C+TAC
COALITION TO TRANSFORM ADVANCED CARE

June 1, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

Here are our comments on aspects of this proposed rule:

Proposal on initiation of therapies within 36 hours from admission
We support the proposal to clarify that all required therapy treatments and/or therapy evaluations ordered must begin no later than 36 hours from midnight of the day of admission, and that a claim that does not comply with this requirement will not be considered reasonable and necessary. Timely rehabilitation is important and should be supported. For many patients

with serious illness, early rehabilitation evaluation can reduce avoidable delays, identify risks quickly, and improve coordination around mobility, swallowing, self-care, communication, and discharge needs.

At the same time, the final policy should recognize that some seriously ill patients are admitted to IRFs with substantial symptom burden or medical instability, including fatigue, pain, dyspnea, delirium, fluctuating cognition, infection, or rapid changes in tolerance for therapy. CMS itself notes elsewhere in the proposed rule that therapy tolerance, cognition, prognosis, and preferences can shift during recovery in post-acute care settings. A rigid operational interpretation of the 36-hour rule could inadvertently disadvantage patients whose clinical condition warrants a short stabilization period before all disciplines can safely begin formal treatment or evaluation. Also, weekends and holidays would likely cause facilities to be unable to meet this target as could the condition of the patient.

For that reason, we recommend that the final rule retain the expectation of prompt therapy initiation while explicitly allowing narrowly defined clinical exceptions when the medical record documents why the patient could not safely participate in all ordered therapies within the 36-hour period. CMS should also clarify that the standard is met when clinically appropriate evaluation or treatment begins within the timeframe, even if the full intensity of therapy must be phased in based on the patient's condition.

Documentation of current functional status in the preadmission screening

As we have in the past, we support the proposal to require that the patient's current functional status be documented in the preadmission screening, in addition to the patient's prior level of function, expected improvement/maintenance/or slowed decline, expected length of time to improvement, risk for clinical complications, needed treatments, and anticipated discharge destination.

For people living with serious illness, prior level of function alone may not adequately capture the patient's actual needs at the point of IRF admission, especially after prolonged hospitalization, infection, deconditioning, stroke, cancer treatment, organ failure, or progressive neurologic disease. Therefore, it is important that the final rule clarify what is meant by “prior”. Requiring documentation of current functional status should improve the accuracy of admission decisions, align expectations among clinicians and families, and support more realistic goal setting and discharge planning.

We would also reiterate that monitoring function should also include as acceptable the goal to slow a functional decline, rather than only to improve function. The latter is often not possible for those with end-stage conditions.

We recommend CMS consider clarifying that current functional status should account not only for mobility and activities of daily living, but also for communication needs, swallowing safety, endurance, cognition, caregiver dependency, and the practical supports required for safe discharge. For seriously ill patients, these domains often determine whether rehabilitation is

meaningful, whether home discharge is feasible, and what level of caregiver training is necessary if so.

Initial interdisciplinary team meeting by day 4

We are strong proponents of interdisciplinary care and so support the proposal that the initial interdisciplinary team meeting must occur on or before the fourth day from midnight of the date the patient is admitted as this addresses a meaningful care coordination gap. For people with serious illness, the first days of an IRF stay are often when the greatest uncertainty exists about prognosis, functional gains, symptom burden, therapy tolerance, caregiver readiness, and discharge feasibility. Earlier interdisciplinary review can help identify problems that could impede progress, revise the plan of care sooner, and reduce the risk that the first formal team discussion happens only when discharge is imminent.

We also recommend that CMS explicitly encourage IRFs to include family caregivers in care planning discussions when appropriate and consistent with patient preferences. Family caregivers are often essential to carrying out safe mobility assistance, medication support, swallowing precautions, transfer assistance, toileting support, and follow-up care after discharge, yet they may learn about changing goals too late when care coordination is delayed.

IRF QRP request for information on advance care planning

We are delighted that CMS is seeking input on future IRF QRP measure concepts related to advance care planning (ACP) and agree that it is a continuous process that supports people in understanding and communicating their goals, values, and preferences regarding future medical decisions. We also agree that in post-acute care settings, factors such as clinical stability, functional status, therapy tolerance, cognition, prognosis, and personal preferences may change during recovery, and that ACP facilitates shared decision-making by documenting patient preferences and ensuring goal-concordant care throughout transitions.

IRFs care for many patients whose rehabilitation decisions are inseparable from larger questions about goals of care, acceptable burdens of treatment, caregiver capacity, and the tradeoffs between safety, independence, comfort, and place of care. A future quality framework that values ACP in IRFs could improve care consistency, reduce avoidable conflict during transitions, and help ensure that rehabilitation plans reflect what matters most to patients. The new measure requiring a care plan for all patients 18+ could be considered once it's validated for non-acute settings.

CMS should prioritize ACP measure concepts that are meaningful, feasible, and focused on goal-concordant processes rather than on document completion alone. Possible concepts include whether the IRF elicited and documented the patient's goals, values, decision-making preferences, and identified surrogate; whether those preferences were incorporated into the plan of care and discharge planning; and whether key information was transmitted during care transitions. Measures that reward only the presence of a form or advance directive risk reducing a nuanced clinical process to a checkbox exercise.

CMS should also explicitly recognize family caregiver involvement in any future ACP framework. For many seriously ill IRF patients, the practical success of rehabilitation and discharge depends on whether family caregivers understand the patient's goals, can carry out the needed care plan, and have been included in transition planning consistent with the patient's wishes.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

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