

**Medicare Program; Fiscal Year 2027 Inpatient Psychiatric Facilities
Prospective Payment System — Rate Update (CMS-1847-P) Summary of
Proposed Rule**

The Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2027 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) proposed rule (CMS-1847-P) on April 2, 2026. The proposed rule was published in the April 7, 2026, *Federal Register*. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals. **The public comment period ends on June 1, 2026.**

This proposed rule updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by IPFs for discharges occurring October 1, 2026, through September 30, 2027 (FY 2027). CMS requests public comment on using alternative data, such as from the Bureau of Labor Statistics, as the basis for the IPF wage index. There is also a proposal to limit an IPF’s outlier payments to no more than 20 percent of its total IPF PPS payments in a year. The proposed rule would implement a standardized IPF patient assessment instrument and remove two quality measures.

Addenda containing payment rates and other relevant information for determination of FY 2027 IPF PPS rates are available at: [Tools and Worksheets | CMS](#). Wage index information is available at: [IPF Wage Index | CMS](#).

TABLE OF CONTENTS		Page
I.	Background	1
II.	Provisions of the FY 2027 IPF PPS Payment Update	2
	A. FY 2027 Market Basket Increase and Productivity Adjustment	2
	B. Updates to the IPF PPS Rates Beginning October 1, 2026	3
	C. Updates to Patient-Level Adjustment Factors	4
	D. Updates to Facility-Level Adjustments	5
	E. Other Payment Adjustments and Policies	8
III.	Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program	10
	A. Background	10
	B. Quality Measures	11
	C. Inpatient Psychiatric Facility-Patient Assessment Instrument (IPF-PAI)	13
IV.	Regulatory Impact Analysis	17

I. Background

Under the IPF PPS, facilities are paid based on a standardized Federal per diem base rate adjusted by a series of patient-level and facility-level adjustments. The rule reviews in detail the statutory basis and regulatory history of the IPF PPS. The system was implemented in January 2005 and was initially updated annually based on a calendar year. Beginning with FY 2013, the IPF PPS has been on a FY update cycle.

The base payment rate was initially based on national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. IPF payment rates have been updated based on statutory requirements in annual notices or rulemaking since then. Additional payment policies apply for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). The ECT per treatment payment rate is also subject to annual updates.

CMS updated the patient specific factors, the qualified emergency department (ED) adjustment and payment for ECT for the first time since the IPF PPS was adopted in the FY 2025 IPF final rule based on an extensive regression analysis (89 FR 23154 through 23161 and 89 FR 64594 through 64601). The patient-level adjustments address age, Medicare Severity Diagnosis-Related Group (MS-DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay; and lower costs for later days of the stay.

Facility-level adjustments are for the area wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED). CMS updated the adjustment for the presence of a qualified ED in the FY 2025 IPF final rule based on the regression analysis cited above. Payment adjustments for teaching status and IPFs located in rural areas were made in the FY 2026 IPF final rule.

II. Provisions of the FY 2027 IPF PPS Payment Update

A. FY 2027 Market Basket Increase and Productivity Adjustment

1. Market Basket Less Productivity

For FY 2027, CMS is proposing an inflation update of 3.1 percent, less 0.8 percentage points for productivity, or 2.3 percent, based on IHS Global Inc.'s 4th quarter 2025 forecast with historical data through the 3rd quarter of 2025. Productivity is based on a rolling 10-year average in economy-wide productivity.

2. FY 2026 IPF Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized Federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2021-based market basket.¹ For FY 2027, CMS is proposing a total labor-related share of 79.1 percent—76.0 percent for operating costs plus 3.1 percent for the labor-related share of capital-related costs. This proposed FY 2027 labor share is 0.1 percentage points higher than the 79.0 percent used for FY 2026.

¹ The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-Related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2021) and FY 2027.

Table 1 of the proposed rule shows how updated data changes the labor-related share:

Table 1: Comparison of FY 2026 and FY 2027 IPF Labor-Related Shares (LRS)

	FY 2026	FY 2027 ¹
Wages and Salaries	53.7	53.8
Employee Benefits	14.2	14.2
Professional Fees: Labor-related	4.7	4.7
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair Services	1.2	1.2
All Other: Labor-related Services	1.5	1.5
Subtotal	75.9	76.0
Labor-related portion of capital (46%)	3.1	3.1
Total LRS	79.0	79.1

1. IHS Global Inc. 4th quarter 2025 forecast of the 2027-based IPF market basket.

B. Updates to the IPF PPS Rates Beginning October 1, 2026

1. Determining the Electroconvulsive Therapy (ECT) Payment per Treatment

CMS has been making a per treatment payment for ECT in addition to per diem and outliers since the inception of the IPF PPS in 2005. To establish the ECT per treatment payment, CMS has used the pre-scaled and pre-adjusted median cost for procedure code 90870 developed for the Hospital Outpatient Prospective Payment System (OPPS) in 2024 updated for inflation and budget neutrality.

2. Increase in IPF PPS Payment

CMS determines the FY 2027 proposed payment rates by applying the update factor of 2.3 percent (1.023) and the wage index budget neutrality adjustment (1.0011) to FY 2026 rates. For hospitals that do not report quality data or meet the quality data reporting requirements, CMS determines the FY 2026 payment rate by applying the reduced update factor of 0.3 percent (1.003) and the wage index budget neutrality adjustment (1.0011) to the full unreduced FY 2026 payment rates.

The table below compares the Federal per diem base rate and the ECT payments per treatment for FY 2027 compared to those finalized for FY 2026.

	FY 2026	FY 2027
Federal per diem base rate	\$892.87	\$912.58
<i>Labor share</i>	<i>\$705.37</i>	<i>\$721.85</i>
<i>Non-labor share</i>	<i>\$187.50</i>	<i>\$190.73</i>
ECT payment per treatment	\$673.85	\$688.73
<i>Rates for IPFs that fail to meet the IPFQR Program requirements</i>		
Per diem base rate	\$892.87	\$894.74
<i>Labor share</i>	<i>\$705.37</i>	<i>\$707.74</i>

	FY 2026	FY 2027
<i>Non-labor share</i>	\$187.50	\$187.00
ECT payment per treatment	\$673.85	\$675.26

Note: The update for FY 2027 for IPFs that do not submit quality data is applied to the full (unreduced) rate for FY 2026, not the actual rate they were paid in FY 2026. The rates in the above table reflect the unreduced rate, not the rate they were actually paid.

C. Updates to the Patient-Level Adjustment Factors

Payment adjustments are made for the following patient-level characteristics: MS-DRG assignment based on a psychiatric principal diagnosis, selected comorbidities, patient age, and variable costs during different points in the patient stay. CMS made changes to the patient-level adjustment factors based on an updated regression model beginning in FY 2025.

1. MS-DRG Adjustment Factors

For FY 2027, CMS is continuing its policy to make payment adjustments for psychiatric diagnoses that group to one of 19 IPF MS-DRGs. Psychiatric principal diagnoses that do not group to one of the 19 designated MS-DRGs would still receive the Federal per diem base rate and all other applicable adjustments, but the payment would not include an MS-DRG adjustment. The 19 MS-DRGs for which an IPF case can receive an MS-DRG adjustment can be found in Addendum A at: [Tools and Worksheets | CMS](#).

The diagnoses for each IPF MS-DRG are being updated as of October 1, 2026, using the IPPS FY 2027 ICD-10-CM/PCS code sets. The FY 2027 IPPS/LTCH PPS rule will include tables of the changes to the ICD-10-CM/PCS code sets that underlie the FY 2027 IPF MS-DRGs. Both the FY 2027 IPPS/LTCH PPS rule and the tables of final changes to the ICD-10-CM/PCS code will be available on the CMS IPPS website: [IPPS Regulations and Notices | CMS](#).

CMS discusses the Code First policy, which follows the ICD-10-CM Official Guidelines for Coding and Reporting. Under the Code First policy, when a primary (psychiatric) diagnosis code has a “code first” note, the provider would follow the instructions in the ICD-10-CM text to determine the proper sequencing of codes.

Annual updates to ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes are made annually April 1 and October 1. Effective April 1, 2025, CMS is making coding updates (including the Code First policy) sub-regulatory to reduce lead time for making routine coding updates to the Code First list, comorbidities, and ECT coding categories. The proposed rule FY 2027 Code First table is shown in Addendum B at the same website as Addendum A.

2. Comorbidity Adjustments

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. Comorbidities are specific patient conditions that are secondary to the patient’s principal diagnosis and that require treatment during the stay. CMS revised the comorbidity adjustment factors based on the results of the updated regression

analysis beginning in FY 2025. For FY 2027, CMS proposes to use the same comorbidity adjustment factors in effect for FY 2025. The proposed FY 2027 comorbidity adjustment factors can be found in Addendum A to the proposed rule.

Coding updates related to the IPF PPS comorbidity categories are adopted following a sub-regulatory process as finalized in the FY 2025 IPF PPS final rule (89 FR 64602 and 64603). For April 1, 2026, CMS added three ICD-10-PCS procedure codes to the Oncology Treatment Procedures list and two ICD-10-PCS procedure codes to the Chronic Obstructive Pulmonary Disease & Sleep Apnea Procedures list. The proposed FY 2027 comorbidity codes are shown in Addendum B of the proposed rule.

3. Revisions to Patient Age Adjustments

In general, CMS has found that the cost per day increases with age. Older age groups are costlier than the under 45 age group. The differences in per diem cost increase for each successive age group are statistically significant. CMS revised the age adjustments based on the updated regression model. The patient age adjustments are shown in Addendum A of the proposed rule.

4. Variable Per Diem Adjustments

Variable per diem adjustments recognize higher ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. CMS revised the variable per diem adjustments based on the results of the updated regression analysis beginning with FY 2025 and is continuing to use those same adjustments for FY 2027 found in Addendum A of the proposed rule.

D. Updates to Facility-Level Adjustments

Facility-level adjustments provided under the IPF PPS are for wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED. In the FY 2026 IPF final rule, CMS revised the facility-level adjustment factors for rural location and teaching status based on the updated regression analysis.

1. Wage Index Adjustment

CMS believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index is the best available to use as a proxy for an IPF specific wage index. Consistent with past practice, CMS is proposing to use the FY 2027 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2027 IPF wage index.

CMS reiterates that it will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. As described earlier, CMS proposes to change the labor-related share of the national rate and ECT payment per treatment from 79.0 percent in FY 2026 to 79.1 percent in FY 2027, reflecting the labor-related share of the 2021-based IPF market basket for FY 2027 as annually adjusted for changes in wages and benefits.

CMS also applies a cap on reductions to an IPF hospital's wage index of 5 percent from its wage index in a prior year. The 5 percent cap on reductions is applied budget neutral.

In the proposed rule, CMS indicates that it began using Bureau of Labor Statistics (BLS) occupation-level wage data for the wage index in calendar year 2025 for the End Stage Renal Disease Prospective Payment System (89 FR 89116). In its 2023 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) explored using county-level wage data from BLS to construct wage indexes specific to the payment setting. **CMS is soliciting comments on using alternative data sources such as BLS to construct an IPF-specific wage index for potential use in future years.** The proposed rule further indicates that CMS is considering the potential use of alternative data for the wage index in the prospective payment systems for inpatient rehabilitation facilities, skilled nursing facilities and hospices.

The wage index used for the IPF PPS is calculated using the unadjusted, pre-reclassified and pre-floor IPPS wage index data and is assigned to the IPF based on the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. CMS adopted changes to the CBSAs based on the 2020 decennial census in the FY 2025 IPF final rule.

CMS is proposing to make a FY 2026 IPF wage index budget neutrality adjustment, based on estimated aggregate IPF PPS payments for FY 2026 and FY 2027 using FY 2023 cost reports. The ratio of FY 2027 to FY 2026 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2027. CMS is proposing a budget neutrality adjustment of 1.0011 (0.11 percent) associated with revisions to the wage index. This proposed budget neutrality adjustment will be updated based on later data in the final rule.

2. Adjustment for Rural Location

CMS provided a 17 percent payment increase for IPFs located in a rural area from the inception of the IPF PPS through FY 2025. Based on its updated regression analysis, CMS increased the adjustment to 18 percent for IPFs located in a rural area beginning in FY 2026.

Under the revised CBSA delineations adopted based on the 2020 decennial census, 54 counties designated as rural would become urban. CMS adopted a policy to phase-out the rural transition adjustment over three years for hospitals located in these counties beginning in FY 2025. The FY 2025 adjustment was 2/3 of the adjustment received in FY 2024 and the FY 2026 adjustment was 1/3 of the amount received in FY 2024. For FY 2027, CMS proposes no rural adjustment for hospitals previously in rural counties that are now urban consistent with a previously adopted policy to phase out the transition over three years.

3. Teaching Adjustment

CMS provided a teaching adjustment based on a coefficient value in the below formula of 0.5150. Based on the updated regression analysis, CMS increased the coefficient value from

0.5150 to 0.7981 beginning in FY 2026. The teaching adjustment formula is below. ADC = average daily census.

$$(1 + Interns\ and\ Residents/ADC)^{0.7981}$$

For example, the teaching adjustment for an IPF with a ratio of interns and residents-to-ADC of 0.2 equals 1.098. This adjustment is applied to the federal per diem base rate. CMS is proposing to retain the coefficient value of the teaching adjustment at 0.7981 for FY 2027.

Beginning with the 2005 IPF PPS, CMS established a cap on the number of full time equivalent (FTE) residents that hospitals may count. This policy limits the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. IPFs are subject to a cap on the number of FTE residents that trained in the IPF’s most recent cost report filed before November 15, 2004. As discussed in the FY 2026 IPF PPS final rule (90 FR 37649 through 37651), CMS made conforming changes to the IPF resident cap policy beginning in FY 2026 to recognize permanent cap increases awarded to hospitals under section 4122 of the Consolidated Appropriations Act, 2023 for the IPPS.

4. Cost of Living Adjustment for Alaska and Hawaii

CMS applies cost of living adjustment (COLA) factors for Alaska and Hawaii to the non-labor related share of the IPF standardized amounts and updates them every four years consistent with the timing of when the IPPS labor share is updated. The COLAs were last updated in FY 2022.

Effective for FY 2027, CMS is proposing to adjust non-labor related costs for IPFs located in Alaska and Hawaii using the Overseas Cost-of-Living Allowance data published by the Department of Defense.² CMS is also proposing to no longer cap the COLA factors for Alaska and Hawaii at 25 percent. The proposed FY 2027 COLA factors will be discussed in more detail in FY 2027 IPPS proposed rule.

COLA Adjustment Factors: IPFs Located in Alaska and Hawaii

Area	FY 2022 through FY 2026	Proposed FY 2027
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22	1.28
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22	1.32
City of Juneau and 80-kilometer (50-mile) radius by road	1.22	1.36
Rest of Alaska	1.24	1.44
Hawaii		
City and County of Honolulu	1.25	1.20
County of Hawaii	1.22	1.32
County of Kauai	1.25	1.26
County of Maui and County of Kalawao	1.25	1.24

² [Overseas Cost-of-Living Allowance | COLA | Defense Travel Management Office](#)

5. Adjustment for IPFs with a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs, which is applied through the variable per diem adjustment. The adjustment applies to a psychiatric hospital, an IPPS-excluded psychiatric unit of an IPPS hospital, or a critical access hospital (CAH) with a qualifying ED. The adjustment is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the OPSS that are furnished to a beneficiary on the date of the beneficiary's admission to the IPF and during the day immediately preceding the date of admission to the IPF, and the overhead cost of maintaining the ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay. CMS updated the adjustment factor for IPFs with qualifying EDs in FY 2025 from 1.31 to 1.54 based on the updated regression analysis. Those IPFs with a qualifying ED receive a variable per diem adjustment factor of 1.54 for day 1 beginning in FY 2025.

With one exception, this facility-level adjustment applies to all admissions to an IPF with a qualifying ED, regardless of whether the patient receives preadmission services in the hospital's ED. The exception is for cases when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. The adjustment is not made in this case because the costs associated with ED services are reflected in the MS-DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH. In these cases, the IPF receives the day 1 variable per diem adjustment of 1.27.

CMS is proposing to continue the ED adjustment unchanged for FY 2027.

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS provides for outlier payments when an IPF's estimated total cost for a case exceeds a fixed loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. For qualifying cases, the outlier payment equals 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay, and 60 percent of the difference for day 10 and after. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2027, CMS is proposing to continue to set the fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS. CMS uses data from the 2nd fiscal year that precedes the payment year to simulate payments for setting the fixed loss threshold (*e.g.*, FY 2025 data for setting the FY 2027 outlier threshold). CMS is proposing to use the same methodology to determine the fixed loss threshold for FY 2027 that it has used dating back to FY 2008 (except for FY 2022 and FY 2023, where specific issues related to the COVID-19 pandemic led to methodological changes for those years).

Based on an analysis of the December 2025 update of FY 2025 IPF claims and the FY 2026 rate increases, CMS estimates that outlier payments for FY 2026 will be 2.2 percent or 0.2 percentage points higher than the target of 2.0 percent.

Following its usual methodology for FY 2027, CMS would have proposed to increase the fixed loss threshold from \$39,360 in FY 2026 to \$42,720 in FY 2027. However, CMS is proposing to change the outlier policy for FY 2027 to minimize the impact of a small number of high-cost IPFs on the outlier fixed dollar loss threshold amount.

CMS' analysis reveals that outlier payments have become increasingly concentrated among a small subset of facilities with exceptionally high reported costs—2.7 percent of IPF providers would receive 47.8 percent of all outlier payments in FY 2027 under the current policy. Each of these provider's outlier payments account for more than 20 percent of its total IPF PPS payments.

Outlier stays tend to be significantly longer than non-outlier stays; however, since the IPF PPS is a per diem payment system in which a longer length of stay results in higher payment, this difference only drives outlier payments when daily costs are also high. Outlier stays, as well as providers with a large share of outlier payments, tend to have higher daily routine charges, which drive higher costs. CMS did not observe case-mix differences that would explain the significantly higher routine costs for facilities with a high share of outlier payments.

Under the current outlier methodology, these high-cost facilities have necessitated substantial increases to the outlier threshold to maintain outlier payments at the 2 percent target. CMS believes that the current concentration of outlier payments may inadvertently limit access to care for high-cost patients at facilities that cannot reach the higher threshold. To address this issue, CMS is proposing to apply a 20 percent limit to an IPF's outlier payments as a percentage of its total payments. As a result, CMS is proposing an FY 2027 outlier threshold of \$37,820. The proposal would allow 40 more providers to receive outlier payments while reducing outlier payments to about 50 providers.

The proposed rule provides information on lower or higher proposed limits on the percentage of an IPF's payments that can be made for outliers. CMS believes the 20-percent facility-level outlier cap would strike an appropriate balance between protecting the outlier fixed dollar loss threshold amount and limiting the impact of the cap to only those IPFs with an unusually high share of outlier payments. CMS is also considering whether to exempt IPFs from this cap policy if they do not exceed a minimum threshold of annual stays such as 25 stays per year.

2. Update to IPF Cost-to-Charge Ratio Ceilings

In estimating the total cost of a case for comparison to the fixed loss threshold amount, CMS multiplies the IPF's charges on the claim by its cost-to-charge ratio (CCR). CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is 3 times the standard deviation from the applicable (*i.e.*, urban or rural) geometric mean CCR. The national median also applies to new IPFs and those for which the data are inaccurate or incomplete.

Based on the most recent CCRs from the 2025 provider-specific file, the proposed FY 2027 national median and ceiling CCRs are:

Proposed National Median and Ceiling CCRs, FY 2027		
CCRs	Rural	Urban
National Median	0.5720	0.4200
National Ceiling	2.4181	1.8850

III. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS proposes to (i) remove two measures from the IPF QRP: the Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a) measure and the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) measure; and (ii) implement a standardized IPF patient assessment instrument, as required by statute.

CMS estimates that, in total, compared to current burden estimates, the IPF QRP proposals in this proposed rule would result in: (i) for 2027 a decrease in burden of 347,681 hours at a savings of \$17,860,317 (with savings in burden attributable to the proposed removal of the two measures, slightly offset by the collection burden for the proposed IPF-PAI for quarter 4 of 2027) and (ii) for 2028 and subsequent years an annual increase in burden of 37,990 hours and \$7,223,725 across all IPFs (with the increase attributable to information collection burden for the proposed IPF-PAI with full year reporting that would begin with 2028).

CMS invites public comment on these proposals.

A. Background

CMS established the IPF QRP beginning in FY 2014, as required under section 1886(s)(4) of the Act. The IPF QRP follows many of the policies established for the Hospital Inpatient Quality Reporting Program but has a distinct set of quality measures. In addition, beginning for FY 2028, IPFs³ participating in the IPF QRP must collect and report certain standardized patient assessment data using a standardized patient assessment instrument (PAI) developed by the Secretary.

Per statute, an IPF that does not meet the requirements of participation in the IPF QRP for a fiscal year is subject to a 2.0 percentage point reduction in the update factor for that year. The payment determination is the year in which an IPF would receive the 2 percentage point reduction to the annual update to the standard federal rate. The data submission period is prior to the payment determination year and is the period during which IPFs are required to submit data on the specified quality measures for that determination year. Substantive changes to the IPF QRP are proposed and finalized through rulemaking.

³ Psychiatric hospitals and psychiatric units within acute care and critical access hospitals that treat Medicare patients paid under the IPF PPS are subject to the IPF QRP. CMS uses the terms “facility” or IPF to refer to both inpatient psychiatric hospitals and psychiatric units.

For more information about the program, see <https://qualitynet.cms.gov/ipf/ipfqr> and <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS>.

B. Quality Measures

1. Proposed Removal of Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a) Measure

CMS proposes to remove the Alcohol Use Brief Intervention Provided or Offered (SUB-2) and subset Alcohol Use Brief Intervention (SUB-2a) measure from the IPF QRP beginning with the 2026 reporting period/FY 2028 payment determination under measure removal factors 3 and 8. Measure removal factor 3 provides that the measure can be replaced by a more broadly applicable measure and measure removal factor 8 provides that the costs associated with the measure outweigh the benefit of its continued use.⁴

In addition to SUB-2/2a, the IPF QRP currently has a second measure that addresses alcohol use disorders, which is the Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB-3/3a) measure. SUB-2/2a assesses whether patients who screened positive for unhealthy alcohol use received or refused a brief alcohol use intervention during their IPF stay, while SUB-3/3a assesses whether patients who are identified as having an alcohol or drug use disorder are offered a referral or prescription for treatment at discharge. SUB-3/3a captures a broader patient population by including those who screened positive for either alcohol use disorder or substance use disorder.

CMS conducted an internal analysis of performance data on the two measures and determined that while performance on both measures show room for improvement, there was no substantial difference in performance between the measures.

To reduce facility burden, CMS is therefore proposing to remove the SUB-2/2a measure because it can be replaced by SUB-3/3a, which is a more broadly applicable measure. CMS estimates the removal would reduce collection of information burden across all IPFs by \$13,110,832 per year.

2. Proposed Removal of the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) Measure

CMS proposes to remove the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and subset Tobacco Use Treatment at Discharge (TOB-3a) measure from the IPF QRP beginning with the 2026 reporting period/FY 2028 payment determination under measure removal factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

TOB-3 assesses whether patients were offered evidence-based outpatient counseling and offered a prescription for FDA-approved cessation medication upon discharge, and TOB-3a identifies the subset of those IPF patients who received such a referral and received such a prescription

⁴ Measure removal factors are criteria used to decide when an existing quality measure should be removed. The IPF QRP's measure removal factors are codified at 42 CFR 412.433(e)(3)(i).

upon discharge. CMS points to performance data median scores of 0.58 to 0.63 on TOB-3 between 2023 and 2025 and believe this is indicative of performance remaining stable with no indication of improvement, suggesting the measure no longer provides incentives for IPFs to offer these interventions. CMS estimates that removal of the measure would reduce collection of information burden across all IPFs by \$13,110,832 per year.

3. Summary of IPF QRP Measures for Future Years

The IPF QRP measure set for the FY 2028 payment determination is set forth in Table 4 of the rule and the measure set for the FY 2029 payment determination is set forth in Table 5 of the rule. The table shown below combines the information from those tables with slight modifications for formatting and explanations. The information from Tables 4 and 5 in the rule do not reflect the proposed measure removals, but those removals are footnoted in the table below.

IPF QRP Measure Set for FY 2028 and 2029 IPF QRP

CBE #	Measure ID	Measure	2028/2029 IPF QRP
Required Measures			
0640	HBIPS-2	Hours of Physical Restraint Use	2028 and 2029
0641	HBIPS-3	Hours of Seclusion Use	2028 and 2029
n/a	FAPH	Follow-Up After Psychiatric Hospitalization	2028 and 2029
n/a*^	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	2028 and 2029
n/a*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	2028 and 2029
n/a*^	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge	2028 and 2029
1659	IMM-2	Influenza Immunization	2028 and 2029
n/a*	TR-1	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2028 and 2029
n/a	SMD	Screening for Metabolic Disorders	2028 and 2029
n/a**	PIX	Psychiatric Inpatient Experience Survey	2028 and 2029
2860	IPF Readmission	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	2028 and 2029
n/a	IPF ED Visit	Thirty-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge^	2029
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge	2028 and 2029

*Measure is no longer endorsed by the consensus-based entity (CBE) but was endorsed at time of adoption. Section 1886(s)(4)(D)(ii) of the Act authorizes the Secretary to specify a measure that is not endorsed by the CBE as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS attempted to find available measures for each of these clinical topics that have been endorsed or

adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

**Reporting for PIX is voluntary for the FY 2027 payment determination and required beginning for the FY 2028 payment determination.

^ CMS is proposing to remove these measures in section IV.B beginning for the FY 2028 payment determination.

C. Inpatient Psychiatric Facility-Patient Assessment Instrument (IPF-PAI)

1. Background

Section 1886(s)(4)(E) of the Act requires IPFs participating in the IPF QRP to submit to the Secretary certain standardized patient assessment data, using a standardized PAI beginning for FY 2028. The standardized PAI must collect data for the following statutorily required categories⁵: (i) functional status; (ii) cognitive function and mental status; (iii) special services, treatments, and interventions or psychiatric conditions; (iv) medical conditions and comorbidities; (v) impairments; and (vi) other categories determined appropriate by the Secretary. The IPF must be standardized to enable each IPF to administer the same assessment instrument with the same questions, response options, standards, and definitions.

2. Considerations in Selecting Assessment Items and Related Data Elements for Proposed IPF-PAI

CMS discusses the multistep process it undertook to conceptualize, design, and test elements of a PAI for the IPF, in accordance with the statutory requirements.

3. Proposal to Implement IPF-PAI

a. Proposed IPF-PAI

CMS proposes to implement the IPF-PAI as the assessment instrument for submission of standardized patient assessment data. CMS proposes that IPFs paid under the IPF PPS be required to complete the IPF-PAI for all patients aged 18 and older, regardless of payer. The agency describes that it selected a minimal set of assessment items to propose in order to minimize burden on IPFs, while meeting the statutory requirements. Assessment items would be administered at admission and discharge, unless specified otherwise in the proposals described below. The IPF-PAI would be codified as part of the IPF QRP under paragraphs (a) and (d) of §412.433.

CMS solicits comments on its proposals related to the IPF-PAI discussed in this section. The agency specifically asks for feedback on the proposed age requirement of 18 years and older and on the potential inclusion of adolescents in the population.

⁵ Section 1886(s)(4)(E)(ii) of the Act.

b. Proposed Assessment Items

The proposed IPF-PAI would collect data related to the statutorily required data categories. Standardized assessment items generally are in the form of a question or instructional text followed by response options. The proposed assessment items, including instructional text and response options, are shown together on the IPF-PAI Item Set, which is available under the IPF-PAI Resources at <https://qualitynet.cms.gov/ipf/PAI>. A draft of the IPF-PAI Guidance Manual, which provides additional guidance and instructions for administering the proposed assessment items, is also available under that same IPF-PAI Resources.

Table 6 of the rule (shown below) shows the proposed assessment items for inclusion in the IPF-PAI and the statutorily required category each measure addresses. The sixth assessment item in the table is being proposed under an administrative items category under the authority provided under section 1886(s)(4)(E)(ii)(VI) for the Secretary to determine other appropriate categories.

Proposed Assessment Items to be Included in the IPF-PAI

Category	Proposed Assessment Item
Functional status	Mobility: Chair/Bed-to-Chair Transfer
Cognitive function and mental status	Suicide Screening
Special services, treatments, and interventions	Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting (Psychiatric Treatments, Restrictive Interventions)
Medical conditions and comorbidities	Primary Medical Condition Category
Impairments	Hearing; Speech Clarity; Vision
Administrative: Assessment items required for record matching and database management	Legal Name of Patient, Birth Date, Sex, Social Security and Medicare Numbers, Facility Provider Numbers (National Provider Identifier, CMS Certification Number), Admission/Discharge Date, Payer Information-Primary Payer, Type of Record, Assessment Reference Date, Reason for Assessment, Type of Admission/Type of Discharge, IPF-PAI Completion Date

CMS describes that the IPF-PAI would be implemented in a way to support interoperable exchange of data. The standardized assessment items and options are intended to produce comparable data across IPFs. The assessment items would be managed in CMS' Data Element Library and each assessment item would be represented as a machine-readable data element. The following is a brief description of each proposed assessment item. Results of inter-rater reliability (IRR) and feasibility from field (beta) testing are shown in Table 7 of the rule. CMS proposes the following assessment items for each category:

Functional Status Category. CMS is proposing Mobility: Chair/Bed-to-Chair Transfer, which evaluates the patient's physical ability to transfer to and from a bed to a chair (or wheelchair). If a patient cannot complete the activity independently, then the level of assistance needed would

be recorded. Most technical expert panel (TEP) members supported inclusion of the assessment item in the IPF-PAI.⁶

Cognitive Function and Mental Status Category. CMS is proposing Suicide Screening, which evaluates whether and with what method (standardized tool, clinical assessment, or not screened) a patient was screened for suicide risk. All TEP members supported inclusion of the assessment item in the IPF-PAI. After field testing, CMS revised this assessment item to reduce its complexity and CMS believes the item being proposed is easier for IPFs to implement than the version used in testing.

Special Services, Treatments, and Interventions for Psychiatric Conditions Category. CMS is proposing Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting, which requires the assessor to indicate from a list which psychiatric treatments (including medications, brain stimulation, and non-pharmacological treatments other than brain stimulation) or restrictive interventions (including use of seclusion, restraints, or other restrictive interventions) may have been used during the IPF stay. Most TEP members supported inclusion of the six treatment or intervention types (100 percent for Medications; 89 percent for Brain Stimulation, Nonpharmacological Treatment, Seclusion, and Restraints; and 67 percent for Other Restrictive Interventions).

Medical Conditions and Comorbidities Category. CMS is proposing Primary Medical Condition, which captures the category of the primary diagnosis (which would be selected from a list of common diagnostic categories, such as anxiety disorders, mood disorder, schizophrenia and other psychotic disorders) associated with the IPF stay. Most (89 percent) of TEP members supported the inclusion of this assessment item.

Impairments Category. CMS is proposing Hearing, Speech Clarity, and Vision, which requires the assessor to record a patient's ability to hear, their ability to see in adequate light, and a description of their speech pattern by selecting their impairment level from a set of response options for each. Unlike the other proposed assessment items, CMS proposes that this assessment item be evaluated at admission only because it is unlikely these assessments would change during an IPF stay, which on average is about 7 days. Most TEP members supported inclusion of this assessment item (89 percent for Hearing; 78 percent for Speech Clarity; 67 percent for Vision).

Administrative Data Category. In addition to the five categories prescribed in statute (and described above), the statute requires IPFs to submit, through the standardized assessment instrument, standardized assessment data for any other category determined appropriate by the Secretary.⁷ Under that authority, CMS proposes including an administrative data category to collect information that enables database management and record keeping. This category would support linking assessment records within the agency's Internet Quality Improvement and Evaluation System (iQIES) and linking such data with other CMS data sources, such as for

⁶ In this summary TEP members who responded Strongly Agree or Agree to an assessment item's inclusion are described as supporting its inclusion.

⁷ Section 1886(s)(4)(E)(ii)(VI).

payment and claims data. The specific data elements are shown in the Proposed Assessment Items table above.

4. Form, Manner, and Timing of Data Collection and Submission of IPF-PAI

a. Proposed Reporting Periods and Data Submission Deadlines Beginning with Data Collection in FY 2028 Impacting FY 2029 Payment Determination

CMS proposes that for the FY 2029 payment determination, IPFs would be required to collect and submit IPF-PAI admission and discharge assessment during the reporting period October 1, 2027 through December 31, 2027, and the assessments conducted during this period would impact that FY 2029 payment determination. CMS proposes that beginning with the FY 2030 payment determination, an IPF would be required to report data for admissions and discharges that occur during the entire calendar year that is two years preceding the FY payment determination (e.g., January 1, 2028 through December 31, 2028 for the FY 2030 payment determination). CMS proposes that for each calendar year reporting period, the data must be submitted as quarterly reporting periods by the 15th day of the second month after the end of the calendar quarter. For the FY 2029 payment determination (proposed reporting period October 1, 2027 through December 31, 2027 (i.e., quarter 4 of 2027), the data submission deadline would be February 15, 2028. The proposed data submission deadlines and associated payment determination years for each of FYs 2029 through 2031 are shown in Table 8 of the rule.

Specifically, CMS proposes that to determine which reporting quarter the admission or discharge falls for purposes of submitting the assessment data, that the Assessment Reference Date (ARD) be used. The Admission ARD would be not later than 3 days after admission and the Discharge ARD would be the day of discharge. Accordingly, an IPF would submit an admission assessment by the 15th day of the second month after the end of the calendar quarter in which the ARD for the admission assessment occurred, and similarly for the discharge assessment. At the same time as proposing the quarterly deadlines, CMS also recommends rolling submission of IPF-PAI records throughout the data collection period.

b. Proposed Compliance Threshold to Receive Applicable Annual Payment Update (APU)

CMS proposes an IPF must complete 100 percent of the IPF-PAI assessment items on 80 percent of the IPF-PAIs submitted to satisfy the program's data reporting requirements for the applicable annual payment determination. Any IPF that fails to meet this threshold would be non-compliant with the reporting requirements and subject to a 2 percentage point reduction to its APU. The compliance rate for each IPF would be calculated for the Q4 2027 reporting quarter for the FY 2029 payment determination and for each subsequent payment determination it would be calculated on the entire CY reporting period.

c. Proposed Methods for Data Submission

CMS believes that the collection and submission of data through health information technology (IT) and the transfer of program data through the use of the FHIR® standard could reduce administrative burden for IPFs over time. Acknowledging that IPFs have not yet used FHIR for

program data submission, the agency proposes that IPFs would need to use one of two possible tools for data collection and submission: (i) Web application (web app) or (ii) FHIR application program interfaces (APIs). The IPF QRP would be the first CMS statutory QRP to use the FHIR standard for patient assessment data submission.

Web App Method of Data Submission. CMS proposes an open-source web app developed by the agency as one method for collecting and submitting IPF-PAI data to the iQIES. CMS would provide and maintain the web app for IPFs, free of charge. IPFs (or third-party vendors on behalf of IPFs) would be able to review, correct, and change data using the web app until the submission deadline. CMS plans to make the web app available in spring or summer 2027.

FHIR API Method of Data Submission. CMS also proposes two APIs it has built from the HL7 FHIR specification as another method for submitting IPF-PAI data – one API would be to retrieve assessment items from electronic health records and the other to submit data to CMS. This method would be appropriate for IPFs that use health IT or use third party vendors.

5. Maintenance of Technical Specifications

CMS proposes that any non-substantive updates to the technical specifications for the IPF-PAI be made through subregulatory mechanisms, such as website postings and listserv messaging. Non-substantive updates would be determined on a case-by-case basis and could include minor changes to data collection or submission specifications. Substantive changes (e.g., addition or removal of data categories or assessment items) would occur through rulemaking.

This policy aligns with the maintenance of technical specifications policy previously finalized for non-substantive updates to measures in the IPF QRP.

IV. Regulatory Impact Analysis

CMS estimates that the net increase in payments to IPF providers for FY 2027 is \$50 million. The update of 2.3 percent is estimated to increase payments \$55 million (\$75 million for the market basket of 3.1 percent less \$20 million for the productivity offset of 0.8 percentage points) and a \$5 million reduction in outlier payments. Not included in this estimate are any reduced payments associated with the required 2.0 percentage point reduction to the market basket increase factor for any IPF that fails to meet the IPFQR Program requirements.

Table 14 in the proposed rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF using the December 2025 update of FY 2025 MedPAR claims data.

TABLE 14: FY 2027 Proposed IPF PPS Payment Impacts

Facility by Type	Number of Facilities	Routine Outlier Update	Proposed 20% Outlier Cap	Proposed FY 27 Wage Index, and Labor-Related Share	Total % Change ¹
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,354	-0.2	0.0	0.0	2.1
Total Urban	1,119	-0.2	0.0	0.0	2.1
Urban unit	601	-0.3	-0.1	0.3	2.2
Urban hospital	518	-0.1	0.1	-0.5	1.9
Total Rural	235	-0.1	0.0	0.4	2.6
Rural unit	171	-0.1	0.1	0.3	2.7
Rural hospital	64	-0.1	-0.2	0.4	2.5
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	106	-0.2	0.4	0.1	2.6
Non-Profit	66	-0.1	0.2	0.1	2.5
For-Profit	346	0.0	0.0	-0.7	1.6
Rural Psychiatric Hospitals					
Government	31	-0.1	0.0	1.2	3.5
Non-Profit	11	-0.7	-1.3	1.7	2.1
For-Profit	22	0.0	0.0	-0.2	2.1
IPF Units					
Urban					
Government	96	-0.6	-0.4	0.5	1.8
Non-Profit	378	-0.3	0.0	0.2	2.2
For-Profit	127	-0.1	0.1	0.4	2.7
Rural					
Government	48	0.0	0.0	0.7	3.0
Non-Profit	93	-0.1	0.2	0.3	2.7
For-Profit	30	0.0	0.1	-0.1	2.3
By Teaching Status:					
Non-teaching	1,147	-0.1	0.0	-0.2	2.0
Less than 10% interns and residents to beds	103	-0.3	0.0	0.9	2.9
10% to 30% interns and residents to beds	77	-0.4	-0.4	0.2	1.7
More than 30% interns and residents to beds	27	-0.4	0.3	-0.2	2.0
By Region:					
New England	95	-0.3	0.1	0.5	2.7
Mid-Atlantic	189	-0.3	-0.5	1.2	2.8
South Atlantic	217	-0.1	0.0	-0.1	2.1
East North Central	211	-0.1	0.0	-0.7	1.4
East South Central	132	-0.1	0.1	-1.1	1.2
West North Central	86	-0.3	0.3	-0.2	2.0
West South Central	208	0.0	0.1	-0.9	1.5
Mountain	90	-0.1	0.1	-0.1	2.1

Facility by Type	Number of Facilities	Routine Outlier Update	Proposed 20% Outlier Cap	Proposed FY 27 Wage Index, and Labor-Related Share	Total % Change ¹
(1)	(2)	(3)	(4)	(5)	(6)
Pacific	126	-0.3	0.2	0.2	2.5
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	89	-0.1	0.0	-0.3	1.9
Beds: 25-49	87	0.0	0.0	-1.2	1.1
Beds: 50-75	94	0.0	0.0	-0.4	1.8
Beds: 76 +	312	-0.1	0.1	-0.2	2.1
Psychiatric Units					
Beds: 0-24	384	-0.2	-0.4	0.1	1.8
Beds: 25-49	220	-0.2	0.2	0.4	2.7
Beds: 50-75	97	-0.3	0.1	0.3	2.5
Beds: 76 +	71	-0.5	0.0	0.6	2.4

¹ This column includes the impact of the updates in columns (3) and (4) above, and of the proposed IPF market basket update factor for FY 2027 (3.1 percent), reduced by 0.8 percentage point for the proposed productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.