under section 1899B(c)(1) of the Act and resource use and other measures specified under 1899B(d)(1) of the Act.[12] Currently, for IRF-PAI assessment-based measures, IRFs have approximately 4.5 months after each quarterly data collection period to complete their data submissions to CMS for purposes of compiling public

[12] See section 1886(j)(7)(E) and subsections (f) and (g) of section 1899B of the Act.

performance reports and making corrections to such data where necessary. There are also three IRF QRP measures submitted through the CDC National Healthcare Safety Network (NHSN). For the NHSN CAUTI and CDI outcome measures, IRFs must submit data no later than 4.5 months after the end of the reporting quarter. For the Influenza Vaccination Coverage among HCP measure, the data collection period is October 1 through March 31 with a data submission deadline of May 15th.

In evaluating this process, CMS has determined that the total time between when data on measures is collected and submitted to CMS and when those data are publicly reported (that is, approximately 9 months) may be too long to provide the most accurate and up to date information for the public. CMS believes that reducing the IRF QRP data submission deadline from 4.5 months after the calendar quarter to instead be the 15th day of the second month after the end of the calendar quarter would improve the timeliness of public reporting by one quarter, which could be beneficial to both consumers and IRFs, with limited change in burden to IRFs.

Final Action. CMS finalizes, without modification, its proposal that, beginning with the FY 2029 IRF QRP, IRFs will be required to complete data submissions and make corrections, as necessary, to their IRF-PAI assessment data and CDC NHSN data not later than the 15th day of the second month after the end of the calendar quarter, except if such 15th day falls on a Friday, weekend, or Federal holiday the deadline would be delayed until the next business day. The finalized data submission deadline is approximately within 45 days of the end of the quarter. According to an analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using 2024 data, 99.08 percent of all IRF-PAI assessments were submitted within a 45-day period. According to another analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using FY 2025 data, 88.5 percent of all IRFs submitted CDC NHSN data within a 45-day period.

The specific data submission deadlines finalized for the FY 2029 IRF QRP for IRF-PAI assessment data are shown in Table 12 of the rule and for CDC NHSN QRP measures are shown in Table 13 of the rule. Both tables are reproduced below. The agency finalizes that similar calendar year data submission deadlines would apply for future years.

Table 12: Data Collection Timeframe and Data Submission Deadlines for IRF-PAI Assessment Data Affecting FY 2029 Payment Determination

Calendar Year (CY) Quarter	Data Collection Timeframe	Final Data Submission Deadlines for FY 2029 Payment Determination
CY 2027 Quarter 1	January 1 – March 31, 2027	May 17, 2027
CY 2027 Quarter 2	April 1 – June 30, 2027	August 16, 2027
CY 2027 Quarter 3	July 1 – September 30, 2027	November 15, 2027
CY 2027 Quarter 4	October 1 – December 31, 2027	February 15, 2028

Table 13: Data Collection Timeframe and Data Submission Deadlines for CDC NHSN QRP Measures Affecting FY 2029 Payment Determination

Measure	Data Collection Timeframe	Final Data Submission Deadlines for FY 2029 Payment Determination
CAUTI and CDI	January 1 – March 31, 2027	May 17, 2027
	April 1 – June 30, 2027	August 16, 2027
	July 1 – September 30, 2027	November 15, 2027
	October 1 – December 31, 2027	February 15, 2028
Influenza Vaccination Coverage among HCP	October 1, 2027 – March 31, 2028	May 15, 2028

Comments/Responses. Many commenters supported the proposal because they believed the revised data submission deadline would produce timelier public reporting to inform patient decision making. Other commenters supported the idea of shortening the deadline, but recommended a longer submission window than was proposed, ranging from 60 to more than 100 days to better support validation and correction of submission errors. However, CMS does not believe that the alternative deadlines would close the 9-month lag between the end of the data collection period and when measures are publicly reported.

Several commenters raised concerns about staffing and additional administrative burden. CMS, however, believes the proposal does not add any new reporting requirements, but instead shifts the existing data submission workflow from 4.5 months after each quarterly data collection period to the 15th day of the second month after the end of the calendar quarter.

E. Policies Regarding Public Display of Measure Data for the IRF QRP

In the 2027 IRF PPS proposed rule, CMS did not propose any policies on the public display of measure data.

X. Change to the DMEPOS Competitive Bidding Program (CBP)

Under CMS' DMEPOS CBP, a bidding entity may not submit a bid(s) and be awarded a contract for a competition unless it obtains, in the amount of $50,000, a bid surety bond for the competitive bidding area (CBA) from an authorized surety on the Department of the Treasury's Listing of Certified Companies and provides proof of having obtained the bond by submitting a copy to CMS by the deadline for bid submission.[13] In the event that a bidding entity is offered a contract for any product category for a CBA, and its composite bid for such product category and area is at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amount (SPA) for the product category and CBA, and the entity does not accept the contract offered, the bid surety bond(s) for the applicable CBA(s) will be forfeited and the Secretary will collect on the bid surety bond(s). CMS will collect on the bid surety bond via Electronic Funds Transfer from the respective bonding company. In instances where a bidding entity does not meet the bid surety bond forfeiture conditions for any product category for a CBA, the bid surety bond liability submitted by the entity for the CBA will be returned to the bidding entity within 90 days of the public announcement of the contract suppliers for such product category and area.

CMS explains that the bid surety bond requirement deters bidding entities from submitting a low, disingenuous bid amount in order to increase the probability that they will be offered a DMEPOS contract, as they will forfeit the bid surety bond if the bid is at or below the median composite bid rate and the bidding entity does not accept the offered contract.

In the 2026 HH PPS final rule (90 FR 55342-55620), CMS established the Remote Item Delivery (RID) CBP wherein contract suppliers are responsible for furnishing remote item delivery items under a product category to all Medicare beneficiaries regardless of where they live in the CBA. The CBA could be one nationwide CBA that includes all areas (all States, territories, and the District of Columbia) or a CBA covering a specific region of the country. Items falling under a RID CBP are those that may be shipped or delivered to a beneficiary's home, regardless of the method of delivery, or picked up at a local pharmacy or supplier storefront if the beneficiary or caregiver for the beneficiary chooses to pick the item up in person. When implementing the RID CBP, CMS stated its intent to implement RID CBPs for certain items designated under the DMEPOS CBP, and further explained that competitions for RID items may involve larger CBAs, including nationwide CBAs.

To discourage DMEPOS suppliers from submitting non-serious or disingenuous bids and to ensure genuine commitment from suppliers awarded contracts under a RID CBP, in the FY 2027 IRF PPS proposed rule, CMS proposed to require one bid surety bond at the maximum allowable amount of $100,000 for any and all bids submitted by a bidding entity for RID CBAs in a round of the DMEPOS CBP. CMS also proposed to maintain the bid surety bond amount of $50,000 for all non-RID competitions. Additionally, CMS proposed that if submitting bids for multiple

[13] See: 2016 ESRD PPS and DMEPOS final rule (81 FR 77834), and as codified at 42 CFR 414.412(g).

competitions under a RID CBP, only one bid surety bond is required, regardless of whether the RID CBP competitions have different CBA bids.

CMS proposed to revise §414.412(g)(2) to implement these changes.

CMS indicates that the agency received "a comment" in support of the proposal to increase the bid surety bond for RID CBP from $50,000 to $100,000. **The agency is thus finalizing its proposal that, under §414.412(g)(2)(iii), to submit a bid(s) and be awarded a contract for a RID CBP, the bidding entity must obtain a bid surety bond of $100,000; that, under §414.412(g)(2)(iii), if submitting bids for multiple competitions under a RID CBP, only one bid surety bond is required, regardless of whether the RID CBP competitions have different CBAs; and that for non-RID competitions in future rounds of the DMEPOS CBP, the bid surety bond amount at §414.412(g)(2)(i)(H) will remain at $50,000**.[14]

XI. Collection of Information Requirements

In compliance with the Paperwork Reduction Act of 1995, CMS is required to solicit comments on the need for the information collection and its usefulness in carrying out the proper functions of the agency, the accuracy of CMS' estimates of the information collection burden, the quality, utility, and clarity of the information to be collected, and recommendations to minimize the information collection burden on the affected public, including automated collection techniques. CMS therefore sought comment on each of these issues for the proposed updates related to the IRF QRP. CMS indicates its belief that the proposal to revise the IRF QRP submission deadlines would not result in additional collection burden or revisions to the currently approved IRF-PAI (OMB control number 0938-0842, expiration 10/31/2027). CMS received no comments in response to this assertion.

XII. Regulatory Impact Analysis

CMS estimates that this final rule will increase Medicare payments to IRFs by $340 million, or 2.7 percent, in FY 2027 compared with FY 2026. This reflects the 3.2 percent increase from the update factor, a -0.9 percent productivity adjustment, and a 0.4 percent increase in estimated IRF outlier payments. Table 14 in the final rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes involving the wage index and labor-related shares and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs.

[14] In a conforming technical change, CMS is also finalizing its proposed revision of §412(g)(2)(i)(H) to no longer use the term "bid bond value" and instead use the more common term "bid surety bond amount."

TABLE 14: IRF Impact for FY 2027 (Columns 4 through 7 in Percentages)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2027 Labor-Related Share & FY 2027 Wage Index	CMG Weights	Total Percent Change *
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,178	475,801	0.4	0.0	0.0	2.7
Urban unit	647	148,744	0.9	0.1	0.0	3.4
Rural unit	127	16,835	0.7	0.4	-0.1	3.3
Urban hospital	390	300,932	0.1	-0.1	0.0	2.3
Rural hospital	14	8,368	0.1	0.8	-0.1	3.1
Urban For-Profit	501	300,739	0.2	-0.1	0.0	2.4
Rural For-Profit	39	12,217	0.3	0.6	-0.1	3.2
Urban Non-Profit	459	131,362	0.8	0.0	0.0	3.1
Rural Non-Profit	84	11,062	0.7	0.4	-0.1	3.3
Urban Government	77	18,497	0.9	0.5	0.0	3.8
Rural Government	18	1,924	0.6	0.5	-0.1	3.4
Urban	1,037	450,598	0.4	0.0	0.0	2.7
Rural	141	25,203	0.5	0.5	-0.1	3.2
Urban by region						
Urban New England	31	17,286	0.3	0.3	0.0	2.9
Urban Middle Atlantic	111	43,867	0.6	0.4	0.0	3.3

Urban South Atlantic	198	110,174	0.3	0.0	0.0	2.6
Urban East North Central	165	53,016	0.4	-0.2	0.0	2.5
Urban East South Central	55	30,724	0.2	-0.7	0.0	1.7
Urban West North Central	79	27,000	0.4	0.7	0.0	3.4
Urban West South Central	214	99,449	0.2	-0.3	0.0	2.2
Urban Mountain	85	39,741	0.3	-0.1	0.0	2.5
Urban Pacific	99	29,341	1.1	0.3	0.1	3.8
Rural by region						
Rural New England	5	1,043	0.6	2.5	0.0	5.5
Rural Middle Atlantic	11	1,437	0.5	0.5	-0.2	3.1
Rural South Atlantic	16	6,737	0.1	1.1	-0.2	3.4
Rural East North Central	22	3,010	0.7	0.7	-0.1	3.7
Rural East South Central	18	3,174	0.4	0.5	0.0	3.2
Rural West North Central	18	2,351	0.9	0.3	-0.1	3.5
Rural West South Central	44	7,084	0.6	-0.3	-0.1	2.5
Rural Mountain	5	254	1.3	-0.7	0.0	2.9
Rural Pacific	2	113	1.7	-0.7	-0.3	3.0
Teaching status						
Non-teaching	1,074	422,778	0.4	-0.1	0.0	2.6
Resident to ADC less than 10%	63	38,803	0.5	0.5	0.0	2.6

Resident to ADC 10%-19%	31	11,87	1.0	0.7	0.1	4.2
Resident to ADC greater than 19%	10	2,342	0.6	0.3	0.0	3.3
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	42	8,467	0.8	0.0	0.0	3.1
DSH PP <5%	234	132,788	0.2	-0.1	0.0	2.3
DSH PP 5%-10%	286	121,549	0.3	0.0	0.0	2.5
DSH PP 10%-20%	372	146,003	0.5	0.2	0.0	3.0
DSH PP greater than 20%	244	66,994	0.7	-0.2	0.1	2.9

[*]This column includes the impact of the updates in columns (4), (5), and (6) above, and of the final IRF market basket update for FY 2027 of 3.2 percent, reduced by 0.9 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note that the products of these impacts may be different from the percentage changes shown here due to rounding.