FY 2027 Inpatient Rehabilitation Facility Final Rule

Summary of the Most Consequential Changes to the IRF Program

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Source and page-number convention: CMS, "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program," Public Inspection PDF, 137 pages. All page references below are to the numbered pages in that PDF viewer (page 1 is the cover page).

Executive Summary

The final rule increases Medicare payments to inpatient rehabilitation facilities (IRFs) while simultaneously imposing two significant operational compliance changes. CMS projects that FY 2027 payments per discharge will rise by approximately 2.7 percent, or $340 million in aggregate. The rule also lowers the high-cost outlier threshold, requires every therapy identified for the admission to begin within the existing 36-hour window, and requires the initial interdisciplinary team meeting by the end of day 4. Beginning with the FY 2029 IRF Quality Reporting Program (QRP), IRFs must also submit and correct assessment and infection-control data much sooner than under the current schedule.

- Payment: 2.3 percent productivity-adjusted market-basket update; approximately 2.7 percent average increase in payments per discharge after all payment changes.
- High-cost cases: outlier threshold decreases from $10,141 to $8,857, increasing projected outlier payments by about $50 million.
- Therapy initiation: all required therapy treatments and/or evaluations identified through the preadmission process must begin within 36 hours from midnight following admission.
- Care coordination: the first interdisciplinary team meeting must occur by the end of day 4, with the admission date counted as day 1; later meetings must occur at least weekly.
- Quality reporting: IRF-PAI and CDC NHSN submissions and corrections will generally be due about 45 days after quarter-end beginning with data affecting FY 2029 payment.

Reference pages (Public Inspection PDF): 1-3, 10-11, 119-124.

1. FY 2027 Payment Update and Overall Financial Impact

CMS finalized a 2.3 percent IRF market-basket update. The update is based on a 3.2 percent forecasted market-basket increase reduced by a 0.9 percentage-point productivity adjustment required by statute. The final update is slightly below the 2.4 percent proposed update because CMS used more recent economic forecast data in the final rule.

The FY 2027 standard payment conversion factor increases from $19,371 to $19,868. The calculation incorporates the 2.3 percent update, a 1.0036 budget-neutral wage-index and labor-share adjustment, and a 0.9990 budget-neutral case-mix-group adjustment.

After all payment policies are combined, CMS estimates an average 2.7 percent increase in payments per discharge and a $340 million increase in aggregate IRF payments. Approximately $285 million is attributable to the market-basket update and approximately $50 million to the outlier-policy change. CMS estimates payment-per-discharge increases of 2.7 percent for urban IRFs and 3.2 percent for rural IRFs. Urban hospital-based units are projected to receive a 3.4 percent increase, rural units 3.3 percent, urban freestanding rehabilitation hospitals 2.3 percent, and rural freestanding hospitals 3.1 percent.

Reference pages (Public Inspection PDF): 25-34, 49-50, 119-124, 132.

2. Lower High-Cost Outlier Threshold

CMS lowers the FY 2027 high-cost outlier threshold to $8,857, compared with $10,141 in FY 2026. The lower threshold is intended to restore estimated outlier payments to approximately 3 percent of aggregate IRF payments; CMS estimated the FY 2026 level at approximately 2.6 percent. This change is projected to increase aggregate outlier payments by about $50 million and contributes approximately 0.4 percentage point to the overall IRF payment increase.

CMS also finalized updated cost-to-charge ratio (CCR) parameters used when facility-specific data are unavailable or exceed the ceiling: a national average CCR of 0.465 for rural IRFs, 0.386 for urban IRFs, and a national CCR ceiling of 1.56. An IRF whose CCR exceeds the ceiling will have the appropriate rural or urban national average substituted for its facility-specific CCR.

Reference pages (Public Inspection PDF): 56-61, 119-123.

3. Wage Index, Labor-Related Share, and Completion of the Rural-Adjustment Phaseout

CMS continues to use the pre-reclassification, pre-rural-floor IPPS wage index for the IRF PPS and retains the permanent 5 percent cap on annual provider-level wage-index decreases. The FY 2027 labor-related share is 74.3 percent, down slightly from 74.4 percent in FY 2026. These updates are implemented in a budget-neutral manner, so they redistribute payments among IRFs rather than increasing aggregate spending.

FY 2027 is the third and final year of the rural-adjustment phaseout for facilities that were rural in FY 2024 but became urban under the revised Core-Based Statistical Area delineations in FY 2025. Affected facilities will receive the full FY 2027 urban wage index and no remaining portion of the former rural adjustment. The policy does not reduce the rural adjustment for facilities that remain rural or that transition from urban to rural status; those IRFs receive the full rural adjustment.

CMS did not adopt an IRF-specific wage index or the IPPS post-reclassification/post-floor wage index. The agency only summarized comments on possible alternative data sources and left any larger wage-index redesign for future rulemaking.

Reference pages (Public Inspection PDF): 34-49, especially 37-47; 119-124.

4. Updated Case-Mix Group Relative Weights and Average Lengths of Stay

CMS updated the case-mix group (CMG) relative weights and average length-of-stay values using the most recent claims and cost-report data. The revisions are budget neutral in the aggregate but redistribute payments among clinical categories, functional-status groupings, and comorbidity tiers. CMS reports that 99.4 percent of IRF cases fall into CMGs and tiers with a relative-weight change of less than 5 percent; approximately 0.4 percent of cases are in categories increasing by 5 to 15 percent, and approximately 0.1 percent are in categories decreasing by 5 to 15 percent.

Reference pages (Public Inspection PDF): 11-22, especially 20-22.

5. All Required Therapies Must Begin Within the 36-Hour Window

CMS revised 42 C.F.R. § 412.622(a)(3)(ii) to make clear that all required therapy treatments and/or therapy evaluations must begin no later than 36 hours from midnight on the day of admission. The previous wording and older subregulatory guidance had been interpreted by some providers to mean that initiating a single therapy was sufficient. The final regulation expressly requires initiation of every therapy required for the admission, not merely one discipline.

The clock begins at midnight immediately following the admission date. For example, a patient admitted at 2:00 p.m. Tuesday must have all required therapies and/or evaluations initiated by noon Thursday. CMS clarified that the requirement applies to therapies ordered through the preadmission screening that support the need for IRF admission; a newly ordered therapy after the initial 36-hour period is not retroactively subject to the admission-based deadline.

CMS did not adopt a general exception, a 48- or 72-hour standard, or a one-year implementation delay. Because compliance is part of the IRF coverage and basis-of-payment requirements, facilities should treat failures as potential claim-denial and medical-review risks, not merely quality concerns.

Reference pages (Public Inspection PDF): 62-68; regulatory text at 135-136.

6. Initial Interdisciplinary Team Meeting Required by Day 4

The initial interdisciplinary team (IDT) meeting must occur on or before the fourth day from the date of admission. The admission date is day 1, and the deadline is the end of day 4. A Thursday admission therefore requires the meeting by 11:59 p.m. Sunday; the rule does not create a next-business-day extension for weekends or federal holidays.

The meeting must address treatment implementation, establish or review rehabilitation goals, and identify barriers that could impede those goals. It is intended to align with the plan-of-care deadline and the 36-hour therapy-start requirement. Documentation of the IDT meeting must remain separate from the plan-of-care documentation.

Subsequent IDT meetings must occur at least once every seven consecutive calendar days, measured from the date of the preceding meeting. The initial meeting date therefore establishes the cadence for later meetings. CMS acknowledged that some facilities may need more than one regularly scheduled IDT session per week. CMS also retained the existing attendance policy: the

rehabilitation physician may participate remotely, but other required team members must attend in person.

Reference pages (Public Inspection PDF): 70-83; regulatory text at 135-136.

7. Accelerated IRF Quality Reporting Program Submission Deadlines

Beginning with the FY 2029 IRF QRP, IRFs must submit and correct both IRF-PAI assessment data and applicable CDC National Healthcare Safety Network data no later than the 15th day of the second month after the end of the calendar quarter. This generally shortens the current approximately 4.5-month submission window to about 45 days. If the 15th falls on a Friday, weekend, or federal holiday, the deadline moves to 11:59 p.m. Eastern Time on the next business day.

For calendar year 2027 data affecting the FY 2029 payment determination, the final deadlines are:

- Quarter 1 (January 1-March 31, 2027): May 17, 2027.
- Quarter 2 (April 1-June 30, 2027): August 16, 2027.
- Quarter 3 (July 1-September 30, 2027): November 15, 2027.
- Quarter 4 (October 1-December 31, 2027): February 15, 2028.

CMS did not add new quality measures in this rule; the consequential change is the timing of existing reporting and correction work. CMS expects the shorter deadline to reduce the lag in public reporting and provide more current feedback, but IRFs may need to revise abstraction, validation, vendor, and IT workflows. Failure to submit required QRP data can trigger the existing 2 percentage-point reduction to the annual payment update.

Reference pages (Public Inspection PDF): 7, 94, 98-110, 116, 126.

8. Significant Proposed Requirements That CMS Did Not Finalize

CMS did not finalize the proposed requirement to document a patient's "current functional status" in the preadmission screening. Commenters raised concerns about the lack of specificity, the appropriate assessment methodology, potential inconsistency between the screening and later IRF assessments, and the possibility of inappropriate coverage denials. CMS stated that it may revisit a more specific policy in future rulemaking.

CMS also did not implement a broader redesign of the IRF case-mix methodology or an IRF-specific wage index. The final rule summarizes comments on possible future use of diagnosis and comorbidity approaches related to the skilled nursing facility Patient Driven Payment Model and on alternative wage-index data sources, but those discussions do not change FY 2027 payment methodology beyond the annual updates described above.

Reference pages (Public Inspection PDF): 37-43, 68-70, 83-97.