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perspectives

***An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg***

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CMS Finalizes Fiscal Year 2027 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update



The Centers for Medicare and Medicaid Services (CMS) are issuing a final rule that will update the Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) for fiscal year (FY) 2027, as required under section 1888(e)(4)(E) of the Social Security Act (the Act).

This final rule updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by IPFs, which include psychiatric hospitals and excluded psychiatric units of an acute care hospital or critical access hospital.

The rule also limits an IPF's outlier payments to no more than 20 percent of its total IPF PPS payments in a year, effective October 1, 2027, and provides for an exemption to that limit for IPFs with fewer than 50 stays per year. Lastly, the rule implements a standardized IPF

patient assessment instrument and removes two quality measures.

The rule updates:

- The IPF PPS Federal per diem base rate from \$892.87 to \$912.40.
- The IPF PPS Federal per diem base rate for providers who failed to report quality data to \$894.56.
- The electroconvulsive therapy (ECT) payment per treatment from \$673.85 to \$688.59.
- The ECT payment per treatment for providers who failed to report quality data to \$675.13.
- The labor-related share from 79.0 percent to 78.9 percent.
- The wage index budget neutrality factor to 0.9989.
- The fixed dollar loss threshold amount from \$39,360 to \$40,750, to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

For the IPF Quality Reporting Program, CMS is implementing a standardized IPF patient assessment instrument (IPF-PAI), as mandated by section 4125(b)(1) of the **Consolidated Appropriations Act** of 2023 (CAA, 2023), and removing two measures from the program: Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a) and Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a).

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Comment

The rule provides “Final Decision” sections. Obviously this is very helpful.

SUMMARY OF IMPACTS (Page 4)

Provision Description	Total Transfers & Cost Reductions
FY 2027 IPF PPS payment update	The overall economic impact of this final rule is an estimated \$60 million in increased payments to IPFs during FY 2027.
IPF Quality Reporting Program update	CMS estimates a net increase of \$1,080,697 in costs associated with the IPF Quality Reporting Program due to policies finalized in this rule.

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PROVISIONS OF THE FY 2027 IPF PPS FINAL RULE AND RESPONSES TO COMMENTS

A. 2027 Market Basket Increase and Productivity Adjustment for the IPF PPS (Page 11)

Based on IHS Global Inc.'s second quarter 2026 forecast with historical data through the first quarter of 2026, the projected 2021-based IPF market basket increase factor for FY 2027 is 3.2 percent, which is 0.1 percentage point higher than the projected FY 2027 market basket increase factor in the proposed rule.

The total factor productivity (TFP) productivity adjustment based on the 10-year period ending with FY for the FY 2027 final rule is a TFP of 0.9 percent for FY 2027, which is 0.1 percentage point higher than the FY 2027 IPF proposed rule mainly due to the incorporation of updated BLS historical data. (Page 17)

Therefore, the final FY 2027 IPF market basket update is equal to **2.3 percent** (3.2 percent market basket percentage increase reduced by the 0.9 percentage point productivity adjustment).

B. FY 2027 IPF Labor-Related Share (Page 19)

The total labor-related share for FY 2027 is 78.9 percent (the sum of 75.8 percent for the labor-related share of operating costs and 3.1 percent for the labor-related share of Capital-Related costs).

FY 2027 Final IPF Labor-Related Share and FY 2026 IPF Labor Related Share

	Relative importance, labor-related share FY 2026	Relative importance, labor-related share FY 2027
Wages and Salaries	53.7	53.6
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	75.8
Labor-related portion of Capital-Related	3.1	3.1
Total Labor-Related Share	79.0	78.9

C. Update of the Federal per Diem Base Rate and Electroconvulsive Therapy Payment per Treatment (Page 25)

The current (FY 2026) Federal per diem base rate is \$892.87 and the ECT payment per treatment is \$673.85. For the final FY 2027 Federal per diem base rate, CMS applied the final IPF market basket update of 2.3 percent (that is, the 2021-based IPF market basket percentage increase for FY 2027 of 3.2 percent reduced by the productivity adjustment of 0.9 percentage point), and the final wage index

budget neutrality factor of 0.9989 to the final FY 2026 Federal per diem base rate of \$892.87, yielding a final Federal per diem base rate of **\$912.40** for FY 2027.

CMS applied the final IPF market basket update of 2.3 percent and the wage index budget neutrality factor of 0.9989 to the final FY 2026 ECT payment per treatment of \$673.85, yielding a final ECT payment per treatment of **\$688.59** for FY 2027.

In the case of an IPF that fails to report required quality data with respect to a RY, the Secretary will reduce any annual update to a standard Federal rate for discharges during the RY by 2.0 percentage points.

For IPFs that fail to report required data, CMS will apply a 0.3 percent payment rate update—that is, the final IPF market basket increase for FY 2027 of 3.2 percent reduced by the final productivity adjustment of 0.9 percentage point for an update of 2.3 percent, and further reduced by 2.0 percentage points. CMS also applied the wage index budget neutrality factor of 0.9989 to the FY 2026 Federal per diem base rate of \$892.87, yielding a Federal per diem base rate of **\$894.56** for FY 2027.

For IPFs that fail to report required data, CMS will apply the 0.3 percent payment rate update and the 0.9989 wage index budget neutrality factor to the FY 2026 ECT payment per treatment of \$673.85, yielding an ECT payment per treatment of **\$675.13** for FY 2027.

D. Updates to the IPF PPS Patient-Level Adjustment Factors (Page 26)

The IPF PPS includes payment adjustments for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS-DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

Update to MS-DRG Assignment (Page 27)

As discussed in the ICD-10-CM Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes (etiology followed by manifestation).

The final FY 2027 Code First table is shown in Addendum B on the CMS website at:

<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/inpatient-psychiatric-facilities-pps-files>.

Payment for Comorbid Conditions (Page 30)

CMS did not propose any changes to the comorbidity adjustment factors, and CMS is retaining the existing comorbidity adjustment factors for FY 2027. The FY 2027 comorbidity adjustment factors are found in Addendum A on the CMS website at:

<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility>.

Patient Age Adjustments (Page 32)

CMS did not propose any changes to the patient age adjustment factors, and are retaining the existing patient age adjustment factors for FY 2027, as shown in Addendum A.

Variable Per Diem Adjustments (Page 32)

Again, CMS did not propose any changes to the variable per diem adjustment factors, and are retaining the existing variable per diem adjustment factors for FY 2027, as shown in Addendum A.

Updates to the IPF PPS Facility-Level Adjustments (Page 33)

The IPF PPS includes facility-level adjustments for the 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.

Wage Index Adjustment (Page 34)

CMS is finalizing its proposal for FY 2027 to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index.

Payment for Rural Location (Page 44)

CMS did not propose any changes to the 18 percent adjustment factor for IPFs located in a rural area.

End of Rural Transition (Page 45)

CMS implemented a 3-year budget neutral phase-out of the rural adjustment for IPFs located in 54 rural counties that would become urban under the adoption of new OMB delineations.

For FY 2027, these IPFs will not receive a rural adjustment.

Teaching Adjustment (Page 45)

In the FY 2026 IPF PPS final rule, CMS increased the teaching adjustment to 0.7957. For FY 2027, CMS did not propose any changes to the teaching adjustment.

Cost of Living Adjustment for IPFs Located in Alaska and Hawaii (Page 45)

The FY 2027 IPF PPS COLA factors for Alaska and Hawaii are shown in the rule's table 2 on page 50.

Adjustment for IPFs with a Qualifying ED (Page 50)

Beginning in FY 2025, IPFs with a qualifying ED receive an adjustment factor of 1.54 as the variable per diem adjustment for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.27 as the variable per diem adjustment for day 1 of each patient stay.

For FY 2027, CMS did not propose any changes to the adjustment factor for IPFs with qualifying EDs.

E. Other Payment Adjustments and Policies (Page 51)

Outlier Payment Overview (Page 51)

CMS is finalizing its proposal to limit outlier payments to 20 percent of a facility's total IPF PPS payments. However, CMS is deferring the effective date of this policy 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. CMS is codifying this policy for the IPF PPS at § 12.424(d)(3)(i)(D) for discharges occurring in cost reporting periods beginning on or after October 1, 2027. (Page 70)

Based on an analysis of the latest available data (the March 2026 update of FY 2025 IPF claims) and rate increases, CMS believes it is necessary to update the fixed dollar loss threshold amount to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments. Based on an analysis of these updated data, CMS estimates that IPF outlier payments as a percentage of total estimated payments are approximately 2.0 percent in FY 2026. Therefore, CMS is finalizing an update to the outlier threshold amount to **\$40,750** to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2027. This update would be an increase from the FY 2026 threshold of \$39,360.

CMS noted in the proposed rule that its analysis found that 47.8 percent of all simulated outlier payments were attributable to approximately 37 IPFs with more than 20 percent outlier payments to total IPF PPS payments.

CMS estimated that if it applied a 20-percent facility-level cap (that is, outlier payments for an IPF are less than or equal to 20 percent of the IPF's total IPF PPS payments, including outliers), the FY 2027 outlier fixed dollar loss threshold amount would be approximately \$37,820, lower than what it would be under our current outlier policy and much closer to the FY 2026 outlier fixed dollar loss threshold amount of \$39,360. CMS estimated further that 40 more providers would receive payments under the outlier adjustment than under our current policy (increasing from 379 providers to 419 providers), due to the lower outlier fixed dollar loss threshold CMS proposed.

Refer page 71 for CMS' calculation steps to calculate the revised 20 percent outlier cap.

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING PROGRAM (Page 73)

CMS is finalizing;

- The removal of the Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a) Measure from the IPF Quality Reporting Program beginning with the calendar year (CY) 2026 reporting period/FY 2028 payment determination. (Page 81)
- The removal of the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) Measure TOB-3/3a measure as proposed. (Page 89)

Summary of IPF Quality Reporting Program Measures for Future Years

The following table sets forth the measures in the FY 2028 IPF Quality Reporting Program and reflects the measures being removed in this final rule.

IPF Quality Reporting Program Measure Set for the FY 2028 IPF Quality Reporting Program

Consensus-Based Entity (CBE) #	Measure ID	Measure
N/A*	HBIPS-2	Hours of Physical Restraint Use
N/A*	HBIPS-3	Hours of Seclusion Use
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
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
N/A*	IMM-2	Influenza Immunization

Consensus-Based Entity (CBE) #	Measure ID	Measure
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)
N/A	SMD	Screening for Metabolic Disorders
N/A	PIX	Psychiatric Inpatient Experience Survey
2860	IPF Readmission	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
N/A	Med Continuation	Medication Continuation Following Inpatient Psychiatric Discharge

Comment

The following material is the longest section of this rule. It extends more than 80 pages.

Implementation of the Inpatient Psychiatric Facilities Patient Assessment Instrument (IPFAI) in the IPF Quality Reporting Program (Page 93)

In the FY 2027 IPF PPS proposed rule, CMS proposed to implement the IPF-PAI as the assessment instrument for the submission of standardized patient assessment data as required by section 1886(s)(4)(E)(ii) of the Act for all patients aged 18 and older.

For IPFs to meet this new data collection and reporting requirement for FY 2028 and each subsequent year, the Secretary must implement a standardized PAI that collects data with respect to the following categories: functional status; cognitive function and mental status; special services, treatments, and interventions for psychiatric conditions; medical conditions and comorbidities; impairments; and other categories as determined appropriate by the Secretary.

CMS proposed to include items for each of the five data categories required by statute in the IPFAI assessment. In addition, CMS proposed an additional category of administrative items. These items are shown in the table below;

CAA, 2023 Category	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 is finalizing its proposal to adopt the IPF-PAI into the IPF Quality Reporting Program. (Page 103)

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CMS is finalizing the above assessment items for the IPF-PAI, to fulfill the categories named in the CAA, 2023, and to establish a new category of Administrative Data, with modifications. CMS will require the assessment item Mobility: Chair/Bed-to-Chair Transfer to be collected at admission only.

CMS is finalizing the reporting periods and data submission policies and deadlines with modifications. Because of concerns expressed by commenters regarding the burden and complexity associated with requiring both admission and discharge assessments for patients with stays of less than 3 calendar days CMS is finalizing a policy under which 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 these patients, IPFs will be required to collect limited items from the discharge assessment item set as part of the admission assessment. (Page 152)

CMS is finalizing, with modification, the compliance threshold for the IPF-PAI. CMS is making four modifications from the policy which was proposed:

- CMS is finalizing three quarters of voluntary reporting beginning October 1, 2027, with mandatory reporting of the IPF-PAI beginning July 1, 2028.
- CMS is finalizing a policy in which the compliance threshold—that is, the required percent of IPF-PAIs submitted by an IPF that are 100 percent complete in order to meet the IPF Quality Reporting Program IPF-PAI requirement for the applicable annual payment determination—will begin at 50 percent for the Q3 and Q4 CY 2028 and CY 2029 reporting periods, and increase to 70 percent for CY 2030 and subsequent reporting periods. In other words, to comply with IPF Quality Reporting Program requirements for the IPF-PAI, at least 50 percent of IPF-PAIs submitted by an IPF must be contain responses for all required items for Q3 and Q4 CY 2028 and CY 2029 reporting periods, and at least 70 percent of IPF-PAIs submitted by an IPF must be fully complete for CY 2030 and subsequent reporting periods. For the FY 2030 payment determination, the compliance rate for each IPF would be calculated using the 2028 Q3 and Q4 reporting period, and for the FY 2031 payment determination and subsequent years, the compliance rate for each IPF would be calculated based on the entire CY reporting period (that is, four CY reporting quarters of IPF-PAI data). 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, would not meet the IPF Quality Reporting Program IPF-PAI requirement. As a result, the IPF would be subject to a 2 percentage-point reduction to its annual payment update, as required by section 1886(s)(4)(A) of the Act. CMS is codifying these data completion thresholds for the IPF-PAI at § 412.433(h).
- CMS is finalizing that Medicare Number will be required only for patients for whom Medicare is the primary payer.
- CMS is also finalizing 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. Specifically, 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.

Methods of Data Submission for the IPF-PAI (Page 160)

In the FY 2027 IPF PPS proposed rule, CMS proposed a CMS-developed web app, Patient Assessment Reporting Interoperability Tool (PARIT), as a method for collecting and submitting IPF-PAI data to the Internet Quality Improvement and Evaluation System (iQIES) system via the Internet.

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CMS is finalizing the web app—PARIT, or a successor tool--as a method of data submission for the IPF-PAI data as proposed. (Page 163)

CMS proposed the use of two APIs built from the HL7® FHIR® specification, based on FHIR® v4.0.1, as another method for submitting IPF-PAI data to iQIES via the Internet. An API is a documented set of rules and specifications that lets one computer program or system request and receive information or data from another; specifically, it defines how one software component or system can request and use the functions or data of another software component or system through a defined interface, without requiring knowledge of its internal implementation.

CMS is finalizing the FHIR® API method of data submission for IPF-PAI data as proposed. CMS is implementing the IPF-PAI on October 1, 2027 with three quarters of voluntary data submission. Mandatory reporting will begin on July 1, 2028. CMS intends that the voluntary data submission period will provide IPFs and their health IT vendors with sufficient time to develop and implement data submission processes. (Page 169)

Final Comments

If it wasn't for the awful amount of unneeded prior history, this is well written rule. The "Final Decision" sections help the reader navigate and understand the many changes at hand. These actions should be required for all CMS regulations.

The payment updates are simple to understand. However, this is another final FY 2027 PPS update in which the payment increases, once again, seem low. Furthermore, CMS declines, as usual to make any adjustments to its forecasted estimation numbers. How they can turn a deaf ear to such is without creditability and reasonableness.

This year's quality Patient Assessment Instrument will add additional burden to providers. While its mandated by statute, one still needs to question how it will improve patient outcomes. To us this item simply seems another methodology to further reduce Medicare payments.

Please remember that not all items in the rulemaking have been discussed. If you have questions, please review the rule, itself.