U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF MANAGEMENT AND BUDGET
PAPERWORK REDUCTION ACT
CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISIONS TO THE IRF-PAI (V4.4) FOR THE COLLECTION OF DATA PERTAINING TO INPATIENT REHABILITATION FACILITY (IRF) PROSPECTIVE PAYMENT SYSTEM (PPS) & QUALITY REPORTING PROGRAM (QRP)

OMB Control Number 0938-0842
CMS-10036

SUPPORTING STATEMENT-PART A

IRF-PAI
FOR THE COLLECTION OF DATA PERTAINING TO
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Supporting Statement PART A

IRF-PAI for the collection of data pertaining to the Inpatient Rehabilitation Facility Prospective Payment System and Quality Reporting Program

A. BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is requesting approval of revisions to the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Version 4.4 that will be effective on October 1, 2026.

On August 5, 2025, the Centers for Medicare & Medicaid Services (CMS) published the IRF Prospective Payment System (PPS) for Federal FY 2026 and Updates to the IRF Quality Reporting Program final rule (CMS-1829-F). The rule, currently available on the Federal Register website (www.federalregister.gov) and published in the Federal Register on August 5, 2025, finalized modifications to the collection of quality reporting data in the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP). Specifically, CMS finalized the removal of four Social Determinants of Health (SDOH) items as standardized patient assessment data elements. The four items being removed were scheduled to be implemented with the IRF-PAI v4.3 (which will now be superseded by IRF-PAI v4.4), and therefore, had previously accounted for the burden associated with these items under OMB Control Number 0938-0842. We also finalized our proposal to remove item (O0350), which collected data for the Patient/Resident COVID-19 Vaccine measure, from the IRF-PAI effective October 1, 2026. Per the final rule, submission of data on this item will be optional beginning with patients discharged on October 1, 2025. The item will be removed with the next iteration of the IRF- PAI, scheduled for October 1, 2026.

In addition, we are modifying two items. Item A1250 Transportation will be modified to item A1255 Transportation. Item 8, Gender will be modified to A0810 Sex to be consistent with EO 14168 *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*.

CMS is asking for approval of the IRF-PAI Version 4.4, which will have an October 1, 2026, implementation date. The IRF-PAI Version 4.2 will have a runoff period through September 30, 2026, and sunset when the IRF-PAI Version 4.4 takes effect on October 1, 2026. The IRF-PAI Version 4.3, previously approved on 12/27/24, will not be implemented and will be superseded by IRF-PAI Version 4.4.

B. JUSTIFICATION

1. Need and Legal Basis

This instrument with its supporting manual is needed to permit the Secretary of Health and Human Services, and CMS, to implement Section 1886(j) of the Social Security Act, 42 U.S.C. 1395ww(j), as enacted by §4421 of the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33. The statute requires the Secretary to develop a prospective payment system for inpatient rehabilitation facility services for the Medicare program. This payment system is to cover both operating and capital costs for inpatient rehabilitation facility services. It applies to inpatient rehabilitation hospitals as well as rehabilitation units of acute care hospitals, both of which are exempt from the current PPS for inpatient hospital services. CMS implemented the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002.

The statute requires that the prospective payment system for each Medicare rehabilitation facility be based on patient case mix groups and directs the Secretary to “establish classes of patients of

rehabilitation facilities based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient, as well as a method of classifying specific patients in rehabilitation facilities within these groups." In addition, for each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups. The statute gives the Secretary authority to require inpatient rehabilitation facilities to submit data as the Secretary deems necessary to establish and administer the prospective payment system. Thus, a comprehensive, reliable system for collecting standardized patient assessment data is necessary for: 1) the objective assignment of Medicare beneficiaries to appropriate Case Mix Groups (CMGs); 2) the development of a system to monitor the effects of an inpatient rehabilitation facility prospective payment system on patient care and outcomes; 3) the determination of whether future adjustments to the CMGs are warranted; and 4) the development of an integrated system for post-acute care in the future.

Since October 1, 2012, the IRF-PAI has also been used to collect quality measure data, using data items in the Quality Indicator section, as required by Section 1886(j)(7) of the Social Security Act added by section 3004 of the Patient Protection and Affordable Care Act[1]. The statute requires the Secretary to establish a quality reporting program for inpatient rehabilitation facilities (IRFs), which was established in the FY 2012 IRF PPS final rule (76 FR 47873 through 47883)[2]. Further, section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce the increase factor with respect to a fiscal year by 2 percentage points for any IRFs that do not submit data to the Secretary in accordance with requirements established by the Secretary for that fiscal year, beginning in fiscal year 2014.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113-185, enacted on Oct. 6, 2014), requires that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which IRF providers are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of the such quality measure data through the use of a post-acute care (PAC) assessment instrument and the modification of such instrument as necessary to enable such use; for IRFs, this requirement refers to the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI).

2. Information Users

The IRF-PAI is required by the CMS as part of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). CMS uses the data to determine the payment for each Medicare Part A fee-for-service patient admitted to an inpatient rehabilitation unit or hospital.

The IRF-PAI is also used to gather data for the IRF Quality Reporting Program (IRF QRP). Section 3004(b) of the Affordable Care Act requires the Secretary to establish the IRF QRP. Beginning with the FY 2014 IRF QRP, the Secretary is required to reduce any annual update to the standard federal rate for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) enacted new data reporting requirements for IRFs. All of the data that must be reported in accordance with section 1899B(a)(1)(A) must be standardized and interoperable so as to allow for the exchange of the information among PAC providers and other providers and the use of such data in order to enable access to longitudinal information and to facilitate coordinated care. The FY 2023 IRF PPS final rule (87 FR 47038) finalized the collection of IRF-PAI assessment data on each patient receiving care in an IRF, regardless of payer. IRFs will be

[1] Patient Protection and Affordable Care Act. Pub. L. 111-148. Stat. 124-119. 23 March 2010. Web. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

[2] Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012, Federal Register/Vol 76, No. 151, Friday, August 5, 2011. https://www.gpo.gov/fdsys/pkg/FR-2011-08-05/pdf/2011-19516.pdf

required to report these data with respect to admission and discharge of all patients, regardless of payer, discharged beginning October 1, 2024.

In addition, the public/consumer is a data user, as CMS is required to make IRF QRP data available to the public after ensuring that an IRF has the opportunity to review its data prior to public display. Measure data is currently displayed on the Inpatient Rehabilitation Facility provider type on the Care Compare tool on Medicare.gov, at https://www.medicare.gov/inpatientrehabilitationfacilitycompare/.

3. Use of Information Technology

CMS uses information technology to decrease the burden associated with data collection of the IRF-PAI. This is accomplished through strategies that (1) streamline information and submission processes, (2) minimize costly documentation requirements, and (3) utilize information technology for improving communication.

First, CMS creates data collection specifications for IRF electronic health record (EHR) software with 'skip' patterns to ensure the IRF-PAI is limited to the minimum data required to meet quality reporting requirements and to calculate IRF payment. When implemented these data collection specifications deliver real-time warnings to the IRF when the data is incomplete and when the data is accepted by the system but may be incomplete for purposes of quality reporting submission. IRFs also receive fatal warnings when the data collection form is not accepted by the system for any reason. These specifications are available free of charge to all IRFs and their technology partners. Further, these minimum requirements are standardized for all users of the IRF-PAI assessment forms. Second, CMS has minimized costly documentation requirements by allowing IRFs to electronically self-attest to the accuracy of the data in the IRF-PAI prior to transmitting the IRF-PAI, eliminating the need for supportive documentation to be submitted with the IRF-PAI.

Third, CMS provides customer support for data collection questions and data submission issues encountered by the providers and their vendors. CMS also has dedicated help desks to respond to questions about issues IRFs may encounter with data submitted through the CMS designated data submission system and its associated reports. CMS also offers IRFs the ability to sign up for listservs that send out timely and important new information, reminders, and alerts via electronic mail related to data submission. Finally, CMS has established a website to assist providers with questions regarding the IRF-PAI, at Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) and IRF-PAI Manual | CMS. This website publishes new information related to the IRF-PAI, houses archived versions of the tool and is available at all times to IRFs.

4. Duplication of Efforts

The data required for reimbursement and monitoring the effects of an IRF PPS on patient care and outcomes are not available from any other source.
This data collection for the QRP does not duplicate any other effort and the standardized data cannot be obtained from any other source. There are no other data sets that will provide comparable information on patients admitted to IRFs.

5. Small Businesses

As part of our PRA analysis for an update of our existing approval, we again considered whether the change impacts a significant number of small entities. Out of a total of 1,166 IRFs, only 145 or 12% are rural IRFs, 13% of which are government-owned.[3] The average number of assessments completed annually is 534 per IRF and is the same across all respondents based on the number of actual assessments completed by IRFs in fiscal year 2024.

[3] FY 2026 IRF PPS final rule published on August 5, 2025: https://www.federalregister.gov/d/2025-14780

CMS requests authorization for IRFs to use the updated IRF-PAI 4.4 for the submission of quality measure information finalized in the FY 2026 IRF PPS final rule. Provider participation in the submission of quality data is mandated by Section 3004 of the Affordable Care Act and Section 1899B(c)(2)(A) of the IMPACT Act. Small business providers viewing the data collection as a burden can elect not to participate. However, if an IRF does not submit the required quality data, this provider shall be subject to a 2% reduction in their payment update for the standard Federal rate for discharges from that IRF during that rate year.

6. Less Frequent Collection

We need to collect the data on the IRF-PAI at the required frequency (that is, at admission and at discharge from the IRF) in order to calculate payment and any possible payment penalty under the IRF PPS. This data frequency is also required for the purposes of measures calculation.

7. Special Circumstances

There are no special circumstances that would require the IRF-PAI Admission and IRF-PAI Discharge assessments to be conducted more than once during a patient's stay.

Statistical Policy Directive No. 15 (SPD-15) Implementation Update

We support implementing the latest SPD-15 directive.

For the FY/CY 2027 Rulemaking seasons, we intend to discuss our plans to implement Figure 3, the Minimum Categories Only with the expectation to implement in our 5 PAC Programs beginning in 2028 The implementation of this standard sooner would be a significant burden for the following reasons—

- Existing patient assessment instruments (PAIs) collect information on patients' race and/or ethnicity using an earlier standard. By statute, all PAIs must propose the data items, including race/ethnicity via notice and comment rulemaking. This means that to add the race/ethnicity from SPD-15, we would need to propose the time, place, and manner of adding the SPD-15 race/ethnicity in each of its rules.

- While we have begun preliminary conversations with our Information Systems Group (ISG) colleagues for implementation following rulemaking, adoption of this standard (like any new work) requires adequate time for vendors, States, other CMS components, and federal agencies to implement updates to their respective systems, databases, finder files, etc.

- We need to allow for the 12-month period allotted prior to implementation of any updates and related trainings to the assessment tools and technical data specifications, our various data bases, and impacted reports. We plan to incorporate the Race and Ethnicity Question with Minimum Categories only (no examples or write-ins) (as shown in Figure 3 of the Federal Register posting)

- The new Race and Ethnicity Question has a longer list of race/ethnicity options, which may be more difficult to administer by PAC staff, due to the age and comorbidities of the Medicare-aged population. The Minimum Categories only question (figure 3) reduce provider burden and patient/resident/family confusion since the staff must read the questions to the patient/resident for their response. We also consider the translations for patients who need staff to ask the questions in a language other than English. CMS has tested write-in options for assessment items and that data cannot be used. Aside from spelling issues and how many write-ins should be allowed, we seek inter-operability, and write-ins do not allow for this.

8. Federal Register/Outside Consultation

The FY 2026 IRF PPS Notice of Proposed Rulemaking (NPRM) was published on the Federal Register on April 30, 2025. CMS invited public comment on the proposed burden estimate. We summarize and provide responses to those comments in the FY 2026 PPS Final rule that was displayed on August 5, 2025, available at: https://www.federalregister.gov/d/2025-14780.

CMS informed the provider community on August 5,025. A reference to the announcement can be found on the IRF QRP webpage found here https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/irf-quality-reporting/spotlights-announcements.

a) Consideration of Burden of Information Collection Requests

CMS continually looks for opportunities to minimize burden associated with collection of the IRF-PAI for information users through strategies that (1) simplify collection and submission requirements, (2) improve IRF-PAI comprehension, and (3) enhance communication, navigation, and outreach, (4) minimize learning costs, and (5) provide flexible time frames for data submission.

First, interviews are conducted with information users before new items are introduced. The interviews provide valuable evidence in order to ensure the item(s) are precise and result in meaningful information.

Second, improving IRF-PAI comprehension is a priority. A number of strategies are used, including standardizing the collection instructions across all IRFs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the IRF-PAI. Human-centered design best practices are used, such as prioritizing key communication in headings, text boxes, and bold text. Close attention is paid to the amount of information required in the forms so that only the necessary data is collected on the IRF-PAI.

Third, CMS looks for opportunities to improve communication with users and conducts outreach. CMS provides a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated IRF QRP webpage houses multiple modes of tools, such as instructional videos, case studies, user manuals, and frequently asked questions which support understanding of the IRF-PAI, and can be used by current and assist new users of the IRF-PAI. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), as well as reminders and alerts related to the IRF-PAI completion. Finally, CMS provides a free internet-based system through which users can access on-demand reports for feedback on the collection of the IRF-PAI associated with their facility.

Fourth, CMS is aware of the learning costs that IRFs may incur when new data collection is required. CMS provides multiple free training resources and opportunities for IRFs to use, reducing the burden to IRFs in creating their own training resources. These training resources include live training, online learning modules, tip sheets, and/or recorded webinars and videos. Having the materials online and on-demand gives IRFs the flexibility to use the materials in a group setting or on an individual basis at times that work for them.

Fifth, CMS allows up to 4.5 months for IRFs to submit all data required in this information collection, providing ample time for data submission. CMS acknowledges that some small providers may experience difficulties complying with data collection requirements, and having additional time may reduce the stress and anxiety IRF providers may experience.

9. Payment/Gifts to Respondents

There will be no payments/gifts to respondents for the use of the IRF-PAI. However, per § 412.604, IRFs must complete the IRF-PAI as a condition for payment under the IRF PPS. If an IRF fails to comply fully, CMS may withhold (in full or in part) or reduce Medicare payment to the IRF.

10. Confidentiality

The system of records notices (SORN) establishes privacy stringent requirements. The IRF-PAI SORN (09-70-0521) was published in the Federal Register on November 9, 2001 (66 FR 56681-56687). A SORN modification notice was published in the Federal Register on November 20, 2006 (71 FR 67143).

CMS has also provided, as part of the current Manual, a section that addresses in writing statements of confidentiality consistent with the Privacy Act of 1974. All patient-level data is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. The data collected is protected and held confidential in accordance with 20 CFR 401.3. Data will be treated in a confidential manner, unless otherwise compelled by law.

11. Sensitive Questions

There are no sensitive questions on the IRF-PAI.

12. Burden Estimates (Hours & Wages)

The burden associated with the IRF QRP is the time and effort required for complying with the IRF QRP. The estimated burden for completing the IRF-PAI was established in the FY 2002 IRF PPS Final Rule. Since the establishment of the IRF PAI, CMS has calculated programmatic burden accounting for the time and cost it takes an IRF to encode the IRF PAI, prepare the data for electronic submission, and transmit the data to CMS. Our estimates of time to complete new items is based on past IRF burden calculations, and our assumptions for staff type are based on the categories generally necessary to collect this data, and subsequently encode it.[4] However, individual providers determine their own processes to collect the information and the staffing resources necessary to collect it. We acknowledge that some IRFs will incur a higher cost than was estimated, while some IRFs will incur a lower cost.

a) Assessing Burden of Information Collection

In the FY 2026 IRF PPS final rule[5] we finalized the removal of five items from the IRF-PAI version 4.4:

- O0350. Patient's COVID-19 vaccination is up to date
- R0310. Living Situation
- R0320A. and R0320B. Food
- R0330. Utilities

We are also modifying two items (Item 8, Gender will be modified to A0810 Sex, and item A1250 Transportation will be modified to item A1255 Transportation) but we estimate no burden change for these item modifications. Overall, we estimate a decrease in the total burden incurred for the FY 2028 IRF QRP as a result of these policies being finalized.

Estimate of the Burden:

The burden will decrease as a result of CMS' decision to finalize the removal of five items from the IRF-PAI, which is a decrease of 1.5 minutes or 0.025 hour of clinical staff time. We identified the staff type based on past IRF burden calculations. We believe that the items would be completed

[4] FY 2002 Final Rule (66 FR 41316), FY 2015 Final Rule (79 FR 45872), FY 2016 Final Rule (80 FR 47036), FY 2020 Final Rule (84 FR 39054), FY 2023 Final Rule (87 FR 47038), FY 2024 Final Rule (88 FR 50956)

[5] FY 2026 IRF PPS final rule published in the Federal Register on August 5, 2025. https://www.federalregister.gov/d/2025-14780

equally by a Registered Nurse (RN) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, IRFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[6] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 1. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $70.10/hr was calculated by weighting each adjusted hourly wage equally (that is, 50 percent) [($82.76/hr × 0.5) + ($57.44/hr × 0.5) = $70.10].

TABLE 1—U.S. Bureau of Labor and Statistics' May 2023 National Occupational Employment and Wage Estimates[7]

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29-1141	$41.38	$41.38	$82.76
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29-2061	$28.72	$28.72	$57.44

We estimate that the burden and cost for IRFs for complying with the finalized requirements of the FY 2028 IRF QRP would decrease under this final rule. We estimate that the removal of five items from the IRF-PAI is a decrease of 1.5 minutes or 0.025 hour of clinical staff time. Using FY 2024 data, we estimate a total of 622,300 assessments from 1,166 IRFs annually for a decrease of 15,557.50 hours in burden for all IRFs (622,300 x 0.025 hour), or a decrease of 13.34 hours per IRF for a total of **1,179,256 hours** across all IRFs. Given 13.34 hours at $70.10 per hour, we estimate the total cost will be decreased by $935.32 per IRF annually, or $1,090,580.75 for all IRFs annually.

Burden Hours and Cost Calculation for IRF-PAI V4.4 for the FY 2028 IRF QRP:

Average number of IRFs in U.S. in 2024[8]	1,166
Average number of IRF-PAI admission reports submitted per each IRF for the FY 2026 IRF QRP	534
Average number of IRF-PAI admission reports submitted for all IRFs for the FY 2026 IRF QRP	622,300
Minutes to complete each IRF-PAI	105.1
Decrease in minutes to complete each IRF-PAI	(1.5)
Decrease in Hours for each IRF annually	(13.34)
Decrease in Hours for all IRFs annually	(15,558)
Previous Cost Burden for all IRFs per year	$82,921,473.96
New Cost Burden for all IRFs beginning with the FY 2028 IRF QRP	$81,830,893.21

[6] U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/tables.htm*.

[7] We realize that the 2024 U.S. Bureau of Labor Statistics (BLS) data is now available. However, we are using the 2023 BLS data to remain consistent with the calculations conducted and costs used in the rule.

[8] FY 2026 IRF PPS proposed rule Public Inspection version: https://public-inspection.federalregister.gov/2025-06336.pdf, expected to publish in the Federal Register on April 30, 2025.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The Department of Health & Human Services (DHHS) will incur costs associated with the administration of the IRF QRP including costs associated with the IT system used to process IRF submissions to CMS and analysis of the data received.

CMS has engaged the services of an in-house CMS contractor to create and manage an online reporting/IT platform for the IRF-PAI. This contractor works with the CMS Center for Clinical Standards and Quality, Division of Post-Acute and Chronic Care (DCPAC) in order to support the IT needs of multiple quality reporting programs. When IRF providers transmit the data contained within the IRF-PAI to CMS it is received by this contractor. Upon receipt of all data sets for each quarter the contractor performs some basic analysis which helps to determine each provider's compliance with the reporting requirements of the IRF QRP. The findings are communicated to the IRF QRP lead in a report. Contractor costs include the development, testing, and roll-out of updates to data submission systems.

DCPAC had also retained the services of a separate contractor for the purpose of performing a more in-depth analysis of the IRF quality data, as well as the calculation of the quality measures, and future public reporting of the IRF quality data. Said contractor will be responsible for obtaining the IRF quality reporting data from the in-house CMS contractor. They will perform statistical analysis on this data and prepare reports of their findings, which will be submitted to the IRF QRP lead.

DCPAC has retained the services of a third contractor to assist us with provider training and support services related to the IRF QRP.

In addition to the contractor costs, the total includes the cost of the following Federal employees:

- GS-13 (locality pay area of Washington-Baltimore-Northern Virginia) at 100% effort for 3 years, or $427,464
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33% effort for 3 years, or $142,488.

The estimated cost to the federal government for the contractor is as follows:

CMS in-house contractor – Maintenance and support of IT platform that supports the IRF-PAI	$750,000
Data analysis contractor	$1,000,000
Provider training & helpdesk contractor	$1,000,000
GS-13 Step 1 Federal Employee (100% X 3 years at $120,579 annually)	$361,737
GS-14 Step 1 Federal Employee (33% X 3 years at $142,488 annually)	$142,488
Total cost to Federal Government:	**$3,254,255**

15. Changes to Burden

Since the IRF PAI 4.3 was previously approved the FY 2026 IRF PPS final rule policies change the burden associated with that package. Additionally, new information demonstrates a change in both the number of IRFs and the number of IRF-PAI assessments completed per IRF. The number of IRFs has increased from 1,600 to 1,166.

We estimate a decrease in the amount of time it will take to complete a single IRF PAI Version 4.4 as compared to the previously approved package. As finalized, the burden will decrease from 106.6 minutes (1,194,814 hours across all IRFs) to 105.1 minutes (1,179,256 hours across all IRFs) beginning October 1, 2026 [(1,194,814 - (1,166 IRFs x 13.34 hr decrease/IRF for FY 2028 IRF QRP) = 1,179,256)].

16. Publication/Tabulation Dates

For the final changes to the IRF-PAI Version 4.4 related to the IRF QRP, the final rule was published on the Federal Register on August 5, 2025. The IRF-PAI Version 4.2 will have a runoff period through September 30, 2026 and sunset when the IRF-PAI Version 4.4 takes effect on October 1, 2026. The IRF-PAI Version 4.3, previously approved on 12/27/24, will not be implemented and will be superseded by IRF-PAI Version 4.4.

17. Expiration Date

The OMB expiration date will be displayed on all disseminated data collection materials.

18. Certification Statement

There are no exceptions to the certifications statement.

APPENDIX A: FINAL IRF-PAI VERSION 4.4

See attached PDF.