Medicare Program; Fiscal Year 2027 Inpatient Psychiatric Facilities Prospective Payment System — Rate Update (CMS-1847-F)
Final Rule Summary

The Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2027 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) final rule (CMS-1847-F) on July 29, 2026. The final rule was published in the July 31, 2026, *Federal Register*. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals.

This final 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). Effective October 1, 2028, CMS will limit an IPF's outlier payment to no more than 20 percent of its total IPF PPS payments in a year with an exception for IPFs with fewer than 50 stays per year. The rule implements a standardized IPF patient assessment instrument and removes 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.

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 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.

Beginning with FY 2028, section 1886(s)(4)(E) of the Social Security Act (the Act) requires IPFs participating in the IPF Quality Reporting Program to submit standardized patient assessment data annually to CMS. The law requires CMS to implement revisions to the methodology for determining IPF payment rates beginning with FY 2031 based on that patient assessment data. CMS is using the FY 2027 IPF rule to implement the patient assessment instrument.

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 proposed 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.

Commenters stated that the proposed payment update is inadequate citing that it is less than the Consumer Price Index (CPI). Additionally, American Hospital Association data shows total hospital expenses, drug costs, and supply costs increased by more than the proposed update and that the Medicare Payment Advisory Commission (MedPAC) reported negative Medicare margins for IPFs for 2016 through 2021. CMS responded that market basket updates may differ from other overall inflation indexes (such as the CPI) as it measures different mixes of products and services.

As in prior rules, commenters expressed concerns about the productivity adjustment stating that hospitals cannot realize the same level of productivity as the general economy—a point supported by the Office of the Actuary's (OACT) own analysis. Other comments requested CMS

use its "special exceptions and adjustments" authority to waive or reduce the productivity adjustment for FY 2027. One commenter objected to the productivity adjustment only being applied to reduce the update. CMS responded that it recognizes the concerns of the commenters but is required by statute to apply the productivity adjustment and only to reduce the update, not increase it.

Commenters again restated concerns that OACT underestimated the market basket in several prior years during and after the pandemic and requested a forecast error correction of 4.2 percentage points to account for the cumulative understatement. CMS responded as it did in the past that forecast errors can go in either direction. Over longer periods of time the cumulative forecast hasn't deviated significantly from the historical measures.

For the final rule, CMS is adopting an inflation update of 3.2 percent offset by a productivity adjustment of 0.9 percentage points or a net update of 2.3 percent based on IHS Global Inc.'s 2nd quarter 2026 forecast with historical data through the 1st quarter of 2026.

2. FY 2027 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 proposed 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. The proposed FY 2027 labor share was 0.1 percentage points higher than the 79.0 percent used for FY 2026. Commenters supported the increase in the labor-related share. However, using updated data for the final rule resulted in the labor-related share declining slightly relative to the proposed rule and FY 2026 as shown in Table 1 below (proposed rule shares in parentheses):

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

	FY 2026	FY 2027
Wages and Salaries	53.7	53.6 (53.8)
Employee Benefits	14.2	14.2 (14.2)
Professional Fees: Labor-related	4.7	4.7 (4.7)
Administrative and Facilities Support Services	0.6	0.6 (0.6)
Installation, Maintenance and Repair Services	1.2	1.2 (1.2)
All Other: Labor-related Services	1.5	1.5 (1.5)
Subtotal	**75.9**	**75.8 (76.0)**
Labor-related portion of capital (46%)	3.1	3.1 (3.1)
Total LRS	**79.0**	**78.9**

[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.

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 determined the FY 2027 final payment rates by applying the update factor of 2.3 percent (1.023) and the wage index budget neutrality adjustment (0.9989) to FY 2026 rates. For hospitals that do not report quality data or meet the quality data reporting requirements, CMS determines the FY 2027 payment rate by applying the reduced update factor of 0.3 percent (1.003) and the wage index budget neutrality adjustment (0.9989) 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 finalized for FY 2027 compared to those for FY 2026.

	FY 2026	**FY 2027**
Federal per diem base rate	$892.87	$912.40
Labor share	*$705.37*	*$719.88*
Non-labor share	*$187.50*	*$192.52*
ECT payment per treatment	$673.85	$688.59
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$892.87	$894.56
Labor share	*$705.37*	*$705.81*
Non-labor share	*$187.50*	*$188.75*
ECT payment per treatment	$673.85	$675.13

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 includes 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 are available on the CMS IPPS website with the FY 2027 IPPS final rule: FY 2027 IPPS Final Rule Home Page | 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. 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 to reduce lead time for making routine coding updates to the Code First list, comorbidities, and ECT coding categories. The 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 proposed to use the same comorbidity adjustment factors in effect for FY 2025. The final FY 2027 comorbidity adjustment factors can be found in Addendum A to the 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. CMS did not receive any comments on these additions. For the FY 2027 final rule, CMS is adding the following ICD–10–CM diagnosis code comorbidity adjustments: ten to the Poisoning Code list, nine to the Cardiac Conditions list, three to the Oncology Treatment Diagnoses list, and six to the Severe Musculoskeletal and Connective Tissue Diseases diagnosis list. In addition, CMS is removing eight diagnoses from the Severe Musculoskeletal and Connective Tissue Diseases list, and twelve diagnosis codes from the Code First list.

The FY 2027 comorbidity codes are shown in Addendum B of the final 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 final 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 final 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 proposed to use the FY 2027 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2027 IPF wage index.

The wage index is applied to the labor-related share of the national base rate and ECT payment per treatment. As described earlier, CMS is changing the labor-related share of the national rate and ECT payment per treatment from 79.0 percent in FY 2026 to 78.9 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.

There were comments on several issues such as using the post-floor, post-reclassified IPPS hospital wage index, the IPPS outmigration adjustment and making the 5 percent cap on reductions to the wage index without applying budget neutrality. CMS responded that it did not propose any of these policies and none of them are required by statute like they are under the IPPS. Further, adopting these proposals under the IPF PPS would increase administrative burden

and have distributional impacts on IPFs. CMS is finalizing all its wage index proposals without change.

In the proposed rule, CMS indicated 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, MedPAC explored using county-level wage data from BLS to construct wage indexes specific to the payment setting. The proposed rule further indicated 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.

CMS solicited comments on using alternative data sources such as BLS to construct an IPF-specific wage index for potential use in future years. Commenters addressed specific aspects of the wage index methodology including information about the extent to which IPFs typically compete with other healthcare settings for labor, thoughts about potential sources of wage data, and considerations related to geographical categorization of IPFs. CMS will consider these comments when making potential future changes to the IPF PPS wage index.

The wage index assigned to an IPF is determined based on the labor market area in which the IPF is 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 that it will continue using for FY 2026.

CMS proposed 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 proposed a budget neutrality adjustment of 1.0011 (0.11 percent) associated with revisions to the wage index. As proposed, CMS is updating the budget neutrality adjustment based on later data in the final rule. The final rule wage index budget neutrality adjustment is 0.9989 (or -0.11 percent).

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 became 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 proposed 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.

No comments on this proposal were presented in the final rule. CMS is finalizing its proposal to end the phase-out of the rural transition as previously planned.

3. Teaching Adjustment

From FY 2005 through FY 2025, CMS provided a teaching adjustment based on a coefficient value 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.

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

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 proposed 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 proposed to adjust non-labor related costs for IPFs located in Alaska and Hawaii using the Overseas Cost-of-Living Allowance (OCALA) data published by the Department of Defense (DOD).[2] CMS also proposed to no longer cap the DOD OCOLA factors for Alaska and Hawaii at 25 percent.

Based on comments received for an analogous policy adopted under the IPPS, CMS is finalizing a "hold harmless" policy in FY 2027 for any area that would experience a reduction to their COLA factor under the OCOLA methodology (which, based on the table below appears to only apply to Maui and Kalawao). The final DOD OCOLA factors are below:

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

COLA Adjustment Factors: IPFs Located in Alaska and Hawaii

Area	FY 2022 through FY 2026	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	1.25
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

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 OPPS 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 did not propose any changes to the ED adjustment 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 proposed to continue setting 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 fixed loss threshold). CMS proposed 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 proposed 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 proposed to apply a 20 percent limit to an IPF's outlier payments as a percentage of its total payments. As a result, CMS proposed 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 provided information on lower or higher proposed limits on the percentage of an IPF's payments that can be made for outliers. CMS selected the proposed 20-percent facility-

level outlier cap to 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 also considered whether to exempt IPFs with fewer than 25 stays per year from the cap.

Under this proposal, if an IPF exceeded the 20 percent facility-level cap, it would no longer receive an outlier payment for high-outlier cases but would receive the IPF PPS per diem payment. Because outlier payments are finalized at cost report settlement, CMS proposed to apply this cap on an annual basis by calculating a facility's outlier percentage using a methodology detailed in the FY 2027 IPF PPS proposed rule (91 FR 17734 and 17735).

Commenters both supported and opposed CMS' proposal to cap IPF outlier payments at 20 percent of total IPF payments. Opponents of CMS' proposal found variation in the providers that would have reached the 20 percent cap from year to year indicating that the proposed cap policy would not target providers with structurally higher costs.

CMS responded that providers with fewer stays would exceed the proposed 20 percent cap less consistently than providers with more stays under a policy that did not have a minimum threshold for the application of the policy. For example, 13 providers had greater than 20 percent outlier payments in FY 2025 and had 25 stays or fewer in that year; only three of these providers would have exceeded 20 percent outliers in FY 2023 and FY 2024. Among the nine providers that had greater than 20 percent outlier payments and between 25 and 50 stays in FY 2025, only three would have exceeded 20 percent outliers in FY 2023 and FY 2024. There were 19 providers with greater than 20 percent outlier payments and 50 or more stays in FY 2025. Only seven of these providers would have exceeded 20 percent outliers in all three years.

As a result of this analysis, CMS is modifying the proposed outlier cap policy to apply only to providers with 50 or more stays per year. Applying the 20 percent cap to providers with 50 or more stays per year would impact 0.8 percent of providers in a typical year, as compared to 3.6 percent of providers under the proposed policy. If this policy were applied for FY 2027, the outlier fixed dollar loss threshold would be approximately $39,390, which is lower than what it would be in the absence of a cap, resulting in 157 more providers receiving outlier payments. Approximately 1.7 percent of IPF PPS stays would qualify for outlier payments with the average outlier payment being $19,054 per stay.

A few commenters opposed to the policy found that facilities whose outlier payments would reach the 20 percent cap were more likely to treat patients with a comorbidity, offer ECT, have longer lengths of stay and, be in an urban area and be a teaching facility. These commenters indicate that variables like whether an IPF is a freestanding hospital or a unit and the IPF's wage index contributed more to variations in costs than patient characteristics did. These commenters indicated that facilities impacted by the cap are likely safety-net providers with high costs due to the unavailability of appropriate discharge options. Opponents of the proposal suggested alternatives like a higher cap of 25 to 30 percent, exemptions for providers treating disproportionate numbers of high acuity or safety-net populations and IPFs in areas with an insufficient number of long-term care beds and an exceptions process based on patient complexity or inappropriate billing or utilization.

CMS responded that commenters' concern about length of stay alone driving high outlier payments is not supported by the data. Outlier stays tend to have higher daily routine charges, which drive higher costs. Overall, these providers charge nearly twice as much per day as compared to the average ($6,000 vs. $2,600). As a per diem payment system, the IPF PPS inherently accounts for the cost impact of longer lengths of stay through higher IPF PPS payments.

Further, CMS stated that the IPF PPS payment framework currently accounts for patient acuity as a driver of cost through adjustments for age, DRG, comorbid conditions, and an additional payment per unit of ECT. In FY 2025, CMS increased the ECT payment per treatment from $385.58 to $661.52. CMS also did not find that IPF PPS outlier payments are associated with the provision of ECT.

Similarly, the final rule indicates that all the facility factors identified as explanations for higher outlier payments are accounted for by the facility adjustment factors (urban location, wage index, teaching status). While CMS considered a provider-specific exceptions process, it believes such an approach would increase administrative burden for both providers and the agency, require individualized determinations that may vary from year to year, and reduce predictability in payment policy.

With respect to the comments about safety net hospitals, CMS explored the application of the disproportionate share hospital (DSH) variable used in other Medicare prospective payment systems at the inception of the IPF PPS. The DSH variable uses measures of low-income patients to apply a DSH adjustment under the IPPS. In the RY 2005 IPF PPS final rule (69 FR 66958 through 66959), CMS found that facilities with higher DSH proportions had lower per diem costs. A study for the American Psychiatric Association came to the same conclusion.

In the FY 2025 IPF PPS proposed rule, CMS solicited comments on a Medicare Safety Net Index (MSNI) for IPFs (89 FR 23196 through 23198). In the FY 2025 IPF PPS final rule, most commenters opposed the addition of an MSNI adjustment either because of insufficient data to support the adjustment, a substantial decrease to the base rate, or the redistribution of resources away from IPFs with a low MSNI (89 FR 64641 through 64642). CMS intends to further study the relationship between safety net status and IPF costs, including outlier payments, and may consider proposing changes to the IPF PPS in the future, if appropriate.

CMS addressed challenges finding post-discharge placement in the November 15, 2004, IPF final rule (69 FR 66952). Days where the patient is no longer eligible for coverage under the IPF PPS cannot account for higher outlier costs. If a patient falls below an active level of care requiring inpatient psychiatric care, the provider identifies the day as such on the claim, and it is not paid under IPF PPS. Instead, the provider can bill, if applicable, Medicare Part B services.

There were comments requesting that CMS address potential program integrity issues by instructing MACs to target providers with high outlier payments on a case-by case basis through post payment review. While targeted audits, medical review, or other program integrity activities may be appropriate to address potential billing or documentation issues in individual cases, CMS

does not believe they would address the broader payment policy concern identified in this rulemaking.

Other commenters requested CMS maintain the 2026 fixed loss threshold and revise the fixed loss threshold if outlier payments do not equal two percent after the year is complete. CMS responded that it must update the fixed loss threshold such that estimated outlier payments equal two percent of total outlier payments. The response reiterated CMS' longstanding policy that it does not revise prospective payments after the fact if outlier payments are not equal to two percent.

Final Decision: CMS is finalizing the proposal to limit outlier payments to 20 percent of a facility's total IPF PPS payments but deferring the effective date until October 1, 2027 (FY 2028). Additionally, CMS is applying an exception to the outlier cap policy for facilities with fewer than 50 stays during the cost reporting year rather than the 25 it proposed.

CMS will calculate and apply this cap on an interim basis on IPF PPS claims beginning in FY 2028 and then determine whether the cap applies at cost report settlement for a hospital with more than 50 stays during the year. In addition, for FY 2027, CMS is updating the final rule outlier threshold based on an analysis of the latest available data (the March 2026 update of FY 2025 IPF claims). Using this data, CMS is finalizing an outlier threshold of $40,750 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2027 including all final rule policies.

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 final FY 2027 national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2027		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.4179	1.8699

III. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS finalizes its policies to 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. CMS also finalizes, with several modifications, implementation of a standardized IPF patient assessment instrument, as required by statute.

As a result of policies finalized, CMS estimates that beginning with the 2029 reporting period/FY 2031 payment determination when all finalized policies will be mandatory for a full CY, the net information collection burden associated with the IPF QRP will decrease by 56,460 hours and increase $1,080,697 in costs associated with these policies.

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 FY 2028, IPFs[3] 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.

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

CMS finalizes without modification its proposal 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]

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) will remain in the

[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.

[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).

measures set and also addresses alcohol use disorders. 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.

To reduce facility burden, CMS is removing 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 will reduce collection of information burden across all IPFs by $13,110,832 per year.

Select Comments/Responses. Many commenters supported removing SUB-2/2a, agreeing that it is duplicative of SUB-3/3a and the burden outweighs its usefulness. Some commenters stated that concerns about the limited clinical usefulness with SUB-2/2a also apply to SUB-3/3a and that SUB-3/3a should also be removed. However, CMS believes SUB-3/3a is still important and clinically meaningful for IPFs and that a justification for removing SUB-2/2a is that SUB-3/3a addresses both alcohol and substance use disorder treatment.

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

CMS finalizes, without modification, its proposal 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 upon discharge. CMS points to performance data median scores of 0.58 to 0.63 on TOB-3 between 2023 and 2025 and believes 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 will reduce collection of information burden across all IPFs by $13,110,832 per year.

Select Comments/Responses. Many commenters supported removal of measures because of administrative burden, the cost of maintaining the measure outweighing the benefit, and the measure no longer driving meaningful improvement. A few commenters supported the removal of the measure but expressed that IPFs should continue certain tobacco cessation activities and interventions. CMS agrees and will continue to evaluate ways to address tobacco and nicotine use in future IPF-PAI or measure development. Several commenters opposed removal, believing that tobacco use, alcohol use, and co-occurring substance use disorders are common among patients in IPFs and tobacco use can complicate psychiatric treatment. CMS agrees these are important issues and IPFs should continue to use clinical judgment in developing care plans,

including tobacco cessation counseling and medication when indicated, even without a publicly reported measure.

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 3 of the rule and the measure set for the FY 2029 payment determination is set forth in Table 4 of the rule. The table shown below combines the information from those tables, including the finalized measure removals, with slight modifications for formatting and explanations.

Measure Set for FY 2028 and 2029 IPF QRP

CBE #	Measure ID	Measure	2028/2029 IPF QRP
Required Measures			
n/a*	HBIPS-2	Hours of Physical Restraint Use	2028 and 2029
n/a*	HBIPS-3	Hours of Seclusion Use	2028 and 2029
n/a	FAPH	Follow-Up After Psychiatric Hospitalization	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*	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*	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge	2028 and 2029
n/a	IPF ED Visit	Thirty-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge^	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.

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 FY 2028. The standardized PAI must collect data for the following statutorily required categories: (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.[5] 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 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. Implementation of IPF-PAI

a. IPF-PAI Finalized Policy Overview

Final Action. CMS finalizes, with modifications, its proposal to implement the IPF-PAI as the assessment instrument for submission of standardized patient assessment data. The agency describes that it selected a minimal set of assessment items to include in order to minimize burden on IPFs, while meeting the statutory requirements. Assessment items will be administered at admission and discharge, unless specified otherwise in the assessment items discussion (including modifications) described below.

IPFs paid under the IPF PPS will be required to complete the IPF-PAI for all patients aged 18 and older, regardless of payer. Among other modifications (as discussed in detail below), CMS is delaying the timeline for mandatory reporting, lowering the compliance threshold, and reducing the number of assessment items collected at each time point. IPFs will have three calendar quarters of voluntary reporting (i.e., without any payment impact for not reporting) beginning October 1, 2027, before mandatory reporting of the IPF-PAI will begin. Beginning July 1, 2028, IPFs will need to complete 100 percent of the required IPF-PAI assessment items (i.e., the completeness threshold) on 50 percent of the IPF-PAIs submitted in order to meet the QRP's IPF-PAI requirement (i.e., the compliance threshold) for the applicable annual payment determination. Beginning with the 2030 reporting period impacting the FY 2032 payment determination, the compliance threshold will increase to 70 percent. Additional modifications are discussed below within the assessment items and data collection discussions.

Overall Comments/Responses. Many commenters supported the proposal to adopt the IPF-PAI onto the IPF QRP because of its potential to provide comparable data across IPFs, support care coordination, and facilitate more consistent data collection. Several commenters expressed

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

concerns that the IPF-PAI is not clinically meaningful, would add burden, and would constrain independent clinical judgment. CMS responds that the IPF-PAI was designed as an initial set of standardized items reflecting statutorily mandated information about patient complexity and resource use and is not intended to replace clinical assessment or treatment planning. Other commenters raised concerns about the staff time and workflow challenges that would result from implementation of the IPF-PAI. A few commenters were concerned about challenges related to electronic health record (EHR) modifications, HL7 FHIR integration, and vendor readiness. In response to these concerns, CMS notes that the agency is finalizing several modifications to the IPF-PAI reporting requirements (discussed in section IV.C.3 and IV.C.4) to reduce burden and will also provide guidance and training resources to support initial implementation.

Many commenters recommended CMS delay implementation of the IPF-PAI, including suggesting non-punitive transition periods, voluntary reporting periods, or other implementation flexibilities. In response, as further discussed in section IV.C.4, CMS is modifying the timelines it had proposed for mandatory reporting, including by adding a voluntary reporting period, and modifying data completeness thresholds.

b. Assessment Items

Final Action. CMS finalizes, with modifications, the assessment items for the IPF-PAI. Modifications (discussed below) include (i) changing collection of the assessment item Mobility: Chair/Bed-to-Chair Transfer to be at admission only, (ii) changing the collection of the assessment item Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting to be collected at discharge only, and (iii) not finalizing inclusion of social security numbers within the Administrative Data category.

The finalized IPF-PAI will 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. Details and instructional text will be available under the IPF-PAI Resources at https://qualitynet.cms.gov/ipf/PAI. The revised IPF-PAI Guidance Manual, which provides additional guidance and instructions for administering the finalized assessment items, is also available under that same IPF-PAI Resources link.

Table 5 of the rule (shown below) shows the assessment items finalized for inclusion in the IPF-PAI and the statutorily required category each measure addresses. The sixth assessment item in the table is included 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.

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, 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

*Note, as proposed, the administrative category would have required SSN in addition to Medicare number.

CMS describes that the IPF-PAI is to 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 following is a brief description of each finalized assessment item for each category:

- *Functional Status Category*. CMS is finalizing 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 is to be recorded.
    - As described below in the comments/response discussion, CMS finalizes this item with a modification to require the assessment to be collected at admission only (rather than both admission and discharge, as proposed). IPFs that collect and submit the assessment item with respect to admission will be deemed to have collected and submitted it with respect to both admission and discharge.
- *Cognitive Function and Mental Status Category*. CMS is finalizing Suicide Screening, which evaluates whether and with what method (standardized tool, clinical assessment, or not screened) a patient was screened for suicide risk. After field testing, CMS revised this assessment item to reduce its complexity.
    - In response to comments, CMS is updating the response options for the Suicide Screening assessment item such that there will be separate response options for "patient declined" and "unable to respond".
- *Special Services, Treatments, and Interventions for Psychiatric Conditions Category*. CMS is finalizing 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.
    - CMS finalizes this item with the modification that it will be collected at discharge only, with an extended lookback period of the entire IPF stay, from admission through discharge.

- *Medical Conditions and Comorbidities Category*. CMS is finalizing Primary Medical Condition, which captures the category of the primary diagnosis (to 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.
- *Impairments Category*. CMS is finalizing 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. CMS finalizes, as proposed, that this assessment item be evaluated at admission only because it is unlikely these assessments will change during an IPF stay, which on average is about 7 days.
- *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.[6] Under that authority, CMS finalizes including an administrative data category to collect information that enables database management and record keeping. This category is to 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 payment and claims data. The specific data elements are shown in the Proposed Assessment Items table above.
    - CMS is not finalizing inclusion of social security numbers as a data element. The Medicare Number will be required for patients for whom Medicare is the primary payer.

Comments/Responses. Many commenters expressed concerns that the IPF-PAI is based on the post-acute care (PAC) model. Since the needs, treatments, and outcomes of the inpatient psychiatric setting are very different from the PAC setting, concerns were raised that the proposed IPF-PAI did not align with the needs of IPFs. CMS responds that the PAC model for a PAI was only one of the many sources used, which included review of clinical practice guidelines, prior public comment, alpha and beta testing, and input from clinicians, administrators, and other individuals with IPF experience.

Several commenters did not believe the IPF-PAI items were clinically relevant to an IPF stay and therefore unlikely to show change during the IPF stay. CMS responds that the initial version of the IPF-PAI is not focused on items expected to improve during the stay. The IPF-PAI is being implemented to collect standardized patient assessment data and section 1886(s)(6) of the Act provides that this data may be considered in future revisions to the IPF PPS payment methodology. Further, in response to suggestions for additional assessment items, CMS repeatedly states that the initial set is focused on satisfying the statutorily required category descriptions.

In response to comments about clear guidance being needed, CMS notes it has posted the revised IPF-PAI Guidance Manual[7] with publication of the final rule and that it incorporates additional guidance based on comments received in response to its proposals.

[6] Section 1886(s)(4)(E)(ii)(VI).
[7] The guidance and other resources can be found at https://qualitynet.cms.gov/ipf/PAI#tab2.

Many commenters expressed that IPF admissions are not related to mobility and the Mobility: Chair/Bed-to-Chair Transfer item does not reflect the IPF setting but instead reflects other settings (such as PAC settings). CMS acknowledges that mobility is generally not related to the primary reason for admission to an IPF. The agency notes that it proposed the assessment item because a majority of TEP members supported its inclusion because the information is routinely collected to inform service delivery during the stay and discharge planning. The item also satisfies the statutorily required category of Functional Status. CMS further notes that the IPF QRP is a pay-for-reporting program and therefore an IPF's performance on any of the assessment items will not impact payments. In response to comments, CMS is finalizing a modification to its proposal so that the Mobility: Chair/Bed-to-Chair Transfer assessment items will be required at admission only. IPFs that collect and submit the item for admission will be deemed to have done so for both admission and discharge. This is the same as had been proposed (and is being finalized) for the Hearing, Speech Clarity, and Vision item.

Similarly, many commenters stated that hearing, speech clarity, and vision assessments do not support psychiatric treatment planning and appear to be more aligned with non-psychiatric settings. CMS believes comprehensive assessment is a basic component of good inpatient care and the information regarding whether a patient can hear, see, and speak is important for communication, safety, and care planning. CMS further notes that these are standardized assessment items in order to collect standardized patient assessment data across IPFs and these are not quality measures. Their inclusion on the IPF-PAI is not intended to provide information on quality or outcomes.

Several commenters raised concerns about collecting a patient's social security number (SSN). CMS is not finalizing the inclusion of SSN for this initial version of the IPF-PAI and will require Medicare Number only for patients for whom Medicare is the primary payer.

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

a. Reporting Periods and Data Submission Deadlines

CMS finalizes the proposed reporting periods and data submission policies and deadlines, with modifications. Many commenters recommended delaying implementation and raised burden concerns, including related to necessary workflow changes and labor resources needed as well as staffing retention and training. In response, CMS is making several modifications to its proposed policy, including:

- IPFs will not be required to complete a separate discharge assessment for patients whose length of stay is less than 3 calendar days – instead for those patients IPFs will be required to collect limited items from the discharge assessment item set as part of the admission assessment.
- For purposes of determining which applicable reporting quarter the admission or discharge falls within, the IPF should use the admission or discharge date (instead of the admission Assessment Reference Date (ARD) and discharge ARD, as proposed).
- The start date for mandatory reporting is being delayed and a voluntary reporting period of three calendar quarters is being provided. Specifically, there will be three calendar

quarters of voluntary reporting starting October 1, 2027, before mandatory reporting begins on July 1, 2028. Reporting during the voluntary period will not impact FY 2029 payment determination. Successful submission of IPF-PAI data for Q3 and Q4 of 2028 will impact FY 2030 payment determination under the IPF QRP. Beginning with the FY 2031 payment determination, IPFs will be required to report data that occur during the entire calendar year that is two years preceding the FY payment determination (e.g., January 1, 2029, through December 31, 2029, for the FY 2031 payment determination).

- By contrast, the proposal had been to (i) require submission of assessment data starting for the reporting period October 1, 2027 through December 31, 2027 (which would have affected FY 2029 payment determination) and (ii) beginning with the FY 2030 payment determination, require IPFs 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 finalizes, as proposed, that for each calendar year reporting period, the data is to be submitted for quarterly reporting periods by the 15th day of the second month after the end of the calendar quarter, except in the case of a federal holiday or weekend in which case the deadline would be moved to the next business day. CMS also recommends rolling submission of IPF-PAI records throughout the data collection period.

The finalized data submission deadlines and associated payment determination years through FY 2031 are shown in Table 8 of the rule.

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

Background on Proposal. CMS had proposed to require an IPF to 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. As proposed, the compliance rate for each IPF would have been 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.

Final Action. After consideration of comments (discussed below), CMS finalizes, with modifications, the compliance threshold for the IPF-PAI. CMS is making the following modifications (in addition to the delay of mandatory reporting and voluntary reporting period, discussed above).

First, the compliance threshold will begin at 50 percent for the Q3 and Q4 2028 reporting period and the 2029 reporting period and will increase to 70 percent for the 2030 reporting period and subsequent reporting periods (instead of the proposed 80 percent beginning with the Q4 2027 reporting period). This means to comply with IPF Quality Reporting Program requirements for the IPF-PAI (i) at least 50 percent of IPF-PAIs submitted by an IPF must contain responses for all required items for the Q3 and Q4 2028 reporting period and the 2029 reporting period, and

(ii) at least 70 percent of IPF-PAIs submitted by an IPF must be fully complete for the 2030 reporting period and subsequent reporting periods. For the FY 2030 payment determination, the compliance rate for each IPF will be calculated using the only two quarters of data (Q3 and Q4 2028 reporting period), and for the FY 2031 payment determination and subsequent years, the compliance rate for each IPF will be calculated based on the entire CY reporting period (that is, four CY reporting quarters of IPF-PAI data from two years prior to the payment determination). An IPF that does not submit 100 percent of the assessment items on at least the required percent of the IPF-PAIs submitted to CMS, as determined by the reporting period, will not meet the IPF QRP IPF-PAI requirement and will be subject to a 2 percentage-point reduction to its annual payment update. Table 9 in the rule (shown below) provides the finalized compliance thresholds for the IPF-PAI.

Compliance Thresholds for the IPF-PAI

Data collection period	Completeness requirements (for mandatory assessment items)	Compliance Threshold (percent of submissions meeting completeness requirements)	Applicable payment determination
Q4 2027 (Oct 1-Dec 31, 2027)	N/A (Voluntary)	N/A (Voluntary)	N/A (Voluntary)
Q1 and Q2 2028 (Jan 1-June 30, 2028)	N/A (Voluntary)	N/A (Voluntary)	N/A (Voluntary)
Q3 and Q4 2028 (July 1-Dec 31, 2028)	100 percent	50 percent	FY 2030
CY 2029 (Jan 1-Dec 31, 2029)	100 percent	50 percent	FY 2031
CY 2030 (Jan 1-Dec 31, 2030)	100 percent	70 percent	FY 2032

In addition, CMS modifies its policy so that Medicare Number will be required only for patients for whom Medicare is the primary payer. Table 10 in the rule shows the finalized assessment items required to meet the 100 percent completeness requirement.

Also, CMS finalizes a modification that an IPF-PAI submitted for patients whose length of stay is less than 3 calendar days will be counted as both an admission and a discharge assessment determining whether the IPF meets the compliance threshold. Although there will not be a separate discharge IPF-PAI for these patients, the admission assessment with some select discharge items will be counted as two assessments for purposes of determining whether the IPF meets the compliance threshold. That is, if all required items are completed, it will be counted as two complete assessments, while if some required items are not complete, it will count as two incomplete assessments for purposes of determining whether the IPF meets the compliance threshold.

c. 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 finalizes its proposal that IPFs will 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).

Web App Method of Data Submission. CMS finalizes an open-source web app developed by the agency (PARIT or a successor tool) as one method for collecting and submitting IPF-PAI data to the iQIES. CMS will provide and maintain the web app for IPFs, free of charge. IPFs (or third-party vendors on behalf of IPFs) will be able to review, correct, and change data using the web app until the submission deadline.

FHIR API Method of Data Submission. CMS also finalizes the FHIR API as another method for submitting IPF-PAI data. This method will be appropriate for IPFs that use health IT or use third party vendors.

Comments/Responses. Several commenters supported offering both a web application and FHIR-based submission as two possible submission options. Many commenters expressed concern about needing time to train staff. CMS plans to provide training on the IPF-PAI. Training on the web app will begin at least six months before the web app becomes available for data submission, with the web app expected to be available for IPF-PAI no later than October 1, 2027, when the first voluntary reporting quarter begins. CMS believes its modifications discussed above regarding providing for the voluntary reporting period will address many concerns raised. CMS also states it will update the Data Element Library (DEL) FHIR Implementation Guide and the iQIES FHIR Receiving System Guide based on the modified policies in the final rule as soon as feasible, between six to twelve months before the start of the voluntary reporting period.

5. Maintenance of Technical Specifications

CMS finalizes, without modification, its proposal 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 will 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) will 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 $60 million from the 2.3 percent update to provider 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 16 in the final 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 16: FY 2027 Final Rule IPF PPS Payment Impacts

Facility by Type	Number of Facilities	Outlier	Final FY27 Wage Index, Labor-Related Share, and COLA	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)
All Facilities	1,336	0.0	0.0	2.3
Total Urban	1,105	0.0	-0.1	2.2
Urban unit	585	0.0	0.3	2.6
Urban hospital	520	0.0	-0.5	1.8
Total Rural	231	0.0	0.4	2.7
Rural unit	167	0.0	0.4	2.7
Rural hospital	64	0.0	0.4	2.7
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	106	0.0	0.2	2.5
Non-Profit	65	0.0	0.1	2.4
For-Profit	349	0.0	-0.7	1.6
Rural Psychiatric Hospitals				
Government	32	0.0	0.9	3.3
Non-Profit	10	0.0	1.6	4.0
For-Profit	22	0.0	-0.1	2.2
IPF Units				
Urban				
Government	96	0.0	0.4	2.8
Non-Profit	370	0.0	0.2	2.5
For-Profit	119	0.0	0.5	2.8
Rural				
Government	46	0.0	0.9	3.2
Non-Profit	91	0.0	0.4	2.7
For-Profit	30	0.0	0.0	2.3
By Teaching Status:				
Non-teaching	1,127	0.0	-0.2	2.1
Less than 10% interns and residents to beds	109	0.0	0.7	3.1
10% to 30% interns and residents to beds	75	0.0	0.4	2.7
More than 30% interns and residents to beds	25	0.0	-0.1	2.1
By Region:				
New England	93	0.0	0.6	2.9
Mid-Atlantic	189	0.0	1.1	3.4
South Atlantic	213	0.0	-0.1	2.2
East North Central	203	0.0	-0.7	1.6
East South Central	132	0.0	-1.0	1.3
West North Central	85	0.0	-0.1	2.2

Facility by Type	Number of Facilities	Outlier	Final FY27 Wage Index, Labor-Related Share, and COLA	Total Percent Change[1]
West South Central	206	0.0	-0.8	1.5
Mountain	90	0.0	-0.1	2.1
Pacific	125	0.0	0.2	2.5
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	87	0.0	-0.2	2.1
Beds: 25-49	69	0.0	-1.1	1.2
Beds: 50-75	95	0.0	-0.6	1.7
Beds: 76 +	333	0.0	-0.2	2.1
Psychiatric Units				
Beds: 0-24	383	0.0	0.0	2.3
Beds: 25-49	211	0.0	0.4	2.7
Beds: 50-75	87	0.0	0.4	2.7
Beds: 76 +	71	0.0	0.8	3.1

[1] This column includes the impact of the updates in columns (3) and (4) above, and of the final IPF market basket update factor for FY 2027 (3.2 percent), reduced by 0.9 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.