DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1847–P]

RIN 0938–AV77

Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This rulemaking proposes to update the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPFs), which include psychiatric hospitals and excluded psychiatric units of an acute care hospital or critical access hospital. This rulemaking also proposes refinement of the IPF PPS outlier policy. These changes would be effective for IPF discharges occurring during the fiscal year beginning October 1, 2026, through September 30, 2027. We are also proposing the implementation of a standardized IPF patient assessment instrument, and the removal of two measures used in the Inpatient Psychiatric Facilities Quality Reporting Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by June 1, 2026.

ADDRESSES: In commenting, please refer to file code CMS–1847–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-1123.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1847–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1847–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: The IPF Payment Policy mailbox at *IPFPaymentPolicy@cms.hhs.gov,* for general information.

Nick Brock, (410) 786–5148, for information regarding the inpatient psychiatric facilities prospective payment system (IPF PPS) and regulatory impact analysis.

Kaleigh Emerson, *kaleigh.emerson1@cms.hhs.gov,* for information regarding the IPF Quality Reporting Program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

Addendum A to this proposed rule summarizes the fiscal year (FY) 2027 IPF PPS payment rates, outlier threshold, cost of living adjustment factors (COLA) for Alaska and Hawaii, national and upper limit cost-to-charge ratios, and adjustment factors. In addition, Addendum B to this proposed rule shows the complete listing of ICD–10 Clinical Modification (CM) and Procedure Coding System (PCS) codes, the FY 2027 IPF PPS comorbidity adjustment, and electroconvulsive therapy (ECT) procedure codes. Addenda A and B to this proposed rule are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets.*

Tables setting forth the FY 2027 Wage Index for Urban Areas Based on Core Based Statistical Area (CBSA) Labor Market Areas, the FY 2027 Wage Index Based on CBSA Labor Market Areas for Rural Areas, and the FY 2027 CBSA Labor Market Areas are available exclusively through the internet, on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/wage-index.*

I. Executive Summary

A. Purpose

This proposed rule would update the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPFs) for discharges occurring during fiscal year (FY) 2027 (beginning October 1, 2026, through September 30, 2027). This proposed rule includes a proposal to limit an IPF's outlier payments to no more than 20 percent of its total IPF PPS payments in a year. Lastly, this proposed rule would implement a standardized IPF patient assessment instrument and remove two quality measures.

B. Summary of the Major Provisions

1. Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)

For the IPF PPS, we propose to:

- Establish a 20-percent cap on outlier payments under the IPF PPS.
- Make technical rate setting updates: The IPF PPS payment rates will be adjusted annually for input price inflation, as well as statutory and other policy factors.

This rule proposes to update:

++ The IPF PPS Federal per diem base rate from $892.87 to $912.58.

++ The IPF PPS Federal per diem base rate for providers who failed to report quality data to $894.74.

++ The electroconvulsive therapy (ECT) payment per treatment from $673.85 to $688.73.

++ The ECT payment per treatment for providers who failed to report quality data to $675.26.

++ The labor-related share from 79.0 percent to 79.1 percent.

++ The wage index budget neutrality factor to 0.9991.

++ The fixed dollar loss threshold amount from $39,360 to $37,820, to

maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

2. Inpatient Psychiatric Facilities Quality Reporting Program

For the IPF Quality Reporting Program, we are proposing to implement 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 to remove 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).

C. Summary of Impacts

Provision description	Total transfers & cost reductions
FY 2027 IPF PPS payment update.	The overall economic impact of this proposed rule is an estimated $50 million in increased payments to IPFs during FY 2027.
IPF Quality Reporting Program update.	We estimate a net increase of $7,223,725 in costs to facilities for the IPF Quality Reporting Program due to policies proposed in this rule.

II. Background

A. Overview of the Legislative Requirements of the IPF PPS

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS in a budget neutral manner. Specifically, section 124 of the BBRA mandated that the Secretary of Health and Human Services (the Secretary) develop a per diem prospective payment system (PPS) for inpatient hospital services furnished in psychiatric hospitals and excluded psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and excluded psychiatric units. ''Excluded psychiatric unit'' means a psychiatric unit of an acute care hospital or of a Critical Access Hospital (CAH), which is excluded from payment under the Inpatient Prospective Payment System (IPPS) or CAH payment system, respectively. These excluded psychiatric units will be paid under the IPF PPS.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to psychiatric distinct part units of CAHs.

Sections 3401(f) and 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to jointly as ''the Affordable Care Act'') added subsection (s) to section 1886 of the Social Security Act (the Act).

Section 1886(s)(1) of the Act titled ''Reference to Establishment and Implementation of System,'' refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the rate year (RY) beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY.

Section 1886(s)(2)(A)(ii) of the Act required the application of an ''other adjustment'' that reduced any update to an IPF PPS base rate by a percentage point amount specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. As noted in the FY 2020 IPF PPS final rule (84 FR 38424), for the RY beginning in 2019, section 1886(s)(3)(E) of the Act required that the other adjustment reduction be equal to 0.75 percentage point; that was the final year the statute required the application of this adjustment. Because FY 2021 was a RY beginning in 2020, FY 2021 was the first year that section 1886(s)(2)(A)(ii) of the Act did not apply since its enactment.

Sections 1886(s)(4)(A) through (D) of the Act require that for RY 2014 and each subsequent RY, IPFs that fail to report required quality data with respect to such a RY will have their annual update to a standard Federal rate for discharges reduced by 2.0 percentage points. This may result in an annual update being less than 0.0 for a RY, and may result in payment rates for the upcoming RY being less than such payment rates for the preceding RY. Any reduction for failure to report required quality data will apply only to the RY involved, and the Secretary will not consider such reduction in computing the payment amount for a subsequent RY. Additional information about the specifics of the current IPF Quality Reporting Program is available in the FY 2020 IPF PPS final rule (84 FR 38459 through 38468).

Section 4125 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117–328), which amended section 1886(s) of the Act, requires CMS to revise the Medicare prospective payment system for psychiatric hospitals and psychiatric units. Specifically, section 4125(a) of the CAA, 2023 added section 1886(s)(5)(A) of the Act to require the Secretary to collect data and information, as the Secretary determines appropriate, to revise payments under the IPF PPS. CMS discussed this data collection in the FY 2024 IPF PPS final rule (88 FR 51054), as CMS was required to begin collecting this data and information not later than October 1, 2023. As discussed in that rule, the agency has already been collecting data and information consistent with the types set forth in the CAA, 2023 as part of our extensive and years-long analyses and consideration of potential payment system refinements. We refer readers to the FY 2024 IPF PPS final rule (88 FR 51095 through 51098) where we discussed existing data collection and requested information to inform future IPF PPS revisions.

In addition, section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 required that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for RY 2025 (FY 2025). Section 1886(s)(5)(D) of the Act provided that these revisions may be based on a review of the data and information collected under section 1886(s)(5)(A) of the Act. For a detailed discussion on the revisions implemented for FY 2025, we refer readers to the FY 2025 IPF PPS final rule (89 FR 64590 through 64636).

Section 4125(b) of the CAA, 2023 amended section 1886(s)(4) of the Act by inserting a new subparagraph (E) and redesignating the existing subparagraph (E) as subparagraph (F) which requires IPFs participating in the IPF Quality Reporting Program to collect and submit to the Secretary standardized patient assessment data, using a standardized patient assessment instrument, for RY 2028 (FY 2028) and each subsequent rate year. IPFs must submit such data with respect to at least the admission and discharge of an individual, or more frequently as the Secretary determines appropriate. For IPFs to meet this new data collection and reporting requirement for RY 2028 and each subsequent rate year, the Secretary must implement a standardized patient assessment instrument that collects data with respect to the following categories: functional status; cognitive function and mental status; special services, treatments, and interventions; medical conditions and comorbidities;

impairments; and other categories as determined appropriate by the Secretary. This patient assessment instrument must enable comparison of such patient assessment data that IPFs submit across all such IPFs to which such data are applicable.

Section 4125(b) of the CAA, 2023 further amended section 1886(s) of the Act by adding a new subparagraph (6) that requires the Secretary to implement revisions to the methodology for determining the payment rates for psychiatric hospitals and psychiatric units (that is, payment rates under the IPF PPS), effective for RY 2031 (FY 2031), as the Secretary determines to be appropriate, to take into account the patient assessment data described in paragraph (4)(E)(ii).

To implement and periodically update the IPF PPS, we have published various proposed and final rules and notices in the **Federal Register**. For more information regarding these documents, we refer readers to the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/InpatientPsychFacilPPS/.*

B. Overview of the IPF PPS

We issued the rate year (RY) 2005 IPF PPS final rule that appeared in the November 15, 2004 **Federal Register** (69 FR 66922). The RY 2005 IPF PPS final rule established the IPF PPS, as required by section 124 of the BBRA and codified at 42 CFR part 412, subpart N. The RY 2005 IPF PPS final rule set forth the Federal per diem base rate for the implementation year (the 18-month period from January 1, 2005, through June 30, 2006) and provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) of the Medicare program.

The IPF PPS established the Federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget neutrality.

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate described previously and certain patient- and facility-level payment adjustments for characteristics that were found in the regression analysis to be associated with statistically significant per diem cost differences, with statistical significance defined as p less than 0.05. A complete discussion of the regression analysis that established the IPF PPS adjustment factors can be found in the RY 2005 IPF PPS final rule (69 FR 66933 through 66936).

The patient-level adjustments include age, Diagnosis-Related Group (DRG) assignment, and comorbidities, as well as adjustments to reflect higher per diem costs at the beginning of a patient's IPF stay and lower costs for later days of the stay. Facility-level adjustments include adjustments for the IPF's 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).

The IPF PPS provides additional payment policies for outlier cases, interrupted stays, and a per-treatment payment for patients who undergo ECT. During the IPF PPS mandatory 3-year transition period, stop-loss payments were also provided; however, since the transition ended as of January 1, 2008, these payments are no longer available.

C. Annual Requirements for Updating the IPF PPS

Section 124 of the BBRA did not specify an annual rate update strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the RY 2005 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final Federal per diem base rate to be budget neutral for the 18-month period of January 1, 2005, through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006, through June 30, 2007.

The RY 2005 final rule (69 FR 66922) implemented the IPF PPS. In developing the IPF PPS, and to ensure that the IPF PPS can account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. That regression analysis is described in detail in our RY 2004 IPF proposed rule (68 FR 66923; 66928 through 66933) and our RY 2005 IPF final rule (69 FR 66933 through 66960). For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In the RY 2005 IPF final rule, we explained the reasons for delaying an update to the adjustment factors, derived from the regression analysis, including waiting until we have IPF PPS data that yields as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We indicated that we did not intend to update the regression analysis and the patient-level and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (69 FR 66966).

We issued a final rule which appeared in the May 6, 2011 **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)'' (76 FR 26432), which changed the payment rate update period to a RY that coincides with a FY update. Therefore, final rules are now published in the **Federal Register** in the summer to be effective on October 1st of each year. When proposing changes in IPF payment policy, a proposed rule is issued in the spring, and the final rule in the summer to be effective on October 1st. For a detailed list of updates to the IPF PPS, we refer readers to our regulations at 42 CFR 412.428. Beginning October 1, 2012, we finalized that we would refer to the 12-month period from October 1 through September 30 as a ''fiscal year'' (FY) rather than a RY (76 FR 26435). Therefore, in this proposed rule we refer to rules that took effect after RY 2012 by the FY, rather than the RY, in which they took effect.

The most recent IPF PPS annual update, the FY 2026 IPF PPS final rule (90 FR 37628), appeared in the **Federal Register** on August 5, 2025. The FY 2026 IPF PPS final rule revised the payment adjustment factors for teaching status and for IPFs located in rural areas in accordance with section 1886(s)(5)(D)(i) of the Act. That final rule also updated the IPF PPS Federal per diem base rates that were published in the FY 2025 IPF PPS final rule (89 FR 64582). In revising the IPF PPS adjustment factors, we performed an

extensive regression analysis of the relationship between the per diem costs and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. That regression analysis is described in detail in our FY 2026 IPF PPS proposed rule (90 FR 18503 through 18507) and our FY 2026 IPF PPS final rule (90 FR 37639 through 37644).

As required by section 1886(s)(5)(D)(iii) of the Act, we finalized a refinement standardization factor for the FY 2026 IPF PPS payment rates to maintain budget neutrality for FY 2026. The application of the FY 2026 standardization factor is described in detail in our FY 2026 IPF PPS proposed rule (90 FR 18513 and18514) and our FY 2026 IPF PPS final rule (90 FR 37652 and 37653). For FY 2027, we are not proposing a refinement standardization factor.

III. Provisions of the FY 2027 IPF PPS Proposed Rule

A. Proposed FY 2027 Market Basket Increase and Productivity Adjustment for the IPF PPS

1. Background

Originally, the input price index used to develop the IPF PPS was the Excluded Hospital with Capital market basket. This market basket was based on 1997 Medicare cost reports for Medicare-participating inpatient rehabilitation facilities (IRFs), IPFs, long-term care hospitals (LTCHs), cancer hospitals, and children's hospitals. Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term ''market basket,'' as used in this document, refers to an input price index.

Since the IPF PPS inception, the market basket used to update IPF PPS payments has been rebased and revised to reflect more recent data on IPF cost structures. We last rebased and revised the IPF market basket in the FY 2024 IPF PPS rule, where we adopted a 2021-based IPF market basket, using Medicare cost report data for both Medicare-participating freestanding psychiatric hospitals and psychiatric units. We refer readers to the FY 2024 IPF PPS final rule for a detailed discussion of the 2021-based IPF market basket and its development (88 FR 51057 through 51081). Prior to the 2021-based IPF market basket, we used the 2016-based IPF market basket that was adopted in the FY 2020 IPF PPS final rule (84 FR 38426 through 38447). References to the historical market baskets used to update IPF PPS payments prior to the FY 2020 IPF PPS rule are listed in the FY 2016 IPF PPS final rule (80 FR 46656).

2. Proposed FY 2027 IPF Market Basket Update

For FY 2027 (beginning October 1, 2026, and ending September 30, 2027), we are proposing to update the IPF PPS payments by a market basket increase factor, with a productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act. Consistent with historical practice, we are proposing to estimate the market basket update for the IPF PPS based on the most recent forecast available at the time of rulemaking. For this proposed rule, based on IHS Global Inc.'s (IGI) fourth quarter 2025 forecast with historical data through the third quarter of 2025, the proposed 2021-based IPF market basket increase factor for FY 2027 is 3.1 percent. IGI is a nationally recognized economic and financial forecasting firm with which CMS currently contracts to forecast the components of the market baskets and productivity adjustment.[1]

Section 1886(s)(2)(A)(i) of the Act requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the U.S. economy. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is published by BLS as private nonfarm business total factor productivity ((TFP) previously referred to as multifactor productivity).[2] We refer readers to *www.bls.gov/productivity* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information*.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (a RY that coincides with a FY) and each subsequent RY. For this FY 2027 IPF PPS proposed rule, based on IGI's fourth quarter 2025 forecast, the proposed productivity adjustment for FY 2027 (the 10-year moving average change of TFP for the period ending FY 2027) is projected to be 0.8 percentage point. Accordingly, we are proposing to reduce the proposed 3.1 percent IPF market basket increase by this proposed 0.8 percentage point productivity adjustment, as mandated by the Act. This results in a proposed FY 2027 IPF PPS payment rate update of 2.3 percent (3.1 percent − 0.8 percentage point = 2.3 percent). We are also proposing that if more recent data become available, we would use such data, if appropriate, to determine the FY 2027 IPF market basket increase and productivity adjustment for the final rule.

We solicit comments on the proposed IPF market basket increase and productivity adjustment for FY 2027.

3. Proposed FY 2027 IPF Labor-Related Share

Due to variations in geographic wage levels and other labor-related costs, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index, which would apply to the labor-related portion of the Federal per diem base rate (hereafter referred to as the ''labor-related share''). The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We are proposing to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2021-based IPF market basket, we are proposing to continue to include in the labor-related share the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a portion of the Capital-Related relative importance from the 2021-based IPF market basket.

[1] *https://www.spglobal.com/en.*

[2] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

For more details regarding the methodology for determining specific cost categories for inclusion in the labor-related share based on the 2021-based IPF market basket, we refer readers to the FY 2024 IPF PPS final rule (88 FR 51078 through 51081).

The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2021) and FY 2027. Based on IGI's fourth quarter 2025 forecast of the 2021-based IPF market basket, the sum of the FY 2027 relative importance moving average of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services is 76.0 percent. We are proposing, consistent with prior rulemaking, that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs is 6.7 percent of the 2021-based IPF market basket for FY 2027, we proposed to take 46 percent of 6.7 percent to determine a labor-related share of Capital-Related costs for FY 2027 of 3.1 percent. Therefore, we are proposing a total labor-related share for FY 2027 of 79.1 percent (the sum of 76.0 percent for the labor-related share of operating costs and 3.1 percent for the labor-related share of Capital-Related costs). We are also proposing that if more recent data become available, we would use such data, if appropriate, to determine the FY 2027 labor-related share for the final rule. For more information on the labor-related share and its calculation, we refer readers to the FY 2024 IPF PPS final rule (88 FR 51078 through 51081).

Table 1 shows the proposed FY 2027 labor-related share and the final FY 2026 labor-related share using the 2021-based IPF market basket relative importance.

TABLE 1—FY 2027 PROPOSED IPF LABOR-RELATED SHARE AND FY 2026 IPF LABOR-RELATED SHARE

	Relative importance, labor-related share FY 2026 [1]	Proposed relative importance, labor-related share FY 2027 [2]
Wages and Salaries	53.7	53.8
Employee Benefits	14.2	14.2
Professional Fees: Labor-Related	4.7	4.7
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair Services	1.2	1.2
All Other Labor-Related Services	1.5	1.5
Subtotal	75.9	76.0
Labor-related portion of Capital-Related (.46)	3.1	3.1
Total Labor-Related Share	79.0	79.1

[1] Based on the 2nd quarter 2025 IGI forecast of the 2021-based IPF market basket.
[2] Based on the 4th quarter 2025 IGI forecast of the 2021-based IPF market basket.

We solicit comment on the proposed labor-related share for FY 2027.

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

The IPF PPS is based on a standardized Federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget neutrality in the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient-level and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the RY 2005 IPF PPS final rule (69 FR 66926).

1. Determining the Standardized Budget Neutral Federal Per Diem Base Rate

Section 124(a)(1) and (c) of the BBRA requires that we implement the IPF PPS in a budget neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented. A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the RY 2005 IPF PPS final rule (69 FR 66926).

Under the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005, through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (October 1, 2005), and this amount was used in the payment model to establish the budget neutrality adjustment.

Next, we standardized the IPF PPS Federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The information concerning this standardization can be found in the RY 2005 IPF PPS final rule (69 FR 66932) and the RY 2006 IPF PPS final rule (71 FR 27045). We then reduced the standardized Federal per diem base rate to account for the outlier policy, the stop loss provision, and anticipated behavioral changes. A complete discussion of how we calculated each component of the budget neutrality adjustment appears in the RY 2005 IPF PPS final rule (69 FR 66932 and 66933) and in the RY 2007 IPF PPS final rule (71 FR 27044 through 27046). The final standardized budget neutral Federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was calculated to be $575.95.

The Federal per diem base rate has been updated in accordance with applicable statutory requirements and 42 CFR 412.428 through publication of annual notices or proposed and final rules. A detailed discussion on the standardized budget neutral Federal per diem base rate and the ECT payment per

treatment appears in the FY 2014 IPF PPS update notice (78 FR 46738 through 46740). These documents are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility.*

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

In the RY 2005 IPF PPS final rule (69 FR 66951), we analyzed the costs of IPF stays that included ECT treatment using the FY 2002 Medicare Provider and Analysis Review (MedPAR) data based on comments we received on the RY 2005 IPF PPS proposed rule. Consistent with the comments we received about ECT, our analysis and review indicated that cases with ECT treatment are substantially more costly than cases without ECT treatment. Based on this analysis, in that final rule we finalized an additional payment for each ECT treatment furnished during the IPF stay. This ECT payment per treatment is made in addition to the per diem and outlier payments under the IPF PPS. To receive the payment per ECT treatment, IPFs must indicate on their claims the revenue code and procedure code for ECT (Rev Code 901; procedure code 90870) and the number of units of ECT, that is, the number of ECT treatments the patient received during the IPF stay.

To establish the ECT per treatment payment, we used the pre-scaled and pre-adjusted median cost for procedure code 90870 developed for the Hospital Outpatient Prospective Payment System (OPPS), based on hospital claims data. We explained in the RY 2005 IPF PPS final rule that we used OPPS data because after careful review and analysis of IPF claims, we were unable to separate out the cost of a single ECT treatment (69 FR 66922). We used the unadjusted hospital claims data under the OPPS because we did not want the ECT payment under the IPF PPS to be affected by factors that are relevant to OPPS, but not specifically applicable to IPFs. The median cost was then standardized and adjusted for budget neutrality. We also adjusted the ECT rate for wage differences in the same manner that we adjust the per diem rate.

Most recently, as we explained in the FY 2025 IPF PPS proposed rule (89 FR 23146), we analyzed recent data from both the IPF PPS and the OPPS. Findings revealed that costs for IPF stays involving ECT were significantly more costly than stays without ECT, with cost driven primarily by longer stays and higher ancillary expenses. To address this, we finalized a new ECT payment calculation based on the pre-scaled and pre-adjusted CY 2024 OPPS geometric mean cost, adjusted by the market basket update and wage index budget neutrality factor. A complete discussion of the final FY 2025 ECT payment per treatment can be found in the FY 2025 IPF PPS final rule (89 FR 64591 through 64593).

Since the ECT payment rate was established in the RY 2005 IPF PPS rule, it has been updated annually by application of each year's market basket, productivity adjustment, and wage index budget neutrality factor to the previous year's ECT payment rate (referred to as our ''standard methodology'' in this section).

3. Proposed Update of the Federal per Diem Base Rate and Electroconvulsive Therapy Payment per Treatment

The current (FY 2026) Federal per diem base rate is $892.87 and the ECT payment per treatment is $673.85. For the proposed FY 2027 Federal per diem base rate, we are proposing to apply the proposed IPF market basket update of 2.3 percent (that is, the proposed 2021-based IPF market basket percentage increase for FY 2027 of 3.1 percent reduced by the proposed productivity adjustment of 0.8 percentage point), and the proposed wage index budget neutrality factor of 0.9991 (as discussed in section III.D.1.c. of this proposed rule) to the final FY 2026 Federal per diem base rate of $892.87, yielding a proposed Federal per diem base rate of $912.58 for FY 2027. We are proposing to apply the proposed IPF market basket update of 2.3 percent and the proposed wage index budget neutrality factor of 0.9991 to the final FY 2026 ECT payment per treatment of $673.85, yielding a proposed ECT payment per treatment of $688.73 for FY 2027.

Section 1886(s)(4)(A)(i) of the Act requires that for RY 2014 and each subsequent RY, in the case of an IPF that fails to report required quality data with respect to such RY, the Secretary will reduce any annual update to a standard Federal rate for discharges during the RY by 2.0 percentage points. Therefore, we applied a 2.0 percentage point reduction to the proposed annual update to the Federal per diem base rate and the proposed ECT payment per treatment as follows:

- For IPFs that fail to report required data under the IPF Quality Reporting Program, we would apply a proposed 0.3 percent payment rate update—that is, the proposed IPF market basket increase for FY 2027 of 3.1 percent reduced by the proposed productivity adjustment of 0.8 percentage point for a proposed update of 2.3 percent, and further reduced by 2.0 percentage points in accordance with section 1886(s)(4)(A)(i) of the Act. We also propose to apply the wage index budget neutrality factor of 0.9991 to the FY 2026 Federal per diem base rate of $892.87, yielding a proposed Federal per diem base rate of $894.74 for FY 2027.
- For IPFs that fail to report required data under the IPF Quality Reporting Program, we would apply the proposed 0.3 percent payment rate update and the 0.9991 wage index budget neutrality factor to the FY 2026 ECT payment per treatment of $673.85, yielding a proposed ECT payment per treatment of $675.26 for FY 2027.

C. Proposed Updates to the IPF PPS Patient-Level Adjustment Factors

1. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustment factors were originally derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. For a more detailed description of the data file used for this regression analysis, we refer readers to the RY 2005 IPF PPS final rule (69 FR 66935 and 66936).

In FY 2025, we implemented revisions to the methodology for determining payment rates under the IPF PPS, as required by section 1886(s)(5)(D) of the Act. We developed the FY 2025 adjustment factors based on a regression analysis of IPF cost and claims data. The primary sources of this analysis were CY 2019 through 2021 MedPAR files and Medicare cost report data (CMS Form 2552–10, OMB No. 0938–0050) from the FY 2019 through 2021 Hospital Cost Report Information System (HCRIS). For a more detailed description of the data files used for this regression analysis, we refer readers to the FY 2025 IPF PPS final rule (89 FR 64593 through 64601).

For FY 2027, we propose to use the existing regression-derived patient-level adjustment factors established for FY 2025. We are not proposing any changes to the patient-level adjustment factors for FY 2027; however, we used more recent claims data to simulate payments, to finalize the outlier fixed dollar loss threshold amount, and to assess the impact of the IPF PPS updates.

2. Proposed IPF PPS Patient-Level Adjustments

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.

a. Proposed Update to MS–DRG Assignment

We believe it is important to maintain for IPFs the same diagnostic coding and DRG classification used under the IPPS for providing psychiatric care. For this reason, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set (ICD–9 Clinical Modification (CM)) and DRG patient classification system (MS–DRGs) that were utilized at the time under the IPPS. In the RY 2009 IPF PPS notice (73 FR 25709), we discussed CMS's effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). In the RY 2009 IPF PPS notice (73 FR 25716), we provided a crosswalk to reflect changes that were made under the IPF PPS to adopt the new MS–DRGs. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the RY 2009 IPF PPS notice (73 FR 25714).

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis discussed in detail in the RY 2004 IPF proposed rule (68 FR 66923; 66928 through 66933) and the RY 2005 IPF final rule (69 FR 66933 through 66960). Mapping the DRGs to the MS–DRGs resulted in 17 IPF MS–DRGs, instead of the original 15 DRGs, for which the IPF PPS provides an adjustment.

In the FY 2015 IPF PPS final rule (79 FR 45945 through 45947), we finalized conversions of the ICD–9–CM–based MS–DRGs to ICD–10–CM/Procedure Coding System (PCS)–based MS–DRGs, which were implemented on October 1, 2015. Further information on the ICD–10–CM/PCS MS–DRG conversion project can be found on the CMS ICD–10–CM website at *https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-ms-drg-conversion-project.*

In the FY 2025 IPF PPS final rule (89 FR 64602 through 64606), we revised the payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis, following our longstanding policy of using the ICD–10–CM/PCS-based MS–DRG system. In that final rule, we identified 19 DRGs for which the IPF PPS adjusts payment. In addition, we implemented a sub-regulatory process to adopt routine coding updates that incorporate new or revised codes with an April 1 effective date (89 FR 64602 and 64603).

For FY 2027, we propose to continue making the existing payment adjustments for psychiatric diagnoses that group to one of the existing 19 IPF MS–DRGs listed in Addendum A to this proposed rule. Addendum A to this proposed rule is available on our website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets.* 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 diagnoses for each IPF MS–DRG will be updated as of October 1, 2026, using the final IPPS FY 2027 ICD–10–CM/PCS code sets. The FY 2027 IPPS/LTCH PPS final rule will include tables of the changes to the ICD–10–CM/PCS code sets that underlie the proposed FY 2027 IPF MS–DRGs. Both the FY 2027 IPPS/LTCH PPS final rule and the tables of final changes to the ICD–10–CM/PCS code sets, which underlie the FY 2027 MS–DRGs, will be available on the CMS IPPS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps.*

Additionally, 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). In accordance with the ICD–10–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a code first note, the provider will follow the instructions in the ICD–10–CM Tabular List. The submitted claim goes through the CMS processing system, which will identify the principal diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment. For more information on the code first policy, we refer readers to the RY 2005 IPF PPS final rule (69 FR 66945). We also refer readers to sections I.A.13 and I.B.7 of the FY 2020 ICD–10–CM Coding Guidelines, which is available at *https://www.cdc.gov/nchs/data/icd/10cmguidelinesFY2020_final.pdf.* In the FY 2015 IPF PPS final rule, we provided a code first table for reference that highlights the same or similar manifestation codes where the code first instructions apply in ICD–10–CM that were present in ICD–10–CM (79 FR 46009).

As discussed in the FY 2025 IPF PPS final rule (89 FR 64602 and 64603), we adopted a sub-regulatory approach to handle the coding updates, rather than discussing coding updates in the **Federal Register** during regulatory updates prior to implementation. This approach mirrors the approach taken by the IPPS, allows for flexibility in the ICD–10 code update process for the IPF PPS, and reduces the lead time for making routine coding updates to the IPF PPS code first list, comorbidities, and ECT coding categories. The proposed 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/tools-and-worksheets.*

b. Proposed Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with active 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 active treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Current billing instructions for discharge claims, on or

after October 1, 2015, require IPFs to enter the complete ICD–10–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission, or develop subsequently and impact the treatment provided.

The IPF PPS comorbidity adjustments were originally determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM code first instructions applied. In a code first situation, the submitted claim goes through the CMS processing system, which identifies the principal diagnosis code as non-psychiatric and searches the secondary codes for a psychiatric code to assign an MS–DRG code for adjustment. The system continues to search the secondary codes for those that are appropriate for a comorbidity adjustment.

In FY 2025, we revised the comorbidity adjustment factors based on the results of the 2019 through 2021 regression analysis described in the FY 2025 IPF PPS final rule (89 FR 64606 through 64612). In addition, we made additions and changes to the comorbidity categories for which we adjust payment based on our analysis of ICD–10–CM codes currently included in each category as well as public comments received in response to the FY 2022 and FY 2023 IPF PPS proposed rules. A detailed discussion of the revised comorbidity adjustment factors is described in the FY 2025 IPF PPS final rule (89 FR 64606 through 64612).

For FY 2027, we propose to use the same comorbidity adjustment factors in effect in FY 2025. The proposed FY 2027 comorbidity adjustment factors are found in Addendum A to this proposed rule, available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets.*

As noted previously, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. In the FY 2015 IPF PPS final rule (79 FR 45947 through 45955), the comorbidity categories formerly defined using ICD–9–CM codes were converted to ICD–10–CM/PCS. The goal for converting the comorbidity categories is referred to as replication, meaning that the payment adjustment for a given patient encounter is the same after ICD–10–CM implementation as it would be if the same record had been coded in ICD–9–CM and submitted prior to ICD–10–CM/PCS implementation on October 1, 2015. All conversion efforts were made with the intent of achieving this goal.

As discussed in section III.C.2.a. of this proposed rule, in the FY 2025 IPF PPS final rule (89 FR 64602 and 64603) we adopted an April 1 implementation date for ICD–10–CM diagnosis and ICD–10–PCS procedure code updates, in addition to the annual October 1 update, beginning with April 1, 2025 for the IPF PPS. 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, we added three ICD–10–PCS procedure codes to the Oncology Treatment Procedures list and two ICD–10–PCS procedure codes to the Chronic Obstructive Pulmonary Disease & Sleep Apnea Procedures list.

The proposed FY 2027 comorbidity codes are shown in Addenda B, available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets.*

c. Proposed Patient Age Adjustments

As explained in the RY 2005 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (range of ages) for payment adjustments. In general, we found that the cost per day increases with age. The older age groups are costlier than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant. In FY 2025, we adopted revised patient age adjustments derived from the regression model using a blended set of 2019 through 2021 data (89 FR 64612 and 64613). For FY 2027, we propose to retain the existing patient age adjustment factors implemented for FY 2025, as shown in Addendum A of this proposed rule (see *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets*).

d. Proposed Variable Per Diem Adjustments

We explained in the RY 2005 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. As discussed in the RY 2005 IPF PPS final rule, where a complete discussion of the variable per diem adjustments can be found, we used a regression analysis to estimate the average differences in per diem cost among stays of different lengths (69 FR 66947 through 66950). As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually over the course of the patient's stay. In addition, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a higher adjustment factor for day 1 of each stay than it would receive if it did not have a qualifying ED. The ED adjustment is explained in more detail in section III.D.5. of this proposed rule.

In FY 2025, we revised the variable per diem adjustment factors based on the 2019 through 2021 regression analysis (89 FR 64613 and 64614). For FY 2027, we propose to retain the existing variable per diem adjustment factors implemented for FY 2025 as shown in Addendum A to this proposed rule (available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets).*

D. Proposed Updates to the IPF PPS Facility-Level Adjustments

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. The IPF PPS facility-level adjustment factors for rural location and teaching status were originally derived from regression analysis of 100 percent of the FY 2002 MedPAR data file. For a more detailed description of the data file used for this regression analysis, we refer readers to the RY 2005 IPF PPS final rule (69 FR 66935 and 66936).

In FY 2026, in a continuation of the FY 2025 implementation of revisions to the methodology for determining payment rates under the IPF PPS as required by section 1886(s)(5)(D) of the Act, we revised the facility-level adjustment factors for rural location and teaching status based on a regression analysis of cost and claims data for IPF stays from FY 2020 to FY 2022 (90 FR 37639 through 37649). As discussed in the following sections, we are proposing annual updates to the FY 2027 IPF PPS wage index and to the cost of living adjustments for IPFs located in Alaska and Hawaii. For FY 2027, we propose to use the facility-level adjustment factors for rural location, teaching status, and IPFs with a qualifying ED currently in

effect for FY 2026, as shown in Addendum A to this proposed rule.

1. Wage Index Adjustment

a. Background

As discussed in the RY 2007 IPF PPS final rule (71 FR 27061), and the RY 2009 IPF PPS (73 FR 25719) and RY 2010 IPF PPS notices (74 FR 20373), to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area, as defined in § 412.64(b)(1)(ii)(A) and (C).

Due to the variation in costs and because of the differences in geographic wage levels, in the RY 2005 IPF PPS final rule, we required that payment rates under the IPF PPS be adjusted by a geographic wage index. We proposed and finalized a policy to use the unadjusted, pre-floor, pre-reclassified IPPS hospital wage index to account for geographic differences in IPF labor costs. We implemented use of the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index since there was not an IPF-specific wage index available. We believe that IPFs generally compete in the same labor market as IPPS hospitals, and therefore, the pre-floor, pre-reclassified IPPS hospital wage data should be reflective of labor costs of IPFs. We believe this pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF-specific wage index. As discussed in the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without considering geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41362 through 41390). Our wage index policy at § 412.424(a)(2) provides that we use the best Medicare data available to estimate costs per day, including an appropriate wage index to adjust for wage differences.

When the IPF PPS was implemented in the RY 2005 IPF PPS final rule, with an effective date of January 1, 2005, the pre-floor, pre-reclassified IPPS hospital wage index that was available at the time was the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index. Historically, the IPF wage index for a given RY has used the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY as its basis. This has been due in part to the pre-floor, pre-reclassified IPPS hospital wage index data that were available during the IPF rulemaking cycle, where an annual IPF notice or IPF final rule was usually published in early May. This publication timeframe was relatively early compared to other Medicare payment rules because the IPF PPS follows a RY, which was defined in the implementation of the IPF PPS as the 12-month period from July 1 to June 30 (69 FR 66927). Therefore, the best available data at the time the IPF PPS was implemented was the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY (for example, the RY 2006 IPF wage index was based on the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index).

In the RY 2012 IPF PPS final rule, we changed the reporting year timeframe for IPFs from a RY to FY, which begins October 1 and ends September 30 (76 FR 26434 and 26435). In that FY 2012 IPF PPS final rule, we continued our established policy of using the pre-floor, pre-reclassified IPPS hospital wage index from the prior year (that is, from FY 2011) as the basis for the FY 2012 IPF wage index. This policy of basing a wage index on the prior year's pre-floor, pre-reclassified IPPS hospital wage index has been followed by other Medicare payment systems, such as hospice and inpatient rehabilitation facilities. By continuing with our established policy, we remained consistent with other Medicare payment systems.

In FY 2020, we finalized the IPF wage index methodology to align the IPF PPS wage index with the same wage data timeframe used by the IPPS for FY 2020 and subsequent years. Specifically, we finalized the use of the pre-floor, pre-reclassified IPPS hospital wage index from the FY concurrent with the IPF FY as the basis for the IPF wage index. For example, the FY 2020 IPF wage index was based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage index rather than on the FY 2019 pre-floor, pre-reclassified IPPS hospital wage index.

We explained in the FY 2020 proposed rule (84 FR 16973), that using the concurrent pre-floor, pre-reclassified IPPS hospital wage index will result in the most up-to-date wage data being the basis for the IPF wage index. We noted that it would also result in more consistency and parity in the wage index methodology used by other Medicare payment systems. We indicated that the Medicare skilled nursing facility (SNF) PPS already used the concurrent IPPS hospital wage index data as the basis for the SNF PPS wage index. We proposed and finalized similar policies to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index data in other Medicare payment systems, such as hospice and inpatient rehabilitation facilities. Thus, the wage adjusted Medicare payments of various provider types are based upon wage index data from the same timeframe.

In the FY 2023 IPF PPS final rule (87 FR 46856 through 46859), we finalized a permanent 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, and we stated that we will apply this cap in a budget neutral manner. In addition, we finalized a policy that a new IPF will be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IPF will not have a wage index in the prior FY. We amended the IPF PPS regulations at § 412.424(d)(1)(i) to reflect this permanent cap on wage index decreases. We refer readers to the FY 2023 IPF PPS final rule for a more detailed discussion about this policy.

For FY 2027, we are proposing to apply the IPF wage index adjustment to the labor-related share of the national IPF PPS base rate and ECT payment per treatment. As discussed in section III.A.3. of this proposed rule, the proposed labor-related share of the IPF PPS national base rate and ECT payment per treatment is 79.1 percent in FY 2027. This percentage reflects the labor-related share relative importance of the 2021-based IPF market basket for FY 2027 and is 0.1 percentage point higher than the FY 2026 labor-related share.

For FY 2027, we are proposing to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index. We continue to consider this an appropriate source of wage index data to estimate costs per day, in accordance with our longstanding wage index policy at § 412.424(a)(2)(ii). At the same time, we routinely assess whether more recent or alternative data sources may further enhance the accuracy and representativeness of our estimates. We note that other payment systems have explored and are exploring alternative wage index methodologies under their specific programmatic and statutory circumstances. For example, CMS finalized changes to the ESRD PPS wage index using Bureau of Labor Statistics (BLS) occupation-level wage data in the CY 2025 ESRD PPS final rule (89 FR 89116). While this approach was developed under the specific

programmatic and statutory circumstances of the ESRD PPS and may not be directly transferable to the IPF PPS, CMS is interested in exploring whether similar methodologies using publicly available wage data could be adapted to better reflect the geographic variation in labor costs for inpatient psychiatric facilities.

In its 2023 Report to Congress,[3] MedPAC discussed various conceptual approaches to Medicare wage indexes, including the use of county-level wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting. MedPAC has previously written about using all-employer, occupation-level wage data to establish different weights for setting-specific occupational labor mixes as one approach to geographic adjustments.

We are soliciting comments on whether we should consider using alternative data sources to construct an IPF-specific wage index for potential use in future years. CMS seeks feedback to understand the potential advantages and limitations of using alternative data sources, such as BLS data and IPF cost reports, as well as other methodologies that interested parties believe could appropriately reflect the geographic variation in labor costs for psychiatric facilities. In addition, as discussed elsewhere in the **Federal Register**, we note that we are also considering the potential use of alternative data sources in other payment systems including the Inpatient Rehabilitation Facilities PPS, Skilled Nursing Facilities PPS, and Hospice payment system. We seek feedback on the unique considerations applicable to IPFs that should inform how CMS could consider the potential use of alternative data sources.

b. Office of Management and Budget (OMB) Bulletins

The wage index used for the IPF PPS is calculated using the unadjusted, pre-reclassified and pre-floor IPPS wage index data and is assigned to the IPF based on the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the Core-Based Statistical Area (CBSAs) established by the OMB.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses through OMB Bulletins. These bulletins contain information regarding CBSA changes, including changes to CBSA numbers and titles. In accordance with our established methodology, the IPF PPS has historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the IPPS hospital wage index used to determine the IPF wage index and, when necessary and appropriate, has proposed and finalized transition policies for these changes.

In the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. We refer readers to the FY 2007 IPF PPS final rule (71 FR 27064 and 27065) for a complete discussion regarding treating Micropolitan Areas as rural. In adopting the OMB CBSA geographic designations in RY 2007, we did not provide a separate transition for the CBSA-based wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

In the RY 2009 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applied to the IPPS hospital wage index used to determine the current IPF wage index and stated that we expected to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721).

Subsequently, CMS adopted the changes that were published in past OMB bulletins in the FY 2016 IPF PPS final rule (80 FR 46682 through 46689), the FY 2018 IPF PPS rate update (82 FR 36778 and 36779), the FY 2020 IPF PPS final rule (84 FR 38453 and 38454), and the FY 2021 IPF PPS final rule (85 FR 47051 through 47059). We direct readers to each of these rules for more information about the changes that were adopted and any associated transition policies.

As discussed in the FY 2023 IPF PPS final rule, we did not adopt OMB Bulletin 20–01, which was issued March 6, 2020, because we determined this bulletin had no material impact on the IPF PPS wage index. This bulletin creates only one Micropolitan statistical area, and Micropolitan areas are considered rural for the IPF PPS wage index. That is, the constituent county of the new Micropolitan area was considered rural effective as of FY 2021 and would continue to be considered rural if we adopted OMB Bulletin 20–01.

In the FY 2025 IPF PPS final rule (89 FR 64614 through 64633), we adopted the updates set forth in OMB Bulletin No. 23–01 effective July 21, 2023, beginning with the FY 2025 IPF PPS wage index. These updates included material changes to the OMB statistical area delineations, which included 53 urban counties that became rural, 54 rural counties that became urban, and 88 counties that moved to a new or modified CBSA. These updates also included replacing the 8 counties in Connecticut with 9 new ''Planning Regions.'' Planning regions now serve as county-equivalents within the CBSA system. OMB Bulletin No. 23 may be accessed online at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.*

Given the scope of changes involved in adopting the CBSA delineations for FY 2025, we finalized a budget neutral 3-year phase out policy for IPFs transitioning from rural to urban based on CBSA revisions, as discussed further in section III.D.2.b. of this proposed rule. We also applied the permanent 5-percent cap on wage index decreases described at § 412.424(d)(1)(i).

c. Proposed Wage Index Budget Neutrality Adjustment

In accordance with § 412.424(c)(5), changes to the wage index are made in a budget neutral manner so that updates do not increase expenditures. Therefore, for FY 2027, we are proposing to continue to apply a budget neutrality adjustment in accordance with our existing budget neutrality policy. This policy requires us to update the wage index in such a way that total estimated payments to IPFs for FY 2027 are the same with or without the changes (that is, in a budget neutral manner) by applying a budget neutrality factor to the IPF PPS rates. We are proposing to use the following steps to ensure that the rates reflect the FY 2027 update to the wage indexes (based on FY 2023 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1: Simulate estimated IPF PPS payments, using the FY 2026 IPF wage index values (available on the CMS website) and labor-related share (as published in the FY 2026 IPF PPS final rule (90 FR 37635)).

Step 2: Simulate estimated IPF PPS payments using the FY 2027 IPF wage index values (available on the CMS website), and the FY 2027 labor-related share (based on the latest available data as discussed previously).

[3] *https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf.*

Step 3: Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2027 budget neutral wage adjustment factor of 0.9991.

Step 4: Apply the FY 2027 budget neutral wage adjustment factor from step 3 to the FY 2026 IPF PPS Federal per diem base rate after the application of the proposed IPF market basket increase reduced by the proposed productivity adjustment described in section III.A.2. of this proposed rule to determine the proposed FY 2027 IPF PPS Federal per diem base rate.

2. Proposed Adjustment for Rural Location

a. Proposed Payment for Rural Location

In the RY 2005 IPF PPS final rule (69 FR 66954), we provided a 17-percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. This 17-percent adjustment has been part of the IPF PPS each year since the inception of the IPF PPS. In the FY 2025 IPF PPS final rule, we revised the patient-level adjustment factors and changed the CBSA delineations. To minimize the scope of changes that would impact providers in any single year, we maintained the existing regression-derived adjustment factor, which was established in RY 2005, for IPFs located in a rural area for FY 2025. Our analysis of more cost and claims data from FY 2020 through 2022 for the FY 2026 final rule indicated that an increase in the payment adjustment for IPFs in rural areas would be appropriate. Based on this analysis, we revised the adjustment for rural location to 18 percent for FY 2026 to more accurately represent the difference in costs between urban and rural IPFs (90 FR 37647). See the FY 2026 IPF PPS final rule for the full explanation of the regression analysis that yielded the revised 18 percent adjustment for rural location (90 FR 37639 through 37644) and the RY 2005 IPF PPS final rule (69 FR 66954) for a complete discussion of the adjustment for rural locations.

For 2027, we are proposing to continue to apply an 18 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C).

b. End of Rural Transition

The adoption of OMB Bulletin No. 23–01 in the FY 2025 IPF PPS final rule (89 FR 64632) in accordance with our established methodology determines whether a facility is classified as urban or rural for purposes of the rural payment adjustment in the IPF PPS. Implementation of the updated OMB delineations results in the rural payment adjustment being applied where it is appropriate to adjust for higher costs incurred by IPFs in rural locations; however, these changes have distributional effects among IPF providers. Some providers lost eligibility for the rural payment adjustment in FY 2025 as a result of these changes. Therefore, we provided a transition period to implement the updated OMB delineations (89 FR 64633).

In the FY 2025 IPF PPS final rule, we phased out the rural adjustment for facilities located in a county that transitioned from rural to urban due to the changes outlined in OMB Bulletin 23–01. We implemented a 3-year budget neutral phase-out of the rural adjustment for IPFs located in the 54 rural counties that would become urban under the new OMB delineations, given the potentially significant payment impacts for these IPFs (89 FR 64632 and 64633), consistent with the transition policy we adopted for IPFs in FY 2016 (80 FR 46682 through 46689). Under this 3-year phase-out, for FY 2026, IPFs that became urban due to these OMB delineation changes received one-third of the rural adjustment that was applicable in FY 2024. For FY 2027, these IPFs will not receive a rural adjustment.

3. Proposed Teaching Adjustment

In the RY 2005 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching hospitals (69 FR 66954 through 66957). The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. As detailed further in the following paragraphs, the payment adjustments are made based on the ratio of the number of fulltime equivalent (FTE) interns and residents training in the IPF to the IPF's average daily census.

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals, including those paid under a PPS and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the RY 2005 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF's ''teaching variable,'' which is (1 + [the number of FTE residents training in the IPFs divided by the IPF's average daily census]). The teaching variable was then raised to the 0.5150 power, resulting in the IPF PPS teaching adjustment. This formula is subject to limitations on the number of FTE residents, which are discussed in greater detail in the following paragraph.

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a ''base year'' and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (69 FR 66955). A complete discussion of the temporary adjustment to the FTE cap to reflect residents due to hospital closure or residency program closure appears in the RY 2012 IPF PPS proposed rule (76 FR 5018 through 5020) and the RY 2012 IPF PPS final rule (76 FR 26453 through 26456). As discussed in section III.D.6.c. of the FY 2026 IPF PPS final rule (90 FR 37649 through 37651), we made conforming changes to the IPF resident cap policy beginning in FY 2026 to recognize permanent cap increases awarded under section 4122 of the CAA, 2023.

In the regression analysis that informed the RY 2004 IPF PPS final rule, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect into a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the

coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant. A complete discussion of how the teaching adjustment was calculated appears in the RY 2005 IPF PPS final rule (69 FR 66954 through 66957) and the RY 2009 IPF PPS notice (73 FR 25721).

In the FY 2025 IPF PPS proposed rule, we included an RFI regarding a potential revision to the payment adjustment for teaching status (89 FR 23194 and 23195); we refer readers to section IV.A. of the FY 2025 IPF PPS final rule (89 FR 64641) for summaries of the comments we received and our responses. We took the comments received into consideration when we developed our proposal for the FY 2026 revision of the payment adjustment for teaching status.

In the FY 2026 IPF PPS final rule, we increased the teaching adjustment to 0.7957 based on the results of our latest regression model (90 FR 37648 and 37649). This cost effect is converted to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We implemented this revision to the teaching adjustment budget-neutrally. For FY 2027, we propose to retain the coefficient value of 0.7957 for the teaching adjustment to the Federal per diem base rate.

4. Proposed Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the area in which the IPF is located. As we explained in the RY 2005 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. As a result of this analysis, we provided a COLA in the RY 2005 IPF PPS final rule. We refer readers to the FY 2024 IPF PPS final rule for a complete discussion of the currently applicable COLA factors (88 FR 51088 and 51089).

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 and 53701), we established a new methodology to update the COLA factors for Alaska and Hawaii and adopted this methodology for the IPF PPS in the FY 2015 IPF PPS final rule (79 FR 45958 through 45960). We also specified that the COLA updates will be determined every 4 years, in alignment with the IPPS market basket labor-related share update (79 FR 45958 through 45960). Because the labor-related share of the IPPS market basket was updated for FY 2022, the COLA factors were updated in FY 2022 IPPS/LTCH rulemaking (86 FR 45547) reflecting CPI data through 2020. As such, we also finalized an update to the IPF PPS COLA factors in the FY 2022 IPF PPS final rule to reflect the updated COLA factors finalized in the FY 2022 IPPS/LTCH rulemaking effective for FY 2022 through FY 2025 (86 FR 42621 and 42622).

In the FY 2026 IPF PPS final rule, we stated that we believe it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii (90 FR 37651 and 37652). We used the FY 2025 COLA factors to adjust the non-labor-related portion of the standardized amount for IPFs located in Alaska and Hawaii for FY 2026. For a complete discussion of the FY 2026 COLA factors, we refer readers to the FY 2026 IPPS/LTCH final rule (90 FR 37229 and 37230).

Effective for FY 2027, to continue our consistent policy approach with that of other hospitals in Alaska and Hawaii, we are proposing to adjust non-labor related costs for IPFs located in Alaska and Hawaii using the Overseas Cost-of-Living Allowance (OCOLA) data [4] published by the Department of Defense (DOD). We believe the DOD OCOLAs are an appropriate data source to capture the cost differences of hospital non-labor-related inputs purchased in the areas in Hawaii and Alaska compared to the continental U.S. Additionally, we are proposing to no longer cap the COLA factors for Alaska and Hawaii at 25 percent. We are soliciting any additional information with regard to these results and may consider finalizing an alternative methodology. For a complete discussion of the proposed FY 2027 COLA factors, we refer readers to the FY 2027 IPPS/LTCH proposed rule, published elsewhere in the **Federal Register**.

The proposed FY 2027 IPF PPS COLA factors for Alaska and Hawaii are shown in Table 2.

TABLE 2—COST OF LIVING ADJUSTMENT (COLA) FACTORS: IPFS LOCATED IN ALASKA AND HAWAII

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

The proposed IPF PPS COLA factors for Alaska and Hawaii for FY 2027 are also shown in Addendum A to this proposed rule, which is available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/tools-and-worksheets.*

5. Proposed Adjustment for IPFs With a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. As defined in § 412.402, qualifying emergency department means an emergency department that is staffed and equipped to furnish a comprehensive array of emergency services and meets the requirements of § 489.24(b) and § 413.65.

[4] *https://www.travel.dod.mil/Allowances/Overseas-Cost-of-Living-Allowance/.*

We provide an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a psychiatric hospital with a qualifying ED, or an excluded psychiatric unit of an IPPS hospital or a critical access hospital (CAH), and the overhead cost of maintaining the ED. This payment applies to all IPF admissions (with one exception which we describe in this section), regardless of whether the patient was admitted through the ED. The ED adjustment is made on every qualifying claim except as described in this section. As specified at § 412.424(d)(1)(v)(B), the ED adjustment is not made 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. We clarified in the RY 2005 IPF PPS final rule (69 FR 66960) that an ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH.

In the FY 2025 IPF PPS final rule, we updated the adjustment factor from 1.31 to 1.54 for IPFs with qualifying EDs using the same methodology used to determine ED adjustments in prior years (89 FR 64636). 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, we propose to maintain the 1.54 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the most recent calculation of the ED adjustment factor can be found in the FY 2025 IPF PPS final rule (89 FR 64636).

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

a. Background on the Current IPF PPS Outlier Payment Policy

The IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In the RY 2005 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per case payment for IPF stays that are extraordinarily costly. Providing an outlier adjustment to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient- and facility-level. These upward payment adjustments reduce the financial losses that would otherwise be incurred in treating patients who require costlier care, and therefore reduce the incentives for IPFs to under-serve these patients. We make payments under the outlier adjustment for discharges where an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment adjustment, we pay 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 (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. The adjusted threshold amount is equal to the outlier threshold amount adjusted for wage area, teaching status, rural area, and the COLA factor (if applicable), plus the amount of the Medicare IPF payment for the case. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total estimated IPF PPS payments.

b. Analysis of Recent Outlier Payments Under the Current Methodology

For this FY 2027 IPF PPS rulemaking, we conducted an analysis of the latest available data (the December 2025 update of FY 2025 IPF claims) and rate increases, following our longstanding methodology. Based on an analysis of these updated data, we believe 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. We estimate that IPF outlier payments as a percentage of total estimated payments would be 2.2 percent in FY 2026. Therefore, under our current policy the outlier threshold amount would need to be updated to $42,720 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.

We also conducted analysis about the distribution of IPF PPS outlier payments. We note that when we first established the IPF PPS outlier policy, we estimated that approximately 5 percent of IPF stays in RY 2005 would meet the fixed dollar loss threshold amount and qualify for an average outlier payment of $3,248 (69 FR 66962). By contrast, our latest analysis of FY 2025 claims data shows that under our current outlier methodology, only around 1.5 percent of IPF stays in FY 2027 would qualify for an outlier payment, which would be on average approximately $20,526. This comparison between outlier payments in RY 2005 and FY 2027 demonstrates that IPF outlier payments are concentrated among a smaller number of stays with significantly higher average costs. Moreover, our analysis shows that over time, the share of IPF PPS stays qualifying for outlier payment declined from above 4 percent during FY 2014 through FY 2022 to 3.2 percent in FY 2023, 2.3 percent in FY 2024, and 2.1 percent in FY 2025. Furthermore, we observed concentrations of IPF PPS outlier payments among a smaller number of IPFs. In FY 2025, the 20 IPFs that had the highest amounts of total outlier payments accounted for more than 50 percent of total outlier payments. We also analyzed clinical characteristics from IPF PPS claims to determine the extent to which such differences could be driving outlier payments. Outlier stays tend to be significantly longer than non-outlier stays (approximately 46 days versus 12 days). 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. Overall, these providers charge nearly twice as much per day as compared to the average ($6,000 vs. $2,600). We note that in its April 2020 report, the Office of the Inspector General studied a sample of IPF claims from FYs 2014 and 2015 and noted similar trends.[5] While CMS did not

[5] *https://www.oversight.gov/sites/default/files/documents/reports/2020-04/11600508.pdf.*

concur with some of the recommendations that report made, we did concur with its recommendation to study the stays qualifying for outlier payments. Our analysis of outlier claims in FYs 2023 through 2024 demonstrate higher cost than the typical IPF stay, and for this FY 2027 IPF PPS proposed rule we conducted further analysis to better understand the drivers of these costs.

Although we note certain case-mix differences between providers with a high share of outliers and those with a lower share or with no outliers, our analysis suggests that these differences alone do not appear to fully explain the substantial difference in per diem routine charges. For example, providers with a high share of outliers tend to have patients who are more often disabled (66.3 percent vs. 57.1 percent) or dual-eligible (68.1 percent vs. 60.8 percent), and they treat a smaller share of aged beneficiaries (33.3 percent vs. 42.7 percent). These facilities also have fewer stays with higher-cost DRGs (12.9 percent vs. 17.4 percent). They treat more patients with DRG 885 (Psychoses) than average (84.0 percent vs. 76.7 percent). Within DRG 885 cases, these facilities treat a slightly larger share of patients with schizophrenia (15.8 percent vs. 13.2 percent) and schizoaffective disorder (30.7 percent vs. 21.0 percent) and a slightly lower share of patients with major depressive disorder (16.2 percent vs. 19.7 percent). We note that the majority of IPF PPS stays (76.7 percent) fall within DRG 885, and our analysis has shown no statistically significant difference in cost between subcategories of conditions within this DRG (89 FR 64604). We also observe that approximately 67 percent of IPF stays that qualify for outlier payment have no reported IPF PPS comorbid conditions.

Our analyses of these clinical characteristics suggest that a substantial share of outlier payments may be driven by higher facility-level costs rather than by patient complexity. As we discuss in the following section, we are soliciting comments about the drivers of high costs in facilities with a large share of outlier payments.

In summary, we are concerned that the current methodology would limit outlier payment to too small a number of IPF PPS stays and providers. Therefore, as discussed in the following sections, we are proposing changes to our outlier policy and the methodology for determining the outlier fixed dollar loss threshold amount for FY 2027.

c. Proposed Changes to the Outlier Payment Policy and Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d)(3)(i)(D), we are proposing to update the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy, which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases. We are proposing to maintain the established 2 percent outlier policy for FY 2027.

Our longstanding methodology for updating the outlier fixed dollar loss threshold involves using the best available data, which is typically the most recent available data. We note that for FY 2022 and FY 2023 only, we made certain methodological changes to our modeling of outlier payments, and we discussed the specific circumstances that led to those changes for those years (86 FR 42623 and 42624; 87 FR 46862 through 46864). We direct readers to the FY 2022 and FY 2023 IPF PPS proposed and final rules for a more complete discussion.

We are proposing to update the IPF outlier threshold amount for FY 2027 using FY 2025 claims data in accordance with the methodology that we have used to set the initial outlier threshold amount each year beginning with the RY 2007 IPF PPS final rule (71 FR 27072 and 27073). That is, we are proposing to determine the FY 2027 fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. However, we are proposing to change the outlier policy for FY 2027 to minimize the impact of a small number of high-cost IPFs on the outlier fixed dollar loss threshold amount. Accordingly, we are proposing to modify our methodology for simulating payments to determine the outlier fixed dollar loss threshold amount for FY 2027. As we discuss in the following paragraphs, we estimate that this proposed change to the outlier policy would have a meaningful impact on the outlier fixed dollar loss threshold amount in FY 2027.

In summary, beginning in FY 2027 we are proposing to modify the IPF PPS outlier payment policy to better align outlier payments with their intended purpose of promoting access to care for patients requiring unusually costly treatment while ensuring an appropriate distribution of outlier payments across all IPFs. We note that the authorizing language for the IPF PPS, Section 124 of the BBRA, requires that the IPF PPS include an adequate patient classification system that reflects the differences in patient resource use and costs among IPFs. The IPF PPS has a longstanding policy of making appropriate adjustments for other factors that drive resource use and costs among IPFs, and of doing so in a way that limits incentives for inappropriate utilization. The IPF PPS facility-level adjustments strengthen the accuracy of the IPF PPS in adjusting payment to align with resource costs that are associated with rural status, geographical location, the presence of a full-service ED, and the higher indirect operating costs experienced by hospitals that participate in GME programs. As discussed in section III.D.3. of this proposed rule, we established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment by imposing a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment.

In addition, section 1886(s)(5)(D) authorizes the Secretary to implement revisions to the methodology for determining the payment rates under the IPF PPS, for FY 2025 and subsequent years. Given the emphasis on patient- and facility-level cost differences in Section 124 of the BBRA, and under the authority of section 1886(s)(5)(D) to consider and implement revisions to our payment methodology, we believe it is appropriate to ensure that IPF outlier payments recognize patient-level cost differences across a broad range of services and facilities. We considered the precedent of the IPF PPS teaching cap policy as a potential tool to strengthen the accuracy of the IPF PPS by limiting potential incentives for IPFs to inappropriately increase their costs and charges for IPF services. Our analysis of recent claims data has revealed that outlier payments have become increasingly concentrated among a small subset of facilities with exceptionally high reported costs. Specifically, our data indicates that approximately 37 high-cost IPFs would receive approximately 47.8 percent of all outlier payments in FY 2027 under the current policy. In contrast, these providers represent 2.7 percent of the

total population (approximately 1,400) of IPF PPS providers. According to our simulations, each of these providers' outlier payments would account for more than 20 percent of its total IPF PPS payments. For additional information about the characteristics of providers included in our payment simulations for this FY 2027 IPF PPS proposed rule, see the FY 2027 IPF PPS Proposed Rate Setting Impact File, available on the CMS web page for the FY 2027 IPF PPS proposed rule at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/ipf-pps-regulations-and-notices.*

We have observed that these facilities' high overall costs are primarily driven by elevated routine costs, which can include costs such as labor, real estate, or overhead expenses. We note that routine costs are fixed at the provider level and do not vary based on individual patient characteristics or treatment intensity. As we discussed in the prior section of this proposed rule, 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. As we discussed in the previous section, we do 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. As we noted earlier, the significant increase to the outlier fixed dollar loss threshold under our current policy would make it more difficult for the majority of IPFs to receive outlier payments for treating Medicare beneficiaries whose care is exceptionally costly. We believe that establishing a policy to limit the impact to the outlier fixed dollar loss threshold amount from the small number of high-cost IPFs that we have identified in our analysis would better align with the outlier policy's core objective of protecting facilities from the financial risk of treating unusually expensive patients. We believe that the current concentration of outlier payments does not best serve the intended purpose of this policy and may inadvertently limit access to care for high-cost patients at facilities that cannot reach the higher threshold.

To address these concerns, we considered changes to limit the impact to the outlier fixed dollar loss threshold amount from high-cost IPFs for which outlier payments comprise an unusually large share of their total IPF PPS payments. As we noted earlier, our 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. We estimate that if we 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. Under this proposal, we estimate 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 that we are proposing. Additionally, we estimate that approximately 1.9 percent of IPF stays would qualify for outlier payments, with an average outlier payment amount of approximately $1,012. In comparison to the current outlier policy, applying a 20-percent facility-level cap on outlier payments would reduce the outlier fixed dollar loss threshold, resulting in outlier payments that would be expanded to a larger number of stays and providers.

At the same time, we considered the potential impact of a facility-level cap on total outlier payments. We believe it would be appropriate to set a facility-level outlier cap at a percentage that protects the outlier fixed dollar loss threshold amount while limiting the number of IPFs that would be subject to the cap. As shown in Table 3, looking retrospectively at FY 2025 billing patterns, if we implement a facility-level outlier cap at 20 percent, we estimate that around 3.6 percent of providers would be affected. If we implement a facility-level outlier cap at a lower percentage, such as 10 or 15 percent, we estimate that a larger share of between 5 and 10 percent of IPFs would be impacted in a typical year; however, a lower cap would also result in a lower outlier fixed dollar loss threshold. Conversely, if we were to implement a facility-level outlier cap at a higher percentage, such as 25 or 30 percent, we estimate that a smaller share of IPFs would be affected in a given year (between 1 and 3 percent), but this policy would require a higher outlier fixed dollar threshold amount.

TABLE 3—SUMMARY OF POTENTIAL OUTLIER CAP LEVELS AND SHARE OF PROVIDERS IMPACTED

Cap level	Share of providers impacted
10 percent	8.8 percent.
15 percent	5.7 percent.
20 percent	3.6 percent.
25 percent	1.9 percent.
30 percent	1.2 percent.

We believe that a 20-percent facility-level outlier cap would strike an appropriate balance between protecting the outlier fixed dollar loss threshold amount and limiting the impact of the cap to only those IPFs with an unusually high share of outlier payments. Therefore, we are proposing to establish a facility-level cap on outlier payments beginning in FY 2027. Specifically, we propose to limit total outlier payments to no more than 20 percent of a facility's total IPF PPS payments. Under this proposal, if an IPF exceeds 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. We solicit comments on this proposed cap policy as well as comments about setting the cap at 20 percent versus an alternative percentage.

We are proposing to codify this policy for the IPF PPS at § 412.424(d) for discharges occurring in cost reporting periods beginning on or after October 1, 2026. This cap would be calculated and applied on an interim basis on IPF PPS claims beginning in FY 2027. Because outlier payments are finalized at cost report settlement, we propose to apply this cap on an annual basis using the following methodology:

Step 1: Calculate each facility's total non-outlier payments (that is, IPF PPS payments excluding outlier payments) for all discharges occurring during the cost reporting year.

Step 2: Divide the facility's total non-outlier payments by 80 percent (0.8) to determine the maximum allowable total IPF PPS payment amount (including outlier payments and non-outlier payments).

Step 3: Subtract the provider's maximum allowable total IPF PPS payment from its actual total IPF PPS payment amount. If the result of this calculation is greater than 0, then the facility's total outlier payments exceed 20 percent of its total IPF PPS payments.

Step 4: If the facility's total outlier payments exceed the 20 percent cap, reduce the outlier payment by the result of the calculation in Step 3.

For example, if a facility has $10 million in total IPF PPS payments (excluding outliers) and would otherwise receive $3 million in outlier payments, the facility would have an actual total IPF PPS payment amount of $13 million. Following the formula in Step 2, the provider's maximum allowable total IPF PPS payment amount would be $10 million/0.8 = $12.5 million. The facility's outlier payments would therefore be capped at $2.5 million (20 percent of $12.5 million).

We seek comment on the proposed implementation approach for interim payments as well as at cost report settlement.

We are also considering whether to exempt IPFs from this cap policy if they do not exceed a minimum threshold of annual stays. For example, our simulations indicate that if we limited the proposed 20 percent facility-level outlier cap policy to providers with more than 25 stays per year, it would exempt very small IPFs from the cap. We believe this could be appropriate, since small facilities may have limited patient volume, and a small number of high-cost cases could more easily result in outlier payments exceeding 20 percent of their total payments.

Our analysis indicates that applying the cap only to facilities with more than 25 stays per year would result in a slightly higher outlier threshold of $37,880 (compared to $37,820 if the cap applies to all facilities) but would reduce the number of facilities subject to the cap (from approximately 2.7 percent of all IPFs to approximately 1.8 percent) and potential payment adjustments. We seek comment on whether such a minimum stay threshold would be appropriate and, if so, what the appropriate threshold should be.

Under our proposed policy, we estimate that the outlier threshold for FY 2027 would be $37,820, which we previously noted would be 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. By moderating the threshold increase, we believe this proposal would make outlier payments accessible to a broader range of facilities treating high-cost patients, which we believe better aligns with the purpose of the IPF PPS outlier policy.

In conjunction with this proposed policy change, we are soliciting comments on the factors that contribute to higher costs at facilities that routinely receive an unusually high share of outlier payments. We are interested in understanding whether there are other factors for which the IPF PPS does not already adjust payment that could explain differences in patient resource use and costs among these IPFs, in accordance with Section 124 of the BBRA. We are particularly interested in understanding the following:

- What specific patient characteristics, clinical complexities, or treatment modalities drive higher costs at these facilities?
- To what extent do geographic factors, local labor market conditions, or real estate costs contribute to elevated routine costs?
- Do these facilities provide specialized services or treat patient populations that are not adequately reflected in the current IPF PPS payment adjustments?
- Are there structural changes to the IPF PPS facility adjustments or case-mix system that would more appropriately account for the notable cost differences across facilities?
- Are facilities incentivized to provide longer lengths of stay to receive to receive outlier payments, particularly if there is bed capacity? If so, what is the impact for beneficiaries who are subject to a 190-day lifetime limit on IPF services? Could the proposed changes to the outlier policy, or potential further changes, reduce incentives for unnecessarily long lengths of stay?
- Do beneficiaries perceive differences in quality, outcomes, or value between higher-cost and lower-cost facilities?

The information gathered through this RFI will help inform our final outlier policy for FY 2027 and may guide other potential future refinements to the IPF PPS payment methodology, including the outlier policy, facility-level adjustments, and case-mix classification system.

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

Under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount plus the IPF PPS amount. To establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the RY 2004 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for IPPS hospitals, because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As indicated in the RY 2005 IPF PPS final rule (69 FR 66961), we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS; therefore, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS. Specifically, we adopted the following procedure in the RY 2005 IPF PPS final rule:

- Calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas.
- Computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs using the most recent CCRs entered in the most recent Provider Specific File (PSF) available.

For FY 2027, we are proposing to continue following this methodology. To determine the final rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The final upper threshold CCR for IPFs in FY 2027 is 2.4181 for rural IPFs and 1.8850 for urban IPFs, based on current CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate, and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. We continue to use these national median CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.
- IPFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for which the Medicare Administrative Contractor (MAC) obtains inaccurate or incomplete data with which to calculate a CCR.

We are proposing to update the FY 2027 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS PSF.

Specifically, for FY 2027, to be used in each of the three situations listed previously, using the most recent CCRs entered in the CY 2025 PSF, we provide an estimated national median CCR of 0.5720 for rural IPFs and a national median CCR of 0.4200 for urban IPFs.

These calculations are based on the IPF's location (either urban or rural) using the current CBSA-based geographic designations. A complete discussion regarding the national median CCRs appears in the RY 2005 IPF PPS final rule (69 FR 66961 through 66964).

Lastly, we are proposing that if more recent data become available, we would consider using such data to calculate the rural and urban national median and ceiling CCRs for FY 2027.

IV. Inpatient Psychiatric Facility Quality Reporting Program

A. Background and Statutory Authority

The IPF Quality Reporting Program is authorized by section 1886(s)(4) of the Act, and it applies to psychiatric hospitals and psychiatric units paid by Medicare under the IPF PPS (see section II.A. of this proposed rule for a detailed discussion of entities covered under the IPF PPS).[6] We refer readers to the FY 2019 IPF PPS final rule (83 FR 38589) for a discussion of the background and statutory authority of the IPF Quality Reporting Program. We have codified procedural requirements and reconsideration and appeals procedures for IPF Quality Reporting Program decisions in our regulations at 42 CFR 412.433 and 412.434. Consistent with previous IPF Quality Reporting Program regulations, we refer to both inpatient psychiatric hospitals and psychiatric units as ''inpatient psychiatric facilities'' (at times, simply ''facilities'' where the context is clear) or ''IPFs.'' This usage follows the terminology in our IPF PPS regulations at § 412.402.

Section 4125(b)(1) of the Consolidated Appropriations Act of 2023 (CAA, 2023) amended section 1886(s)(4)(E) of the Act, which requires IPFs participating in the IPF Quality Reporting Program to collect and submit to the Secretary certain standardized patient assessment data, using a standardized patient assessment instrument (PAI) developed by the Secretary, for RY 2028 (FY 2028) and each subsequent rate year. We discuss proposals related to the implementation of the IPF–PAI in section IV.C. of this proposed rule.

B. Quality Measures in the IPF Quality Reporting Program

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

We are proposing to remove the Alcohol Use Brief Intervention Provided or Offered (SUB–2) and subset Alcohol Use Brief Intervention (SUB–2a) measure from the IPF Quality Reporting Program beginning with the Calendar Year (CY) 2026 reporting period/FY 2028 payment determination and subsequent years under measure removal factor 8—that is, that the costs associated with a measure outweigh the benefit of its continued use in the program—and measure removal factor 3—that is, that the measure can be replaced by a more broadly applicable measure.[7] The IPF Quality Reporting Program measure set currently includes two measures that address alcohol use disorders: SUB–2/2a, described above, and Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB–3) and the subset Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB–3a). 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 (80 FR 46699 through 46701). 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–2/2a was adopted into the IPF Quality Reporting Program beginning with the CY 2016 reporting period (80 FR 46699 through 46701), and SUB–3/3a was adopted in the program beginning with the CY 2017 reporting period (81 FR 57239 through 57241). Both measures require facilities to submit chart-abstracted measure data for a sample of IPF patient records, in accordance with established sampling policies (80 FR 46717 through 46719).

The IPF Quality Reporting Program strives to maintain a balanced set of meaningful quality measures with minimal burden. To meet that goal, we evaluated both SUB–2/2a and SUB–3/3a to ensure that the IPF Quality Reporting Program measure set is responsive to our objectives for improving quality of care and minimizing burden for facilities. We conducted an internal analysis of performance data for SUB–2 and SUB–3 to determine performance gaps and greater potential for improvement. Mean and median scores for the most recent three years of performance for both measures show room for improvement—median scores on SUB–2 and SUB–3 ranged from 0.73 to 0.79 between 2023 and 2025[8]—but we observed no substantial difference in performance between the two measures.

While SUB–2 and SUB–3 are similar measures, with similar performance rates, SUB–3/3a captures a broader patient population than SUB–2/2a—specifically, it includes patients who have screened positive for either alcohol use disorder or substance use disorder while SUB–2/2a only includes patients who have screened positive for alcohol use disorder. Therefore, we are proposing to remove the SUB–2/2a measure to reduce reporting burden associated with the IPF Quality Reporting Program. This would reduce the collection of information burden for IPFs by $13,110,832[9] per year and eliminate CMS program costs for oversight of the measure. At this time, we believe the costs of keeping the SUB–2/2a measure in the IPF Quality Reporting Program exceed the benefits of retaining the measure. The SUB–2/2a measure was also recently retired from The Joint Commission's ORYX® requirements effective CY 2026.[10] [11]

We are proposing to remove the SUB–2/2 measure from the IPF Quality Reporting measure to reduce burden on facilities for collecting and reporting these data and because the measure can be replaced by SUB–3/3a, a more

[6] We note that the statute uses the term ''rate year'' (RY). However, beginning with the annual update of the inpatient psychiatric facility prospective payment system (IPF PPS) that took effect on July 1, 2011 (RY 2012), we aligned the IPF PPS update with the annual update of the ICD codes, effective on October 1 of each year. This change allowed for annual payment updates and the ICD coding update to occur on the same schedule and appear in the same **Federal Register** document, promoting administrative efficiency. To reflect the change to the annual payment rate update cycle, we revised the regulations at 42 CFR 412.402 to specify that, beginning October 1, 2012, the IPF PPS RY means the 12-month period from October 1 through September 30, which we refer to as a ''fiscal year'' (FY) (76 FR 26435). Therefore, with respect to the IPF Quality Reporting Program, the terms ''rate year,'' as used in the statute, and ''fiscal year'' as used in the regulation, both refer to the period from October 1 through September 30. For more information regarding this terminology change, we refer readers to section III of the RY 2012 IPF PPS final rule (76 FR 26434 through 26435).

[7] The IPF Quality Reporting Program uses measure removal factors as criteria to decide when an existing quality measure should be retired from the program. Removal factors 3 and 8 are codified at 42 CFR 412.433(e)(3)(i)(C), (H).

[8] CMS internal analysis.

[9] For further discussion of the collection of information costs of this measure, see section V.C. of this proposed rule.

[10] The Joint Commission. (Oct. 2025). 2026 ORYX Performance Measurement Reporting Requirements. Available at *https://jointcommission-ddsp.atlassian.net/wiki/spaces/DCS/pages/1030619137/2026+ORYX+Performance+Measurement+Reporting+Requirements.* Accessed on: December 17, 2025.

[11] The ORYX initiative integrates performance measurement data into The Joint Commission's standards-based survey and accreditation process to support hospitals in their quality improvement efforts through the continuous monitoring and evaluation. For more details on The Joint Commission's accreditation, we refer readers to: *https://www.jointcommission.org/en-us/accreditation/performance-measurement.* Accessed on: December 17, 2025.

broadly applicable measure. However, we continue to believe that brief alcohol use interventions are valuable and encourage IPFs to continue to offer this intervention to patients for whom it is appropriate should we finalize removal of the SUB–2/2a measure from the program. We also recognize that the goals and priorities of an IPF stay vary among patients based on their clinical needs as well as personal preferences. By proposing to remove this measure we intend for IPF clinicians to collaborate with patients to prioritize the types of activities and areas of focus that best support individual patient treatment goals while reducing the burden associated with the current collection of measures related to substance use treatment. While both SUB–2/2a and SUB–3/3a address alcohol use and show similar performance trends, the retention of SUB–3/3a in the program addresses both alcohol and substance use disorder treatment in the IPF setting while reducing the burden of having two measures addressing the same condition.

We solicit public comment on this proposal.

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

We are proposing 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 Quality Reporting Program beginning with the CY 2026 reporting period/FY 2028 payment determination and subsequent years under measure removal factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.[12] TOB–3 assesses whether patients were offered evidence-based outpatient counseling and offered a prescription for FDA-approved cessation medication upon discharge. TOB–3a identifies the subset of those IPF patients who received a referral and received a prescription for FDA-approved cessation medication upon discharge. This measure began to be used in the IPF Quality Reporting Program with the CY 2016 reporting period (80 FR 46696 through 46699), and requires facilities to submit chart-abstracted measure data on a sample of IPF patient records, in accordance with established sampling policies (80 FR 46717 through 46719). Our internal analysis of performance data for TOB–3 found median scores on TOB–3 from 0.58 to 0.63 between 2023 and 2025, remaining stable over time, with no indication of improvement.[13] This suggests that this measure is no longer driving facilities to increase their offerings of these interventions.

The IPF Quality Reporting Program strives to maintain a balanced set of meaningful quality measures with minimal burden. Removal of this measure would reduce collection of information burden for IPFs by $13,110,832 [14] per year and eliminate CMS program costs for oversight of the measure. We recognize that smoking and other forms of tobacco use are common among IPF patients [15] [16] and it remains appropriate for IPFs to offer evidence-based tobacco cessation counseling and FDA-approved cessation medication to patients for whom it is clinically indicated even if we finalize the proposal to remove the TOB–3/3a measure from the program. We note the TOB–3/3a measure was also recently retired from The Joint Commission's ORYX® requirements effective CY 2026.[17] Given the burden, we believe the costs of keeping the measure in the IPF Quality Reporting Program now exceed the benefits of retaining the measure.

We solicit public comments on this proposal.

In addition, as discussed above, we recognize the prevalence of nicotine use in patients treated in IPFs, and the importance of interventions and treatment. Therefore, we are also soliciting comment on alternative ways to address this topic, potentially through the proposed standardized patient assessment, the IPF Patient Assessment Instrument (IPF–PAI), described in Section IV.C. of this proposed rule. We welcome comments on how to assess nicotine use (for example, mode of delivery, frequency of use, level of dependence) as well as treatments and interventions for nicotine use (for example, type of treatment or intervention, timing of delivery).

3. Summary of IPF Quality Reporting Program Measures for Future Years

We are not proposing any new measures for the IPF Quality Reporting Program in this proposed rule. Table 4 sets forth the measures in the FY 2028 IPF Quality Reporting Program.

TABLE 4—IPF QUALITY REPORTING PROGRAM MEASURE SET FOR THE FY 2028 IPF QUALITY REPORTING PROGRAM

Consensus-Based Entity (CBE) #	Measure ID	Measure
0640	HBIPS–2	Hours of Physical Restraint Use.
0641	HBIPS–3	Hours of Seclusion Use.
N/A	FAPH	Follow-Up After Psychiatric Hospitalization.
N/A * †	SUB–2 and SUB–2a	Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention.
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 * †	TOB–3 and TOB–3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB–3a Tobacco Use Treatment at Discharge.
1659	IMM–2	Influenza Immunization.

[12] 42 CFR 412.433(e)(3)(i)(H).

[13] CMS internal analysis.

[14] For further discussion of the collection of information costs of this measure, see section V.C. of this proposed rule.

[15] Kagabo, R., Gordon, A.J., & Okuyemi, K. (2020). Smoking cessation in inpatient psychiatry treatment facilities: A review. *Addictive Behaviors Reports, 11,* 100255. *https://doi.org/10.1016/j.abrep.2020.100255.*

[16] Fornaro, M., Carvalho, A.F., De Prisco, M., Mondin, A.M., Billeci, M., Selby, P., Iasevoli, F., Berk, M., Castle, D.J., & De Bartolomeis, A. (2021). The prevalence, odds, predictors, and management of tobacco use disorder or nicotine dependence among people with severe mental illness: Systematic review and meta-analysis. Neuroscience & Biobehavioral Reviews, 132, 289–303. *https://doi.org/10.1016/j.neubiorev.2021.11.039.*

[17] The Joint Commission. (Oct. 2025). 2026 ORYX Performance Measurement Reporting Requirements. Available at *https://jointcommission-ddsp.atlassian.net/wiki/spaces/DCS/pages/1030619137/2026+ORYX+Performance+Measurement+Reporting+Requirements.* Access on: December 17, 2025.

TABLE 4—IPF QUALITY REPORTING PROGRAM MEASURE SET FOR THE FY 2028 IPF QUALITY REPORTING PROGRAM—Continued

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 Cont	Medication Continuation Following Inpatient Psychiatric Discharge.

* Measure is no longer endorsed by the CBE but was endorsed at the time of adoption. We note that although section 1886(s)(4)(D)(i) of the Act generally requires measures specified by the Secretary be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We 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.

† We note that we are proposing to remove these measures in section IV.B. of this proposed rule for the FY 2028 payment determination. If finalized, this measure would not be included in FY 2028 IPF Quality Reporting Program measure set.

Table 5 sets forth the measures in the FY 2029 IPF Quality Reporting Program.

TABLE 5—IPF QUALITY REPORTING PROGRAM MEASURE SET FOR THE FY 2029 IPF QUALITY REPORTING PROGRAM

CBE #	Measure ID	Measure
0640	HBIPS–2	Hours of Physical Restraint Use.
0641	HBIPS–3	Hours of Seclusion Use.
N/A	FAPH	Follow-Up After Psychiatric Hospitalization.
N/A *†	SUB–2 and SUB–2a	Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention.
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 *†	TOB–3 and TOB–3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB–3a Tobacco Use Treatment at Discharge.
1659	IMM–2	Influenza Immunization.
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	IPF ED Visit	30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge.
N/A *	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge.

* Measure is no longer endorsed by the CBE but was endorsed at the time of adoption. We note that although section 1886(s)(4)(D)(i) of the Act generally requires measures specified by the Secretary be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We 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.

† We note that we are proposing to remove these measures in section IV.B. of this proposed rule for the FY 2028 payment determination. If finalized, this measure would not be included in FY 2029 IPF Quality Reporting Program measure set.

C. Proposal To Implement the Inpatient Psychiatric Facility-Patient Assessment Instrument (IPF–PAI)

1. Background

Section 4125(b)(1) of the Consolidated Appropriations Act of 2023 (CAA, 2023) amended section 1886(s)(4) of the Act, by inserting a new paragraph (E), to require IPFs participating in the IPF Quality Reporting Program to collect and submit to the Secretary certain standardized patient assessment data, using a standardized patient assessment instrument (PAI) for RY 2028 (FY 2028) and each subsequent rate year. IPFs must submit such data with respect to admissions to and discharges of an individual from the IPF, and more frequently as the Secretary determines appropriate. 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.[18] To enable meaningful comparison of the patient assessment data across all IPFs submitting data, the IPF–PAI must be standardized. Each IPF must administer the same assessment instrument with identical questions, response options, standards and definitions.[19]

In the FY 2025 IPF PPS proposed rule, we solicited comments for consideration in the development of a standardized assessment instrument (89 FR 23200 through 23204). Specifically, we solicited comment on the following considerations: a set of principles for selecting standardized patient assessment data elements [20] (to include overall clinical relevance; interoperable exchange to facilitate care coordination during transitions in care; ability to capture medical complexity and risk factors that can inform both payment and quality; and scientific reliability and validity, including general consensus agreement for its usability); any patient assessments recommended for use in the IPF–PAI on clinical topics related to the data categories required by statute; implementation considerations; and the relationship between the IPF–PAI and the IPF Quality Reporting Program, such as use of IPF–PAI data in program measures. In the FY 2026 IPF PPS proposed rule, we further solicited comments for consideration with respect to potential interoperable exchange of IPF–PAI data using the Fast Healthcare Interoperability Resources® (FHIR®) [21] standards (90 FR 18520 through 18523).

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

Between 2023 and 2025, CMS and its contractors engaged in a multi-stage process to conceptualize and scope a new, statutorily mandated PAI for the IPF setting that included: identifying key clinical topic areas within the broad CAA, 2023 data categories, identifying and evaluating candidate assessment items within those topic areas, and conducting formative (alpha) and field (beta) testing on those candidate assessment items. This process also included engagement with subject matter experts, clinicians and administrators at IPFs, and individuals who have experience as patients in an IPF setting, as well as guidance from interoperability experts on how to structure assessment items and their related data elements so that the patient-level data that are collected by the IPF–PAI would be interoperable and aligned with current health IT standards.

We first identified key topics and candidate assessment items that aligned with the data categories identified in section 1886(s)(4)(E)(ii) of the Act by reviewing clinical practice guidelines; papers and reports from academic journals, government agencies, and other organizations; clinical assessments related to inpatient psychiatric care; and existing standardized patient assessment data elements used in other provider settings. We reviewed the United States Core Data for Interoperability (USCDI) [22] and USCDI+ Behavioral Health [23] data elements to understand the interoperable data landscape for inpatient acute care as well as outpatient and ambulatory behavioral health care. We also considered comments submitted in response to the requests for information in the FY 2025 IPF PPS final rule (89 FR 64645 through 89 FR 64650) described above. Candidate assessment items were reviewed for relevance and feasibility for the IPF setting, as well as the potential to capture resource use or quality of care. An initial list of candidate assessment items selected from our review was advanced to subsequent phases of testing and expert input. Formative (alpha) testing was conducted to evaluate the feasibility and face validity of candidate assessment items in the IPF setting. Field (beta) testing was conducted to assess inter-rater reliability (IRR),[24] estimate burden, and to confirm content validity and feasibility in the IPF setting. More information about the design and results of the testing is available in the IPF–PAI Testing Report, available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* In addition, a technical expert panel (TEP) was convened by the IPF–PAI development contractor to give input on the extent to which topics of assessment items were clinically relevant to patient care in IPFs, likely to inform CMS' understanding of resource use or costs of care, and considered feasible and relatively low burden to collect. The TEP included clinicians and administrators at IPFs, behavioral health clinicians, academic researchers, health information technology specialists, and individuals who have experience as patients in an IPF setting. More information on the two meetings of the TEP held during IPF–PAI development is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.*

3. Proposal To Implement the Inpatient Psychiatric Facility Patient Assessment Instrument (IPF–PAI) in the IPF Quality Reporting Program

a. Proposed IPF–PAI

We propose 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. This initial version of the IPF–PAI is intended to meet our statutory obligation to collect standardized patient assessment data on each of the statutorily-delineated data categories [25] while being mindful of reporting burden on IPFs; we purposefully selected a minimal set of assessment items to propose at this time. We reiterate that the IPF Quality Reporting Program strives to maintain a minimal set of requirements while meeting statutory requirements and encouraging quality through transparency and public reporting. To that end, the proposed IPF–PAI is also intended to establish a structure and processes for data collection and submission that we can modify or expand through future rulemaking, to stay responsive to priorities of IPF quality and payment. Future enhancements may include the addition, removal, or changes of assessment items, but we also anticipate using results and feedback from the proposed IPF–PAI to propose revisions or improvements to policies that will increase utility or reduce burden of the IPF–PAI for patients and IPFs.

We propose that IPFs paid under the IPF PPS be required to complete the IPF–PAI for all patients aged 18 and older. Assessment items should be administered at admission and discharge, except where specified in the proposals below. Later in this section, we discuss the standardized patient assessment items and related data

[18] Sections 1886(s)(4)(E)(ii)(I) through 1886(s)(4)(E)(ii)(VI) of the Act.

[19] We note that while the proposed data elements of the proposed IPF–PAI would be standardized—that is, identical question and identical sets of response options—standardization does not extend to the order of the data elements within the instrument.

[20] While this RFI discussed ''data elements,'' we note that we have transitioned to using the term ''assessment items'' to refer to the components of the standardized patient assessment.

[21] FHIR® is the registered trademark of Health Level Seven International (HL7) and the use does not constitute endorsement by HL7.

[22] *https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.* Accessed February 4, 2026.

[23] *https://www.healthit.gov/topic/interoperability/uscdi-plus.* Accessed February 4, 2026.

[24] Interrater reliability is the extent of agreement among data collectors. See: McHugh, M.L., 2012. Interrater reliability: the kappa statistic. *Biochemia medica, 22*(3), pp.276–282.

[25] Sections 1886(s)(4)(E)(ii)(I) through 1886(s)(4)(E)(ii)(VI) of the Act.

elements for the initial version of the IPF–PAI. We refer readers to section IV.C.4. of this proposed rule for more information on the proposed method and schedule for data submission, as well as compliance thresholds for annual payment determination under the IPF Quality Reporting Program.

We acknowledge that this new requirement of the IPF Quality Reporting Program may impact workflow and increase administrative burden, especially in the first year of implementation as IPFs become familiar with the assessment and work to integrate it into their workflows. The assessment items discussed in section IV.3.b that will comprise the IPF–PAI are proposed to be collected at admission and discharge. We estimate that completing both assessments for a patient would take 14.7 minutes, and that the majority of administrative and clinical data on the IPF–PAI would be available in the patient's medical record as part of routine medical record keeping practices. We refer readers to section V.C.3. of this proposed rule for further discussion of the estimated costs associated with the collection of the IPF–PAI.

We propose to codify the IPF–PAI as part of the IPF Quality Reporting Program at § 412.433(a) and (d) by adding ''standardized patient assessment data'' in the description of the statutory authority and as a type of data that IPFs that participate in the IPF Quality Reporting Program must submit to CMS.

We solicit comment on these proposals.

Additionally, we solicit comment on the proposed age requirement for the IPF–PAI of 18 years and older, specifically the potential inclusion of adolescents in the population for the IPF–PAI. Are there any specific guardrails or sensitivities CMS should consider with the potential inclusion of adolescents, or specific assessment items that would not be appropriate for this population?

b. Proposed Assessment Items for the IPF–PAI

The proposed IPF–PAI would collect data related to the five statutory data categories specified in section 1886(s)(4)(E)(ii) of the Act and fulfill the requirements of section 4125(b) of the CAA, 2023 for a standardized assessment instrument. In the FY 2025 IPF PPS proposed rule (89 FR 23200 through 23204) we issued a Request for Information (RFI) to solicit public input to inform the development of the IPF–PAI. In this RFI, we noted that goals for the IPF–PAI include improving the quality of care in IPFs and improving the accuracy of the IPF PPS. As provided by section 1886(s)(6) of the Act, added by section 4125(b) of the CAA, 2023, data collected through the IPF–PAI may be considered in future revisions to the methodology for determining the IPF PPS payment.

Standardized assessment items generally take the form of a question or instructional text that is followed by a set of response options. For example, the assessment item *Speech Clarity* would contain instructional text ''Select best description of speech pattern,'' and three response options: 0. Clear speech—distinct intelligible words; 1. Unclear speech—slurred or mumbled words; 2. No speech—absence of spoken words. Responses to assessment items can also take the form of structured numeric or text input, such as the responses given to Admission Date or Patient Last Name. These assessment items are standardized in the sense that all IPFs will be assessing patients using the same assessment items—that is, the same question or instructions and response options. In this proposal of assessment items to include in the IPF–PAI, we refer to the name of the assessment item. The complete assessment items, including instructional text and response options, are shown together on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* The IPF–PAI Item Set is a PDF document that shows the proposed assessment items displayed like a questionnaire. In order to support consistency in the administration of the IPF–PAI, as we have done for assessment instruments used in post-acute care settings, we will provide IPFs with a detailed reference manual that would provide additional guidance. A draft of the IPF–PAI Guidance Manual is available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.*

We propose to include in the IPF–PAI assessment items for each of the five data categories required by statute, and data elements in a category of administrative items as an additional category determined appropriate by the Secretary that are necessary for record matching and database management. Table 6 lists the proposed IPF–PAI assessment items by category. The Admission and Discharge forms that contain the proposed assessment items of the IPF–PAI are available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* For additional information on the testing process and the testing results in further details, we refer readers to the IPF–PAI Testing Report, available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.*

TABLE 6—PROPOSED ASSESSMENT ITEMS TO BE INCLUDED IN THE IPF–PAI

CAA, 2023 category	Proposed assessment item
Functional status	Mobility: Chair/Bed-to-Chair Transfer.
Cognitive function and mental status	Suicide Screening.
Special services, treatments, and interventions	Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting (Psychiatric Treatments, Restrictive Interventions).
Medical conditions and comorbidities	Primary Medical Condition Category.
Impairments	Hearing; Speech Clarity; Vision.
Administrative: Assessment items required for record matching and database management.	Legal Name of Patient, Birth Date, Sex, Social Security and Medicare Numbers, Facility Provider Numbers (National Provider Identifier, CMS Certification Number), Admission/Discharge Date, Payer Information—Primary Payer, Type of Record, Assessment Reference Date, Reason for Assessment, Type of Admission/Type of Discharge, IPF–PAI Completion Date.

Evidence from field (beta) testing and engagement with experts and interested parties support these proposed assessment items as meeting our goals for the IPF–PAI, as stated in prior rulemaking (89 FR 23200 through 23204): clinically relevant to patients in IPFs; standardized and interoperable; capturing medical complexity and risk factors that can inform payment and quality; and reliable and valid, with consensus agreement for usability (89

FR 23200 through 23204). To determine the clinical relevance to patients in IPFs and the ability of assessment items to capture medical complexity and risk factors that would inform payment and quality, we sought and summarized input through the RFI in the FY 2025 IPF PPS proposed and final rules (89 FR 64642 through 64649). Building on that feedback we reviewed potential assessment items with CMS Medical Officers and engaged with clinicians through a TEP. To ensure that the assessment items allowed data to be captured in a standardized format we evaluated the Inter-rater Reliability (IRR) of each of the items as part of our field (beta) testing. High IRR scores show that the data are likely to be standardized across different raters at different IPFs. We also evaluated each assessment item in the field (beta) test for feasibility. Information about the TEP's input on each assessment item is included in the following subsections. Information about field (beta) test results for IRR and feasibility is included in Table 7.

We note that the IPF–PAI was developed and would be implemented in a way to support interoperable exchange of data. The standardized assessment items and response options are intended to yield comparable data across IPFs. The assessment items would be managed centrally in CMS' Data Element Library (DEL),[26] enabling consistency in usage across versions or updates. Each assessment item is represented as a machine-readable data element with a stable identifier and metadata, such as definition, datatype, and permissible values. The DEL would assign LOINC [27] and SNOMED [28] codes to questions and response options, where possible; LOINC and SNOMED are widely-used terminology standards for clinical data that support consistent meaning across systems.

i. IPF–PAI Functional Status Category

Section 1886(s)(4)(E)(i)(I) of the Act requires the inclusion of patient assessment data with respect to functional status, such as mobility and self-care at admission to an IPF and before discharge from an IPF. We propose the assessment item *Mobility: Chair/Bed-to-Chair Transfer* for the Functional Status category of the IPF–PAI. This assessment item evaluates the patient's physical ability to move around, one of the basic activities of daily living. Specifically, the proposed assessment item captures the patient's ability to transfer to and from a bed to a chair (or wheelchair). For patients who do not complete this activity independently, the level of assistance required would need to be recorded. This information would be recorded by selecting the patient's functional status from the options provided. The instructional text and response options are included in the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* For results of inter-rater reliability (IRR) and feasibility from field (beta) testing, see Table 7. Most TEP members (78 percent) responded Strongly Agree or Agree to including the *Mobility* assessment item on the IPF–PAI.

ii. IPF–PAI Cognitive Function and Mental Status Category

Section 1886(s)(4)(E)(i)(II) of the Act requires the inclusion of patient assessment data with respect to cognitive function, such as the ability to express ideas and to understand, and mental status, such as depression and dementia. We propose the assessment item *Suicide Screening* for the Cognitive Function and Mental Status category of the IPF–PAI. We note that we do not consider suicide-related thoughts and behaviors to be related to cognitive impairment. Rather, we understand mental status to encompass a wide range of cognition, orientation, mood, and decision-making capacities, including thought content. In our review of IPFs' core clinical assessment practice, the mental status exam,[29] we identified screening for suicidal thoughts and behaviors to be an important clinical topic with relevance to quality of care and resource use.

The assessment item evaluates whether and with what method a patient was screened for suicide risk. This information would be recorded by indicating that a patient was screened with a standardized tool, screened through clinical assessment, or not screened, in the case that the patient declined or was unable to respond. This assessment item, including instructional text and response options, is shown on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* For results of IRR and feasibility from field (beta) testing, see Table 7. All TEP members (100 percent) responded Strongly Agree or Agree to including a *Suicide Screening* assessment item on the proposed IPF–PAI. After the field (beta) test and receiving TEP input, we revised this assessment item based on further input from individuals who have experience as patients in an IPF, clinical subject matter experts, and assessment item developers to reduce complexity. We believe the proposed assessment item included in the IPF–PAI is less complex and easier for IPFs to implement than the version used in testing.

iii. IPF–PAI Special Services, Treatments, and Interventions for Psychiatric Conditions Category

Section 1886(s)(4)(E)(i)(III) of the Act requires the inclusion of patient assessment data with respect to special services, treatments, and interventions for psychiatric conditions. We propose the assessment item *Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting* for the Special Services, Treatments, and Interventions category of the IPF–PAI. This assessment item requires the assessor to indicate which psychiatric treatments, or restrictive interventions may have been used during the IPF stay.

Psychiatric Treatments and Restrictive Interventions allow the assessor to check off all that apply from the list. Psychiatric Treatments include medications, brain stimulation, and non-pharmacological treatments other than brain stimulation. Restrictive Interventions, which we focused on because of their particular use in the IPF setting, include the use of seclusion, restraints, or other restrictive interventions. This assessment item, including instructional text and response options, is shown on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* For results of IRR and feasibility from field (beta) testing, see Table 7. When asked

[26] *https://del.cms.gov/DELWeb/pubHome.* Accessed March 19, 2026.

[27] *https://loinc.org/.* Accessed March 19, 2026.

[28] *https://www.snomed.org/.* Accessed March 19, 2026.

[29] Voss RM, Das JM. Mental Status Examination. [Updated 2024 Apr 30]. In: StatPearls [internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available at *https://www.ncbi.nlm.nih.gov/books/NBK546682/.*

about their agreement for including the six treatment or intervention types, most TEP members replied Strongly Agree or Agree (100 percent for Medications; 89 percent for Brain Stimulation, Non-pharmacological Treatment, Seclusion, and Restraints; and 67 percent for Other Restrictive Interventions).

We noted that the IRR for some assessment items in this category were low. In our investigation of the low reliability statistics for the treatment or intervention *Non-pharmacological Treatment,* which included reviewing the testing data, comparing discrepancies in coding responses, and reviewing the hypothetical case studies and guidance manuals, we determined that the structure and definitions in some of the assessment items related to this treatment/intervention type were not well understood. We did not find this to be unexpected considering the complexity of the assessment item (that is, a multi-part, branch item), and that IPF staff were unfamiliar with administering this assessment. Non-pharmacological treatments, including but not limited to psychotherapy and psychosocial interventions, are recommended by clinical practice guidelines,[30] [31] and have been shown to be beneficial to patients.[32] [33] For these reasons, we consider it important to retain an assessment item on this topic. As noted, 89 percent of TEP members responded Strongly Agree or Agree with the inclusion of *Non-pharmacological Treatment* in the IPF–PAI. We believe low reliability indicates a need for targeted support, by means of revising the guidance manual to provide distinct definitions for each component of this assessment item, examples of coding to emphasize the multi-part nature of the item, provider training, and focused Frequently Asked Questions documents to help select the appropriate response, which we will develop and provide if this proposal is finalized.

iv. IPF–PAI Medical Conditions and Comorbidities Category

Section 1886(s)(4)(E)(i)(IV) of the Act requires the inclusion of patient assessment data with respect to medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers. We propose the assessment item *Primary Medical Condition* for the Medical Conditions and Comorbidities category of the proposed IPF–PAI. This assessment item captures the category of the primary diagnosis associated with the IPF stay; assessors would select their response from the list of common diagnostic categories (for example, anxiety disorders, mood disorders, schizophrenia and other psychotic disorders). This assessment item, including instructional text and response options, is shown on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* For results of IRR and feasibility from field (beta) testing, see Table 7. Most TEP members (89 percent) responded Strongly Agree or Agree to including the *Primary Medical Condition* data element on the IPF–PAI. In future potential versions of the IPF–PAI, we could consider the addition of secondary mental health and physical conditions and comorbidities.

v. IPF–PAI Impairments Category

Section 1886(s)(4)(E)(i)(V) of the Act requires the inclusion of patient assessment data with respect to impairments, such as incontinence and an impaired ability to hear, see, or swallow. We propose the *Hearing, Speech Clarity,* and *Vision* assessment item for the Impairments category of the IPF–PAI. In these assessment items, the assessor records a patient's ability to hear, a description of their speech pattern, and their ability to see in adequate light by selecting the level of impairment from a set of response options within each assessment item. These assessment items, including instructional text and response options, are shown on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* We propose that the *Hearing, Speech Clarity,* and *Vision* assessment item be evaluated at admission only, in recognition that they are unlikely to change during the IPF stay, which is typically brief (about 7 days, on average [34]). For results of IRR and feasibility from field (beta) testing, see Table 7. When asked about their agreement for including these assessment items in the proposed IPF–PAI, most TEP members replied Strongly Agree or Agree (89 percent for Hearing; 78 percent for Speech Clarity; 67 percent for Vision).

TABLE 7—FIELD (BETA) TESTING RESULTS FOR PROPOSED ASSESSMENT ITEMS FOR THE IPF–PAI

Assessment item and related data elements	Inter-rater reliability (IRR)		Feasibility ‡
	% Agreement	Cohen's Kappa	
Mobility: Chair/bed-to-chair transfer	75.18	Moderate (0.44)	Y
Suicide Screening	89.78	(*)	Y
Special Services, Treatments, and Interventions: Psychiatric Interventions			
Psychiatric Treatments			
Medications	94.89	(*)	Y
Brain Stimulation	100.00	(†)	Y
Non-pharmacological treatment other than brain stimulation	36.50	(*)	Y
Restrictive Interventions			
Seclusion	77.37	Poor (0.13)	Y

[30] Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition (2021) *https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424841.*

[31] VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder Version 4.0—2022. VA/DoD Clinical Practice Guideline. (2022). The Management of Major Depressive Disorder Work Group. Washington, DC: U.S. Government Printing Office. *https://www.healthquality.va.gov/guidelines/MH/mdd/.*

[32] McGuire, Alan B., et al. ''Recovery-oriented inpatient mental health care and readmission.'' Psychiatric *Rehabilitation Journal* 45.4 (2022): 331.

[33] Kinney, Adam R., et al. ''Association of inpatient occupational therapy utilization with reduced risk for psychiatric readmission among Veterans.'' *Psychiatric Services* 75.11 (2024): 1084–1091.

[34] Weighted national estimates from HCUP National (Nationwide) Inpatient Sample (NIS), 2018 to 2022, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual State Partners and provided to AHRQ. Source: HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. *https://datatools.ahrq.gov/hcupnet.* Accessed February 4, 2026.

TABLE 7—FIELD (BETA) TESTING RESULTS FOR PROPOSED ASSESSMENT ITEMS FOR THE IPF–PAI—Continued

Assessment item and related data elements	Inter-rater reliability (IRR)		Feasibility ‡
	% Agreement	Cohen's Kappa	
Restraints	94.89	Very Good (0.86)	Y
Other restrictive interventions	36.50	Poor (0.08)	Y
None of the Above	98.54	(*)	Y
Primary Medical Condition Category	75.18	Good (0.64)	Y
Hearing	85.40	Good (0.74)	Y
Speech Clarity	93.43	Very Good (0.83)	Y
Vision	62.77	Fair (0.23)	Y

Note: In the field (beta) test, IRR was assessed by calculating both percent agreement (that is, the percent of assessment items that were coded correctly by assessors, as determined by clinical subject matter experts) and Cohen's kappa. Interpretation of Cohen's kappa used standard categories of Poor, Fair, Moderate, Good, and Very Good as defined by Altman, D.G. (1990). *Practical statistics for medical research.* Chapman and Hall/CRC.

* Kappa not calculated due to low item response variability. That is, responses to the assessment item or assessment item components across raters were too similar for Kappa to be a useful measure of inter-rater reliability.

† Kappa not calculated due to perfect agreement.

‡ We considered an assessment item to be feasible for use in the IPF setting if data were able to be collected from over 90 percent of patients assessed (that is, <10 percent missing data) and if no feedback was received around challenges or obstacles to assessing the assessment item from IPF staff who participated in the field (beta) test.

vi. Proposed Administrative Data Category

Section 1886(s)(4)(E)(ii)(VI) of the Act authorizes other categories of assessment items as determined appropriate by the Secretary. In addition to the assessment items discussed above, we propose including an Administrative data category to collect certain administrative information to enable database management and record matching. Collecting data in this category would support accurate linkage of assessment records within CMS' internet Quality Improvement and Evaluation System (iQIES),[35] or a successor system, and facilitate analyses by CMS, including linking assessment data with other CMS data sources (for example, payment and claims data). These data could also enable stratification of outcomes by patient and stay characteristics, which would support accurate comparisons between facilities and patient populations. These proposed data elements include: Legal Name of Patient, Birth Date, Sex, Social Security and Medicare Numbers, Facility Provider Numbers (National Provider Identifier, CMS Certification Number (CCN)), Admission/Discharge Date, Payer Information—Primary Payer, Type of Record, Assessment Reference Date, Reason for Assessment, Type of Admission/Type of Discharge, and IPF–PAI Completion Date. These assessment items, including instructional text and response options, are shown on the IPF–PAI Item Set, available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI.* Additionally, detailed instructions for administration would be provided through training and the IPF–PAI Guidance Manual, the draft of which is available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.* We propose that assessment items for the Administrative category be collected at both admission and discharge.

We invite public comment on these proposals.

4. Form, Manner, and Timing of Data Collection and Submission of the Proposed IPF–PAI

In this section, we discuss how we propose to incorporate the IPF–PAI into the IPF Quality Reporting Program, including the timing and form of initial data collection.

a. Proposed Reporting Periods and Data Submission Deadlines for the IPF–PAI Beginning With Data Collection in FY 2028 Impacting the FY 2029 Payment Determination

We propose mandatory reporting of the proposed IPF–PAI beginning with a reporting period of October 1, 2027, through December 31, 2027, impacting the FY 2029 payment determination. That is, IPFs would be required to collect and submit IPF–PAI admission and discharge assessments for all patients age 18 years and older, regardless of payer, beginning October 1, 2027; admission and discharge assessments conducted October 1, 2027, through December 31, 2027, would impact the FY 2029 payment determination.

Beginning with the FY 2030 payment determination and for subsequent years, we propose that an IPF must report data with respect to admissions and discharges for all patients age 18 years and older that occur during the calendar year from January 1 through December 31, that is, the calendar year two years preceding the FY payment determination year (for example, January 1, 2028 through December 31, 2028 for the FY 2030 payment determination, January 1, 2029 through December 31, 2029 for the FY 2031 payment determination, and so on). We propose that for each calendar year reporting period, the IPF–PAI data must be submitted as quarterly reporting periods by a submission deadline of the 15th day of the second month after the end of the calendar quarter, as outlined in Table 8. See Table 8 for submission deadlines through the FY 2031 payment determination. We would also publish upcoming submission deadlines on the CMS QualityNet website at *https://qualitynet.cms.gov/.*

Specifically for the purposes of determining which applicable reporting quarter the admission or discharge falls within, we propose to use the Assessment Reference Date (ARD) associated with each admission and discharge. The Admission ARD would be not later than 3 days after the admission and the Discharge ARD would be the day of discharge. We propose to require that an IPF submits an admission assessment by the 15th day of the second month after the end of the calendar quarter in which the ARD for the admission assessment occurred.[36] We likewise propose that an IPF submits a discharge assessment by the 15th day of the second month after the calendar quarter in which the ARD for the discharge occurred. The

[35] *https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/internet-quality-improvement-evaluation-system-iqies.* Accessed February 5, 2026.

[36] For example, an admission that occurs on September 30 has an admission reference date (Day 3) of October 2. The IPF would submit those data with Quarter 4 data (ARD), not Quarter 3 data (admission date).

proposed submission deadlines and associated payment determination years for the first nine quarters of IPF–PAI data collection are shown in Table 8. We note that when the submission deadline falls on a Friday, Saturday, Sunday, or Federal holiday, we would move the data submission deadline to the next business day.

TABLE 8—PROPOSED DATA SUBMISSION DEADLINES AND ASSOCIATED PAYMENT DETERMINATION YEARS FOR THE IPF–PAI

Quarter of IPF–PAI data collection	Data submission deadline *	Applicable payment determination
Q4 2027 (Oct 1–Dec 31, 2027)	February 15, 2028	FY 2029.
Q1 2028 (Jan 1–Mar 31, 2028)	May 15, 2028	FY 2030.
Q2 2028 (Apr 1—Jun 30, 2028)	August 15, 2028.	
Q3 2028 (Jul 1–Sept 30, 2028)	November 15, 2028.	
Q4 2028 (Oct 1–Dec 31, 2028)	February 15, 2029.	
Q1 2029 (Jan 1–Mar 31, 2029)	May 15, 2029	FY 2031.
Q2 2029 (Apr 1–Jun 30, 2029)	August 15, 2029.	
Q3 2029 (Jul 1–Sept 30, 2029)	November 15, 2029.	
Q4 2029 (Oct 1–Dec 31, 2029)	February 19, 2030.	

* Submission deadlines reflect consideration of federal holidays and weekends. When that occurs, the data submission deadline will be moved to the next business day.

Notwithstanding the proposed quarterly submission deadlines of IPF–PAI data described in this section, based on best practices learned from our long-standing experience with standardized patient assessment instruments for post-acute care providers, we recommend rolling submissions of IPF–PAI records to CMS throughout the data collection period as patients are admitted and discharged for more timely, accurate, and efficiently collected assessment data. We describe the proposed data submission methods in section IV.C.4.c. of this proposed rule. Ongoing submission of IPF–PAI records would allow an IPF to monitor their compliance rates through on-demand provider reports available through iQIES. We would issue technical sub-regulatory guidance for the IPF–PAI assessment items and data collection, including recommended frequency of submissions via the IPF–PAI Guidance Manual (draft available under IPF–PAI Resources at *https://qualitynet.cms.gov/ipf/PAI*).

We invite public comment on these proposals.

b. Proposed Compliance Threshold for the IPF–PAI To Receive the Applicable Annual Payment Update Beginning With the FY 2029 Payment Determination

We propose that an IPF would need to complete 100 percent of the IPF–PAI assessment items on 80 percent of the IPF–PAIs submitted to satisfy the IPF Quality Reporting Program data reporting requirements for the applicable annual payment determination. An IPF that fails to submit 100 percent of the assessment items on at least 80 percent of the IPF–PAIs submitted to CMS would be deemed non-compliant with the IPF Quality Reporting Program reporting requirements and, as a result, would be subject to a 2 percentage point reduction to its APU as required by section 1886(s)(4)(A) of the Act.

We are proposing this 80 percent threshold as a starting point (rather than proposing a 100 percent threshold), understanding that it will take time for IPFs to become familiar with the data collection and submission workflows of this new program requirement. We will monitor data completion rates and provide training and other implementation resources to help IPFs be successful in meeting or exceeding the 80 percent completion threshold. Over time, in future rulemaking, we plan to incrementally increase the completion rate that an IPF would need to achieve in order to be considered compliant with the IPF Quality Reporting Program. We adopted a similar approach of incrementally increasing the compliance threshold over time with the standardized patient assessment instruments used by post-acute care providers.

For the FY 2029 payment determination, the compliance rate for each IPF would be calculated for the Q4 2027 reporting quarter. For the FY 2030 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).

We propose to codify the data completion threshold of 100 percent of assessment items for at least 80 percent of submitted assessments for the IPF–PAI at the proposed new § 412.433(h).

We invite public comment on these proposals.

c. Proposed Methods of Data Submission for IPF–PAI

i. Background

In the FY 2026 IPF PPS proposed rule (90 FR 18520 through 18523), we requested comments on the potential use of the FHIR® standard for IPF–PAI data submission because we believe that the collection and submission of data through health information technology (IT), including digital capture and transfer of program data through FHIR®, could reduce administrative burden on IPFs submitting the IPF–PAI in the long-term. In response to this request for comment, commenters expressed support for CMS' intent to transition to the FHIR-based standard in the IPF Quality Reporting Program, particularly for the IPF–PAI, noting the opportunity for a FHIR-based standard to improve care coordination, enable actionable insights, and integrate structured data into electronic health records (EHRs) (90 FR 37665 through 37666). A few commenters highlighted the potential for FHIR® to modernize behavioral health data reporting, enhance discharge planning, and enable meaningful performance measurement. As IPFs have not yet used FHIR® for program data submission, we acknowledge that technological, monetary, and staffing barriers may present challenges to adoption and use in some facilities. Therefore, for the proposed mandatory submission of IPF–PAI data, we would offer facilities two tools to integrate into their existing systems and workflows:

- Web application (web app)
- FHIR® application programming interfaces (APIs)

We describe these submission methods in detail in the following sections.

Both methods of data submission would require user or system authentication using CMS' Health Care

Quality Information Systems (HCQIS) Access Roles and Profile (HARP), or a successor or equivalent CMS-designated identity management system, consistent with CMS security and access control requirements. This is the same identity management system that IPFs and their vendors currently use to submit other IPF Quality Reporting Program data to the CMS Hospital Quality Reporting system. Both proposed methods of IPF–PAI data submission would transmit IPF–PAI data securely to CMS, using data security standards required for any CMS system, where it would be received and reside in the iQIES environment. iQIES is CMS' long-standing system for patient assessment data; post-acute care providers have been reporting assessment data electronically to iQIES since 2019. Data transfer to CMS via either method—the FHIR® API or web app—would follow standard HIPAA-compliant encryption protocols.

If finalized, the IPF Quality Reporting Program would be the first CMS statutory quality reporting program to use the FHIR® standard to support patient assessment data submission, as both data submission methods—the free web app and the FHIR® API—are reliant on underlying FHIR® resources.[37] Introducing the FHIR® standard to the IPF Quality Reporting Program involves establishing related policies and requirements, such as submission methods, data standards and formats, and other program-specific requirements.

ii. Proposed Web App Method of Data Submission for IPF–PAI Data

We propose a CMS-developed web app as a method for collecting and submitting IPF–PAI data to the iQIES system via the internet. We would provide and maintain this web app for IPFs to use, free of charge, to enter and submit the proposed IPF–PAI admission and discharge assessments for individual patients. An IPF would be able to review, correct, and change these data until the close of each submission deadline using the web app. An IPF could use a third party vendor to submit IPF–PAI data via the web app on the IPF's behalf. The open-source web app would be accessible in one of two ways: directly through a web browser, or configured for launch from an EHR using Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR®.[38] In accordance with the Source code Harmonization And Reuse in Information Technology Act (SHARE IT Act; Pub. L. 118–187), we would ensure that the source code, documentation, configuration scripts, as appropriate, revision history, and other files are located in a software storage location (that, a public repository) to which access is open to the public.

We plan to make this web app available in spring or summer 2027, prior to the start of the proposed reporting period that would begin October 1, 2027, to allow time for IPFs to gain familiarity with the web app and for CMS to provide training.

We invite public comment on this proposal.

iii. Proposed FHIR® API Method of Data Submission for IPF–PAI Data

We propose the use of two APIs we have built from the HL7 FHIR® specification,[39] 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.[40] For healthcare data exchange using an API, the FHIR standard defines how such data are structured and exchanged. It organizes the data into discrete clinical and administrative units called resources, such as Patient, Observation, Condition, Medication, and Encounter.[41] [42] This method is suitable for IPFs that use health IT or that engage with third-party vendors to implement a custom tool or a custom SMART on FHIR application using the APIs we have developed to collect and submit IPF–PAI data to CMS. Under this proposed submission method, an IPF could integrate IPF–PAI data collection and submission within their EHR workflow using one API to retrieve the applicable IPF–PAI assessment items from the EHR, and another API to submit IPF–PAI data to CMS. An IPF could also use a third party vendor to submit IPF–PAI data via the FHIR® API on the IPF's behalf.

For this proposed implementation of the IPF–PAI, the Data Element Library (DEL) FHIR® API and associated DEL FHIR Implementation Guide would support the retrieval of the assessment items, and the iQIES FHIR® API and associated iQIES FHIR Receiving System Implementation Guide would support the assessment data submission to CMS. Current draft versions of the DEL FHIR Implementation Guide and the iQIES FHIR® Receiving System Implementation Guide are accessible at *https://qualitynet.cms.gov/ipf/PAI.* These implementation guides would be updated as needed on an annual basis for technical updates and published at the same location. Annual updates would be limited to technical, non-substantive updates; substantive changes to the IPF–PAI would be implemented through notice and comment rulemaking. IPFs and their vendors would need to use the most recently published implementation guides for the applicable IPF–PAI reporting period, which we would publish at least six months before the beginning of the applicable reporting period. Additional technical resources for IPFs and health IT vendors would be made available at *https://qualitynet.cms.gov/ipf/PAI* from time to time to support FHIR® API implementation. We would also engage with software developers and vendors through various interested parties engagement efforts, during which we would respond to questions, comments, and suggestions about technical requirements.

We recognize that IPFs and the health IT vendors that support IPFs would require time to develop and implement data collection and submission tools for the proposed IPF–PAI. Therefore, we propose that, if an IPF does not submit IPF–PAI data via the FHIR® API method proposed in section IV.C.4.d.ii of this proposed rule, the IPF would be required to use the web app for IPF–PAI data submission. Likewise, if an IPF does not submit IPF–PAI data using the web app, the IPF would not meet the IPF–PAI data submission requirement unless the IPF submits the data via the FHIR® API method proposed in section IV.C.4.d.iii. of this proposed rule.

We invite public comment on these proposals.

[37] Either method of IPF–PAI data submission includes an opportunity to use the Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR® framework to either configure an EHR-launched workflow that securely authenticates and launches the web app, or to implement a custom SMART on FHIR® application, developed by an IPF or a third-party vendor, that integrates with the publicly available CMS FHIR® APIs.

[38] SMART on FHIR® is a set of standards that enables third-party application to securely integrate with electronic health records. *https://smarthealthit.org/.*

[39] For more information on the FHIR® standard, we refer readers to *https://hl7.org/fhir/R4/overview-arch.html.* Accessed March 19, 2026.

[40] *https://www.nnlm.gov/resources/data-glossary/application-program-interface-api.* Accessed March 19, 2026.

[41] *https://ecqi.healthit.gov/fhir/about.* Accessed March 19, 2026.

[42] *https://hl7.org/fhir/terminology-module.html.* Accessed March 19, 2026.

Additionally, we invite public comment on ways that CMS can reduce burden in implementing the IPF–PAI. For example, are any of the requirements currently proposed for the IPF–PAI duplicative of any other CMS reporting and recordkeeping requirements?

5. Maintenance of Technical Specifications for the IPF–PAI

a. Background

In the FY 2013 IPPS/LTCH PPS final rule, we adopted a policy to use a subregulatory process to make non-substantive updates to measures used in the IPF Quality Reporting Program, to make the determination of what constitutes a substantive versus a nonsubstantive change on a case-by-case basis, and to continue to use rulemaking to adopt substantive updates (77 FR 53653). In addition, in the FY 2014 IPPS/LTCH PPS final rule, we established a policy under which we provide and maintain information to support collection of measures used in the program (78 FR 50896). As part of this policy, we provide a user manual with links to measure specifications, data abstraction information, data submission information, and other information necessary for IPFs to participate in the IPF Quality Reporting Program. We maintain this manual at the IPF Quality Reporting Program Quality Net website at *https://qualitynet.cms.gov/ipf/specifications-manuals.* In addition, we update technical specifications in this manual periodically, notify program participants of changes, and strive to provide sufficient time to allow users to respond to changes.

b. Proposal To Adopt Policy for Maintenance of Technical Specifications for the IPF–PAI

In alignment with our policy for maintaining the IPF Quality Reporting Program specifications manual for quality measures, described in the previous sub-section, we propose that non-substantive updates to the technical specifications for the IPF–PAI would be made through subregulatory mechanisms such as website postings and listserv messaging. Non-substantive updates could include minor changes to data collection or submission specifications, such as might be required to align with updates to FHIR or other health IT standards, and will be determined on a case-in-case basis. We would provide notification of any future changes to the CMS designated system and the required format for IPF–PAI data submission designated by CMS to IPFs and vendors using subregulatory mechanisms including updates of technical specifications in the Guidance Manual and Implementation Guides as well as through our regular program communication channels such as website postings, listserv messaging, and webinars. We note that substantive changes to the IPF–PAI, such as the addition or removal of data categories or assessment items or changes in the data collection deadlines, would be done through rulemaking.

We invite public comment on this proposal.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs). Comments, if received, will be responded to within the subsequent final rule.

The following changes will be submitted to OMB for review under control number 0938–1171 (CMS–10432). In addition, we are submitting a Paperwork Reduction Act package for the IPF Patient Assessment Instrument (IPF–PAI) required by section 4125(b)(1) of the Consolidated Appropriations Act of 2023, to OMB for review under a new control number.

In section V.C.1. of this proposed rule, we restate our currently approved burden estimates. In section V.C.2. of this proposed rule, we estimate the changes in burden associated with the update to more recent wage rates. In section V.C.3. of this proposed rule, we discuss the policies proposed in this proposed rule that will impact information collection burden.

A. Wage Estimates

In the FY 2026 IPF PPS final rule, we utilized the median hourly wage rate of $27.69 for Medical Records Specialists, in accordance with the Bureau of Labor Statistics (BLS), to calculate our burden estimates for the IPF Quality Reporting Program (90 FR 37667). Using the most recent data from the BLS for medical records specialists (SOC 29–2072), entitled, the May 2024 Occupational Employment and Wage Estimates, we propose to use the median hourly wage for medical records specialists for the industry, ''general medical and surgical hospitals,'' which is $27.53.[43] We believe the industry of ''general medical and surgical hospitals'' is more specific to the IPF setting for use in our calculations compared to other industries under medical records specialists, such as ''office of physicians'' or ''nursing care facilities.'' We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ($27.53 × 2 = $55.06) to estimate total cost is a reasonably accurate estimation method. Unless otherwise specified, we will calculate cost burden to hospitals using a wage plus benefits estimate of $55.06 per hour throughout the discussion in this section of this proposed rule. If BLS releases updated wage rates after this proposed rule appears in the **Federal Register** and before the final rule appears in the **Federal Register**, we will maintain the wage rates used in this proposed rule.

Some of the activities previously finalized for the IPF Quality Reporting Program require beneficiaries to undertake tasks such as responding to survey questions on their own time. In the FY 2026 IPF PPS final rule, we estimated the hourly wage rate for these activities to be $25.63/hr (90 FR 37667). We are updating that estimate to a post-tax wage of $25.89/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals

[43] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics: General Medical and Surgical Hospitals, Medical Records Specialists. Accessed January 8, 2026. Available at *https://data.bls.gov/oes/#/industry/622100.*

undertake activities on their own time.[44] For FY 2027 we propose to derive the costs for beneficiaries using the usual weekly earnings of wage and salary workers of $1,204, divided by 40 hours to calculate an hourly pre-tax wage rate of $30.10/hr.[45] We propose to adjust this rate downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre and post-tax income,[46] resulting in the post-tax hourly wage rate of $25.89/hr. Unlike our state and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

B. Estimates of the Number of Respondents

In the FY 2026 IPF PPS final rule, we based estimates of information collection burden on the assumption that 1,596 IPFs would report data for 1,261 discharges, on average per facility, for the IPF Quality Reporting Program in CY 2026 and subsequent years. For this proposed rule, based on data from the FY 2027 payment determination, we are updating our assumption and estimate that 1,564 IPFs will report data for an average of 1,342 discharges annually per facility for the IPF Quality Reporting Program in CY 2027 and subsequent years.

C. Information Collection Requirements for the IPF Quality Reporting Program

1. Previously Finalized IPF Quality Reporting Program Estimates

For the purposes of calculating burden, we attribute the costs to the year in which the costs begin. Under our previously finalized policies, data submission for the measures that affect the FY 2029 payment determination occurs during CY 2028 and generally reflects care provided during CY 2027. Our currently approved burden for CY 2027 is set forth in Table 9.

TABLE 9—PREVIOUSLY FINALIZED IPF QUALITY REPORTING PROGRAM INFORMATION COLLECTION BURDEN FOR CY 2027
[Under OMB Control Number 0938–1171]

Measure/response description	Number respondents	Number of responses/ respondent	Total annual responses	Time per response (hrs)	Time per facility (hrs)	Total annual time (hrs)	Applicable wage rate ($/hr)	Cost per facility ($)	Total annual cost ($)
Hours of Physical Restraint Use	1,596	1,261	2,012,556	0.25	315	503,139	55.38	17,459	27,863,838
Hours of Seclusion Use	1,596	1,261	2,012,556	0.25	315	503,139	55.38	17,459	27,863,838
Follow-Up After Psychiatric Hospitalization	1,596	0	0	0	0	0	55.38	0	0
Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention*	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge*	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Influenza Immunization	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Screening for Metabolic Disorders	1,596	609	971,964	0.25	152	242,991	55.38	8,432	13,456,842
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	1,596	0	0	0	0	0	55.38	0	0
30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure	1,596	0	0	0	0	0	55.38	0	0
Medication Continuation Following Inpatient Psychiatric Discharge	1,596	0	0	0	0	0	55.38	0	0
Psychiatric Inpatient Experience Survey Data Submission	1,596	300	478,800	0.25	75	119,700	55.38	4,154	6,628,986
Non Measure Data Collection	1,596	4	6,384	0.5	2	3,192	55.38	111	176,773
Subtotal for Medical Records Specialists	*1,596*	*6,480*	*10,342,080*	*Varies*	*1,621*	*2,587,116*	55.38	*89,771*	*143,274,484*

[44] *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework*. Accessed January 16, 2026.

[45] *https://www.bls.gov/news.release/pdf/wkyeng.pdf*. Accessed February 18, 2026.

[46] *https://www2.census.gov/library/publications/2025/demo/p60-286.pdf*. Accessed January 9, 2026.

TABLE 9—PREVIOUSLY FINALIZED IPF QUALITY REPORTING PROGRAM INFORMATION COLLECTION BURDEN FOR CY 2027—Continued

[Under OMB Control Number 0938–1171]

Measure/response description	Number respondents	Number of responses/ respondent	Total annual responses	Time per response (hrs)	Time per facility (hrs)	Total annual time (hrs)	Applicable wage rate ($/hr)	Cost per facility ($)	Total annual cost ($)
Psychiatric Inpatient Experience Survey	1,596	300	478,800	0.121	36	57,935	25.63	930	1,484,869
Subtotal for Individuals	*1,596*	*300*	*478,800*	*0.121*	*36*	*57,935*	*25.63*	*930*	*1,484,869*
Totals	1,596	6,780	10,820,880	Varies	1,657	2,645,051	N/A	**90,702	**144,759,353

*These measures are proposed for removal in this proposed rule.
**Due to rounding, totals may not equal the sum of respondent totals.

2. Updates Due to More Recent Information

In section V.A. of this proposed rule, we describe our updated wage rates which decrease from $55.38/hr to $55.06/hr (a decrease of $0.32/hr) for activities performed by Medical Records Specialists and increase from $25.63/hr to $25.89/hr (an increase of $0.26/hr) for activities performed by individuals. The effects of these updates are set forth in Table 10.

TABLE 10—EFFECTS OF WAGE RATE UPDATES

Respondent	Total annual responses	Time per response (hrs)	Time per facility (hrs)	Total annual time (hrs)	Change in applicable wage rate ($/hr)	Change in cost per facility ($)	Change in total annual cost $)
Subtotal for Medical Records Specialists	10,342,080	Varies	1,621	2,587,116	−0.32	−519	−827,877
Subtotal for Individuals	478,800	Varies	36	57,935	0.26	9	15,063
Totals	10,820,880	Varies	1,657	2,645,051	Varies	*−509	*−812,814

*Due to rounding, totals may not equal the sum of respondent totals.

In section V.B. of this proposed rule, we describe our updated assumptions of the number of responses which decrease from 1,596 facilities to 1,564 (a decrease of 32) and an increase in the number of annual discharges per IPF from 1,261 to 1,342 (an increase of 81). The effects of these updates are set forth in Table 11.

TABLE 11—EFFECTS OF UPDATED RESPONDENT ESTIMATES

Measure/response description	Total annual responses	Change in total annual responses	Time per response (hrs)	Time per facility (hrs)	Total annual time (hrs)	Change in total annual time (hrs)	Change in cost per facility ($)*	Change in total annual cost ($)
Subtotal for Medical Records Specialists.	10,388,088	46,008	Varies	1,662	2,598,586	11,470	2,230	631,538
Subtotal for Individuals	469,200	−9,600	Varies	36	56,773	−1,162	0	−30,074
Totals	10,857,288	36,408	Varies	1,698	2,655,359	10,308	2,230	601,464

*Calculated using updated wage rates.

The total net impact of updates due to more recent information is an increase of 10,308 hours and $601,464 annually.

3. Updates Due to Proposals in This Proposed Rule

In section IV.B.1. of this proposed rule, we are proposing to remove the Alcohol Use Brief Intervention Provided or Offered (SUB–2) and subset Alcohol Use Brief Intervention (SUB–2a) measure from the IPF Quality Reporting Program beginning with the FY 2028 payment determination and subsequent years. This measure and the associated information collection burden were previously finalized in the FY 2016 IPF PPS final rule and are approved under OMB control number 0938–1171 (expiration date February 29, 2028) (80 FR 46699 through 46701 and 46720 through 46721). Using the currently approved burden estimate under OMB control number 0938–1171 of 15 minutes (0.25 hours) per case per IPF, we estimate this proposal would result in a decrease in burden of 238,119 hours (0.25 hours × 609 cases × 1,564 IPFs) at a savings of $13,110,832 (238,119 × $55.06/hour) across all 1,564 IPFs.

In section IV.B.2. of this proposed rule, we are proposing 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 Quality Reporting Program beginning with the FY 2028 payment determination and subsequent years. This measure and the associated information collection burden were previously finalized in the FY 2016 IPF PPS final rule and are approved under OMB control number 0938–1171 (expiration date February 29, 2028) (80 FR 46696 through 46701 and 46720 through 46721). Using the currently approved burden estimate under OMB control number 0938–1171 of 15 minutes (0.25 hours) per case per IPF, we estimate this proposal would result in a decrease in burden of 238,119 hours (0.25 hours × 609 cases × 1,564 IPFs) at a savings of $13,110,832 (238,119 × $55.06/hour) across all 1,564 IPFs.

In section IV.C. of this proposed rule, we are proposing to implement the IPF–PAI beginning with Quarter 4 of the CY 2027 reporting period/FY 2029 payment determination. The IPF–PAI consists of

two assessments, one administered at the time of patient admission and the other administered at discharge, consisting of 26 and 23 assessment item parts,[47] respectively. For the purposes of estimating collection of information burden, we estimate that each assessment item part in the IPF–PAI will require approximately 0.3 minutes (18 seconds) to complete. Our estimate of 0.3 minutes is similar to estimates used in other CMS PAI data collections,[48] and is supported by the IPF–PAI field (beta) test. In field testing, which used volunteer assessors and a convenience sample of patients, assessors completed the beta test assessments, which contained 86 assessment item parts at Admission and 85 assessment parts at Discharge, in a median time of 13 minutes, or approximately 0.15 minutes per assessment item part; time per assessment item part was slightly higher for admission assessments (median time to complete of 16 minutes, or 0.19 minutes per assessment item part) than for discharges (median time to complete of 11 minutes, or 0.13 minutes).[49] We propose using 0.3 minutes for each assessment item part and estimate that the IPF–PAI will require 14.7 minutes (0.3 minutes × 49 assessment item parts) or 0.245 hours per patient.

We also assume the IPF–PAI will be completed by a variety of clinical or support staff. We estimate that approximately 50 percent of data collected associated with the IPF–PAI will be completed by Medical Records Specialists with the remaining 50 percent being split equally by Registered Nurses (RNs), Licensed Practical/Licensed Vocational Nurses (LP/LVNs), and Mental Health and Substance Abuse Social Workers. Similar to our calculation of the wage rate for Medical Records Specialists discussed in section V.A. of this proposed rule, we utilize the BLS median hourly wage rates of $46.74/hour, $28.09/hour, and $37.49/hour for RNs (SOC 29–1141), LP/LVNs (SOC 29–2061), and Mental Health and Substance Abuse Social Workers (SOC 21–1023) for the industry, ''general medical and surgical hospitals'' and calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage. As a result, we calculate a weighted average labor rate of $65.04/hour [($55.06/hour × 50 percent) + ($46.74/hour × 2 × 16.7 percent) + ($28.09/hour × 2 × 16.7 percent) + ($37.49/hour × 2 × 16.7 percent)]. To calculate the number of patients for which the IPF–PAI will be administered, we multiply the number of IPFs by the average discharges per IPF, for a total of 2,098,888 patients (1,564 IPFs × 1,342 discharges/IPF). We estimate this proposal would result in an increase in burden of 514,228 hours annually (0. 245 hours × 2,098,888 patients) at a cost of $33,445,389 (514,228 × $65.04/hour), beginning with the CY 2028 reporting period which is the first full reporting period that the IPF–PAI will be implemented. Because we are proposing to implement the IPF–PAI beginning with Quarter 4 of the CY 2027 Reporting Period, we estimate the number of patients for which the IPF–PAI will be administered to be 25 percent of the annual total of 2,098,888 patients, or 524,722 patients (2,098,888 patients × 25 percent). As a result, for the CY 2027 reporting period, we estimate this proposal would result in an increase in burden of 128,557 hours (0. 245 hours × 524,722 patients) at a cost of $8,361,347 (128,557 × $65.04/hour). Because IPF–PAI data will be submitted using the same web application or FHIR® API used to enter assessment item responses into the assessment, the time to transmit data to CMS is negligible, and therefore we assume no additional burden for IPFs to submit IPF–PAI data. We note that our burden estimate assumes manual entry of patient assessment data (that is, entry using the web application) for all IPFs and therefore represents the most conservative estimate. We expect that some IPFs will utilize the FHIR® API and related guidance to partially or fully automate their data collection and submission process, thereby reducing the collection of information burden.

4. Summary of Information Collection Requirements and Associated Burden

In total for the CY 2027 reporting period, we estimate a decrease in burden of 347,681 hours at a savings of $17,860,317 associated with these proposals. For the CY 2028 reporting period and subsequent years, we estimate an annual increase in burden of 37,990 hours at a cost of $7,223,725 associated with these proposals. We will submit a revised PRA package for OMB control number 0938–1171 reflecting the information collection burden decrease of 476,238 hours at a cost of $26,221,664 associated with removal of the SUB–2/2a and TOB–3/3a measures. We will also submit a new PRA package under a new OMB control number reflecting the information collection burden of 514,228 hours at a cost of $33,445,389 associated with implementation of the IPF–PAI.

TABLE 12—TOTAL CY 2027 IPF INFORMATION COLLECTION BURDEN CHANGES

Measure/response description	Number respondents	Number of responses/respondent	Total responses	Time per response (hrs)	Time per facility (hrs)	Total time (hrs)	Total cost ($)
Removal of Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB–2/2a)	1,564	(609)	(952,476)	0.25	(152)	(238,119)	(13,110,832)
Removal of Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3/3a)	1,564	(609)	(952,476)	0.25	(152)	(238,119)	(13,110,832)
Implementation of IPF–PAI *	1,564	335.5	524,722	0.245	82	128,557	8,361,347
Total	1,564	(882.5)	(1,380,230)	Varies	(222)	(347,681)	(17,860,317)

* Information collection burden for the IPF–PAI in CY 2027 is prorated to reflect the proposal that IPFs begin administering and reporting data from the IPF–PAI to CMS October 1, 2027. The number of IPF–PAI records estimated to be collected per facility is approximately 335.5, or one-quarter of 1,342; representing the fact that we are only collecting data for Q4 of CY 2027.

[47] For the purposes of estimating a realistic information collection burden, some multi-part assessment items are counted as more than one item, out of recognition that they may require multiple responses.

[48] The Inpatient Rehabilitation Facility-PAI (OMB control number 0938–0842), the Outcome and Assessment Information Set (OMB control number 0938–1279), the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (OMB control number 0938–1163), and the Minimum Data Set (OMB control number 0938–1140) estimate time required to complete assessment items at 0.15, 0.25, or 0.3 minutes.

[49] CMS internal analysis based on IPF–PAI Testing Report, available under IPF–PAI Development and Testing resources at *https://qualitynet.cms.gov/ipf/PAI.*

TABLE 13—TOTAL ANNUAL IPF INFORMATION COLLECTION BURDEN CHANGES ASSOCIATED WITH ALL PROPOSALS IN THIS RULE

Measure/response description	Number respondents	Number of responses/ respondent	Total annual responses	Time per response (hrs)	Time per facility (hrs)	Total annual time (hrs)	Total annual cost ($)
Removal of Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB–2/2a)	1,564	(609)	(952,476)	0.25	(152)	(238,119)	(13,110,832)
Removal of Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3/3a)	1,564	(609)	(952,476)	0.25	(152)	(238,119)	(13,110,832)
Implementation of IPF–PAI	1,564	1,342	2,098,888	0.245	329	514,228	33,445,389
Total	1,564	124	193,936	Varies	25	37,990	7,223,725

If you comment on these information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received by the date and time specified in the **DATES** section of this rule.

VI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Statement of Need

This rule proposes updates to the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2027 (October 1, 2026, through September 30, 2027). We are proposing to apply the 2021-based IPF market basket increase for FY 2027 of 3.1 percent, reduced by the productivity adjustment of 0.8 percentage point as required by section 1886(s)(2)(A)(i) of the Act for a total FY 2027 payment rate update of 2.3 percent. In this proposed rule, we are proposing to update the outlier fixed dollar loss threshold amount, update the IPF labor-related share, and update the IPF wage index to reflect the FY 2027 hospital inpatient wage index. Section 1886(s)(4) of the Act requires IPFs to report data in accordance with the requirements of the IPF Quality Reporting Program for purposes of measuring and making publicly available information on health care quality; and links the quality data submission to the annual applicable percentage increase.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 801–808).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. We estimate that the total impact of these changes for FY 2027 payments compared to FY 2026 payments will be an increase of approximately $50 million. This reflects a $55 million increase from the update to the payment rates (+$75 million from the 2021-based IPF market basket increase of 3.1 percent, and −$20 million for the productivity adjustment of 0.8 percentage point). Outlier payments are estimated to change from 2.2 percent in FY 2026 to 2.0 percent of total estimated IPF payments in FY 2027. While it does not affect the overall impact, we estimate this change in outlier payments will reduce total IPF PPS payments by approximately $5 million.

Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is ''significant'' under section 3(f) of Executive Order 12866, though not significant under section 3(f)(1). Nevertheless, because of the potentially substantial impact to IPF providers, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking. OMB has reviewed these final regulations, and the Departments have provided the following assessment of their impact.

C. Detailed Economic Analysis

In this section, we discuss the historical background of the IPF PPS and the impact of the final rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the RY 2005 and RY 2007 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem base rate and ECT payment per treatment to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. This budget neutrality factor included the following components: outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the RY 2009 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

As discussed in section III.D.1.c. of this proposed rule, we are proposing to update the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem base rate and ECT payment per treatment. Therefore, the budgetary impact to the Medicare program of this proposed rule would be due to the proposed market basket increase for FY 2027 of 3.1 percent (see section III.A.2. of this proposed rule) reduced by the proposed productivity adjustment of 0.8 percentage point required by section 1886(s)(2)(A)(i) of the Act and the proposed update to the outlier fixed dollar loss threshold amount.

We estimate that the impact of the FY 2027 IPF PPS proposed rule would be a net increase of $50 million in payments to IPF providers. This reflects an estimated $55 million increase from the update to the payment rates and a $5 million decrease as a result of the update to the outlier threshold amount as noted earlier. This estimate does not include the implementation of the required 2.0 percentage point reduction of the market basket update factor for any IPF that fails to meet the IPF Quality Reporting requirements (as discussed in section III.B.3. of this proposed rule).

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this proposed rule, we compared estimated payments under the proposed IPF PPS rates and factors for FY 2027 versus those under FY 2026. We determined the percent change in the estimated FY 2027 IPF PPS payments compared to the estimated FY 2026 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the update to the outlier fixed dollar loss threshold amount; the updated wage index data and proposed labor-related share; and the proposed market basket increase for FY 2027, as reduced by the productivity adjustment according to section 1886(s)(2)(A)(i) of the Act.

To illustrate the impacts of the proposed FY 2027 changes to the IPF PPS discussed in this proposed rule, our analysis begins with FY 2025 IPF PPS claims (based on the 2025 MedPAR claims, December 2025 update). We estimated FY 2026 IPF PPS payments using these 2025 claims, the finalized FY 2026 IPF PPS Federal per diem base rate and ECT per treatment amount, and the finalized FY 2026 IPF PPS patient- and facility-level adjustment factors (as published in the FY 2026 IPF PPS final rule (90 FR 37628)). We then estimated the FY 2026 outlier payments based on these simulated FY 2026 IPF PPS payments using the same methodology as finalized in the FY 2026 IPF PPS final rule (90 FR 37653 and 37654) where total outlier payments are maintained at 2 percent of total estimated FY 2026 IPF PPS payments.

Each of the following changes is added incrementally to this baseline model in order to isolate the effects of each change:

- The proposed update to the outlier fixed dollar loss threshold amount.
- The proposed FY 2027 IPF wage index and the proposed FY 2027 labor-related share.
- The proposed IPF market basket increase for FY 2027 of 3.1 percent reduced by the proposed productivity adjustment of 0.8 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act for a proposed FY 2027 payment rate update of 2.3 percent.

Our proposed column comparison in Table 14 illustrates the percent change in payments from FY 2026 (that is, October 1, 2025, to September 30, 2026) to FY 2027 (that is, October 1, 2026, to September 30, 2027) including all the final payment policy changes.

TABLE 14—FY 2027 IPF PPS PROPOSED PAYMENT IMPACTS

Facility by type	Number of facilities	Routine outlier update	Proposed 20% outlier cap	Proposed FY 27 wage index, and labor-related share	Total % change [1]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,354	−0.2	0.0	0.0	2.1
Total Urban	1,119	−0.2	0.0	0.0	2.1
Urban unit	601	−0.3	−0.1	0.3	2.2
Urban hospital	518	−0.1	0.1	−0.5	1.9
Total Rural	235	−0.1	0.0	0.4	2.6
Rural unit	171	−0.1	0.1	0.3	2.7
Rural hospital	64	−0.1	−0.2	0.4	2.5
By Type of Ownership					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	106	−0.2	0.4	0.1	2.6
Non-Profit	66	−0.1	0.2	0.1	2.5
For-Profit	346	0.0	0.0	−0.7	1.6
Rural Psychiatric Hospitals					
Government	31	−0.1	0.0	1.2	3.5
Non-Profit	11	−0.7	−1.3	1.7	2.1
For-Profit	22	0.0	0.0	−0.2	2.1
IPF Units					
Urban					
Government	96	−0.6	−0.4	0.5	1.8
Non-Profit	378	−0.3	0.0	0.2	2.2
For-Profit	127	−0.1	0.1	0.4	2.7
Rural					
Government	48	0.0	0.0	0.7	3.0
Non-Profit	93	−0.1	0.2	0.3	2.7

TABLE 14—FY 2027 IPF PPS PROPOSED PAYMENT IMPACTS—Continued

Facility by type	Number of facilities	Routine outlier update	Proposed 20% outlier cap	Proposed FY 27 wage index, and labor-related share	Total % change [1]
(1)	(2)	(3)	(4)	(5)	(6)
For-Profit	30	0.0	0.1	−0.1	2.3
By Teaching Status					
Non-teaching	1,147	−0.1	0.0	−0.2	2.0
Less than 10% interns and residents to beds	103	−0.3	0.0	0.9	2.9
10% to 30% interns and residents to beds	77	−0.4	−0.4	0.2	1.7
More than 30% interns and residents to beds	27	−0.4	0.3	−0.2	2.0
By Region					
New England	95	−0.3	0.1	0.5	2.7
Mid-Atlantic	189	−0.3	−0.5	1.2	2.8
South Atlantic	217	−0.1	0.0	−0.1	2.1
East North Central	211	−0.1	0.0	−0.7	1.4
East South Central	132	−0.1	0.1	−1.1	1.2
West North Central	86	−0.3	0.3	−0.2	2.0
West South Central	208	0.0	0.1	−0.9	1.5
Mountain	90	−0.1	0.1	−0.1	2.1
Pacific	126	−0.3	0.2	0.2	2.5
By Bed Size					
Psychiatric Hospitals					
Beds: 0–24	89	−0.1	0.0	−0.3	1.9
Beds: 25–49	87	0.0	0.0	−1.2	1.1
Beds: 50–75	94	0.0	0.0	−0.4	1.8
Beds: 76 +	312	−0.1	0.1	−0.2	2.1
Psychiatric Units					
Beds: 0–24	384	−0.2	−0.4	0.1	1.8
Beds: 25–49	220	−0.2	0.2	0.4	2.7
Beds: 50–75	97	−0.3	0.1	0.3	2.5
Beds: 76 +	71	−0.5	0.0	0.6	2.4

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

3. Impact Results

Table 14 displays the results of our analysis. The table groups IPFs into the categories listed here based on characteristics provided in the Provider of Services file, the IPF PSF, and cost report data from the Healthcare Cost Report Information System:

- Facility Type.
- Location.
- Teaching Status Adjustment.
- Census Region.
- Size.

The top row of Table 14 shows the overall impact on the 1,354 IPFs included in the analysis. In column 2, we present the number of facilities of each type that had information available in the PSF and had claims in the MedPAR dataset for FY 2025.

In column 3, we present the effects of the proposed update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.2 percent in FY 2026. Therefore, we are proposing to adjust the outlier threshold amount to maintain total estimated outlier payments equal to 2.0 percent of total payments in FY 2027. The estimated change in total IPF payments for FY 2027, therefore, includes an approximate 0.2 percent decrease in payments because we would expect the outlier portion of total payments to decrease from approximately 2.2 percent to 2.0 percent.

The overall impact of the estimated decrease to payments due to updating the outlier fixed dollar loss threshold (as shown in column 3 of Table 14), across all hospital groups, is a 0.2 percent decrease. The largest decrease in payments due to this change is estimated to be 0.7 percent for non-profit IPF hospitals in rural areas.

In column 4, we present the effects of the proposed 20 percent facility-level outlier cap. The change in this column represents the proposed changes to the outlier payment policy as discussed in section III.E.1.c. of this proposed rule.

We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4; however, there would be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 0.4 percent for government-owned IPF hospitals in urban areas, and the largest decrease in payments to be 1.3 percent for non-profit IPF hospitals in rural areas.

In column 5, we present the effects of the proposed budget-neutral update to the IPF wage index and the proposed labor-related share. In addition, this column includes the application of the 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year as finalized in the FY 2023 IPF PPS final rule (87 FR 46856 through 46859). The change in this column represents the effect of using the concurrent hospital wage data as discussed in section III.D.1.c. of this proposed rule. That is, the impact

represented in this column reflects the proposed update from the FY 2026 IPF wage index to the proposed FY 2027 IPF wage index, which includes basing the FY 2027 IPF wage index on the FY 2027 pre-floor, pre-reclassified IPPS hospital wage index data, applying a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, and updating the labor-related share from 79.0 percent in FY 2026 to 79.1 percent in FY 2027. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 5; however, there would be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 1.7 percent for non-profit IPF hospitals in rural areas, and the largest decrease in payments to be 1.2 percent for IPF hospitals with 25 to 49 beds.

Overall, IPFs are estimated to experience a net increase in payments of 2.1 percent as a result of the updates in this proposed rule. IPF payments are therefore estimated to increase by 2.1 percent in urban areas and 2.6 percent in rural areas. The largest payment increase is estimated at 3.5 percent for government-owned IPF hospitals in rural areas.

4. Effect on Beneficiaries

Under the FY 2027 IPF PPS, IPFs will continue to receive payment based on the average resources consumed by patients for each day. Our longstanding payment methodology reflects the differences in patient resource use and costs among IPFs, as required under section 124 of the BBRA. We expect that updating IPF PPS rates in this rule will improve or maintain beneficiary access to high-quality care by ensuring that payment rates reflect the best available data on the resources involved in inpatient psychiatric care and the costs of these resources. We continue to expect that paying prospectively for IPF services under the FY 2027 IPF PPS will enhance the efficiency of the Medicare program.

5. Effects of the Updates to the IPF Quality Reporting Program

In section IV.B. of this proposed rule, we are proposing to remove two measures from the IPF Quality Reporting Program beginning with the FY 2028 payment determination: 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). Because these measures require IPFs to abstract data from a sample of patients' medical records, we expect the removal of these measures to reduce 476,238 hours of annual information collection burden on IPFs, valued at $26,221,664, in CY 2027.

In section IV.C. of this proposed rule, we are proposing to implement the IPF Patient Assessment Instrument (IPF–PAI), required by section 4125(b)(1) of the Consolidated Appropriations Act of 2023, beginning with Quarter 4 of the CY 2027 reporting period for the FY 2029 payment determination. IPFs would have the option of two methods for submission of IPF–PAI data to CMS: web application and FHIR® API. As IPFs have not yet used FHIR® for program data submission, we acknowledge that technological, financial, and staffing barriers may present challenges to adoption and use in some facilities. We also recognize that IPFs and the health IT vendors that support IPFs would require time to develop and implement data collection and submission tools for the proposed IPF–PAI. Because each IPF and health IT vendor is unique and we lack sufficient insight into the individual workflows and decisions or each, the extent of these costs is difficult to quantify. However, in Section V.C.3. of this proposed rule, we estimate the IPF–PAI proposal to increase collection of information burden by 514,228 hours annually, valued at $33,445,389, when fully implemented.

In accordance with section 1886(s)(4)(A) of the Act, we will apply a 2-percentage point reduction to the FY 2027 market basket update for IPFs that have failed to comply with the IPF Quality Reporting Program requirements for the FY 2027 payment determination, including reporting on the mandatory measures. Historically, approximately 70 IPFs, or about 5 percent of IPFs that participate in the IPF Quality Reporting Program do not receive the full annual percentage increase in any fiscal year due to the failure to meet all requirements of the program. We anticipate that the number of IPFs not receiving the full annual percentage increase will be approximately the same as in past years based on review of previous performance. We intend to closely monitor the effects of the IPF Quality Reporting Program on IPFs and help facilitate successful reporting outcomes through ongoing education, national trainings, and a technical help desk.

6. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with the regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this proposed rule, we assume that the total number of unique commenters on the most recent IPF PPS proposed rule will be the number of reviewers of this proposed rule. For this FY 2027 IPF PPS proposed rule, the most recent IPF proposed rule was the FY 2026 IPF PPS proposed rule, and we received 55 unique comments on the proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed the FY 2026 IPF proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of commenters would be a fair estimate of the number of reviewers of this rule. We welcome any public comments on the approach in estimating the number of entities that would review the proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule. We seek public comments on this assumption.

Using the May, 2024 mean (average) wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this proposed rule is $132.44 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 1.23 hours for the staff to review half of this proposed rule which contains a total of approximately 37,000 words. For each entity that reviews the rule, the estimated cost is $163.34 (1.23 hours × $132.44). Therefore, we estimate that the total cost of reviewing this regulation is $8,983.85 ($163.34 × 55 reviewers).

D. Alternatives Considered

The statute gives the Secretary discretion in establishing an update methodology to the IPF PPS. We continued to believe it is appropriate to routinely update the IPF PPS so that it reflects the best available data about differences in patient resource use and costs among IPFs, as required by the statute. Therefore, we are proposing updates to the IPF PPS using the methodology published in the RY 2005 IPF PPS final rule (our ''standard

methodology''), with the pre-floor, pre-reclassified IPPS hospital wage index as its basis. Additionally, we apply a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year. Lastly, as discussed in section III.D.4. of this proposed rule, we are proposing to adjust non-labor related costs for IPFs located in Alaska and Hawaii using the Overseas Cost-of-Living Allowance (OCOLA) data published by the Department of Defense (DOD) for FY 2027 consistent with payments for other hospitals located in Alaska and Hawaii. We considered, but did not propose, updating the COLA factors for IPFs based on the results of our existing methodology.

We considered, but did not propose, setting the proposed facility-level outlier cap at a level other than 20 percent. We also considered applying the outlier cap only to facilities with a minimum number of stays. We are soliciting comments on both of these alternatives.

E. Accounting Statement

Consistent with OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), in Table 15, we have prepared an accounting statement showing the classification of the expenditures associated with the updates to the IPF wage index and payment rates in this proposed rule. Table 15 provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this proposed rule and based on 1,354 IPFs that had data available in the PSF and claims in our FY 2025 MedPAR claims dataset. Lastly, Table 14 also includes our best estimate of the costs of reviewing and understanding this proposed rule.

TABLE 15—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTMATED COSTS, SAVINGS, AND TRANSFERS

[in millions]

Category	Primary estimate ($million/year)	Year dollars	Period covered
Regulatory Review Costs	0.0089	2026	FY 2026.
IPF Quality Reporting Information Collection Burden	7.23	2026	FY 2027.
Annualized Monetized Transfers from Federal Government to IPF Medicare Providers	50	2026	FY 2027.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions.

1. The Need for, Objectives of, and Legal Basis for the Rule

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS in a budget neutral manner. Specifically, section 124 of the BBRA mandated that the Secretary of Health and Human Services (the Secretary) develop a per diem prospective payment system (PPS) for inpatient hospital services furnished in psychiatric hospitals and excluded psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and excluded psychiatric units.

Sections 3401(f) and 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (''the Affordable Care Act'') added subsection (s) to section 1886 of the Social Security Act (the Act).

Section 1886(s)(1) of the Act titled ''Reference to Establishment and Implementation of System,'' refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

2. Identify the Impacted Small Entities

According to the SBA's website at *http://www.sba.gov/content/small-business-size-standards,* IPFs fall into the North American Industrial Classification System (NAICS) code 622210, Psychiatric and Substance Abuse hospitals. The SBA defines small Psychiatric and Substance Abuse hospitals as businesses having less than $47 million in total annual revenue. SUSB data shows there are 190 firms below this threshold.

TABLE 16—CONCENTRATION RATIOS (NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS

Firm size (by receipts)	Firm count	Percentage of small firms	Average revenue ($)
Small Hospitals	190	100.0	$19,736,628.87
<100,000	4	2.1	20,000
100,000–499,999	6	3.2	225,667
1,000,000–2,499,999	5	2.6	1,890,000
2,500,000–4,999,999	10	5.3	3,622,800
5,000,000–7,499,999	6	3.2	5,485,333
7,500,000–9,999,999	20	10.5	8,288,050
10,000,000–14,999,999	12	6.3	11,324,833
15,000,000–19,999,999	24	12.6	15,943,667
20,000,000–24,999,999	22	11.6	20,138,000
25,000,000–29,999,999	18	9.5	23,777,278
30,000,000–34,999,999	19	10.0	28,946,895
35,000,000–39,999,999	21	11.1	30,214,762
40,000,000–47,000,000	23	12.1	40,439,152
Large Hospitals			

TABLE 16—CONCENTRATION RATIOS (NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS—Continued

Firm size (by receipts)	Firm count	Percentage of small firms	Average revenue ($)
Receipts >47 million	228	NA	123,983,594.37

Source: US Census 2022 SUSB.

According to Table 16, 190 psychiatric and substance abuse hospitals, at the firm level, can be considered small according to the SBA. As we stated earlier, the SBA defines small Psychiatric and Substance Abuse hospitals (firms) as businesses having less than $47 million in total annual revenue. According to the U.S. Census, a firm is a legal entity or parent company that owns and operates the business, or hospital, in this case. Therefore, Table 16 only reflects data at the firm level and not at the establishment level, where multiple establishments could be owned by a firm.

3. Define ''Significant Impact'' and ''Substantial Number'' Thresholds

As its measure of significant economic impact on small entities, HHS uses a change in revenue of more than 3 to 5 percent. The agency considers the rule to have a significant impact on a substantial number of small businesses when more than 5 percent of impacted small entities meet the significant impact threshold defined above.

TABLE 17—(NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS IMPACTS ON SMALL ENTITES

Firm size (by receipts)	Average annual revenue	Annualized cost per firm	Percentage of small firms	Revenue test (%)
All Hospitals	$317,625,550.10	$4,782	N/A	0.00
Small Hospitals	19,736,628.87	4,782	100	0.02
<100,000	20,000	4,782	2.1	23.91
100,000–499,999	225,667	4,782	3.2	2.12
1,000,000–2,499,999	1,890,000	4,782	2.6	0.25
2,500,000–4,999,999	3,622,800	4,782	5.3	0.13
5,000,000–7,499,999	5,485,333	4,782	3.2	0.09
7,500,000–9,999,999	8,288,050	4,782	10.5	0.06
10,000,000–14,999,999	11,324,833	4,782	6.3	0.04
15,000,000–19,999,999	15,943,667	4,782	12.6	0.03
20,000,000–24,999,999	20,138,000	4,782	11.6	0.02
25,000,000–29,999,999	23,777,278	4,782	9.5	0.02
30,000,000–34,999,999	28,946,895	4,782	10.0	0.02
35,000,000–39,999,999	30,214,762	4,782	11.1	0.02
40,000,000–47,000,000	40,439,152	4,782	12.1	0.01

Source: US Census 2022 SUSB.

4. The Estimated Impact to Small Businesses

As discussed in sections VII.C.5 and VII.C.6, costs imposed by this proposed include the regulatory review costs, which we estimate at $163.34 per IPF; and the proposed implementation of the Inpatient Psychiatric Facility-Patient Assessment Instrument (IPF–PAI), which we estimate at $21,384.52 per IPF. However, as discussed in sections IV.B.1 and IV.B.2 of this proposed rule, the proposed removal of the Alcohol Use Brief Intervention Provided or Offered (SUB–2) and subset Alcohol Use Brief Intervention (SUB–2a) measure and the Tobacco Use Treatment Provided or Offered at Discharge (TOB–3) and subset Tobacco Use Treatment at Discharge (TOB–3a) measure from the IPF Quality Reporting Program would result in an estimated decrease in cost of $16,765.77 per IPF. As a result, there are increased costs of $4,782.09 per IPF (($163.34 + $21,384.52) − $16,765.77) imposed as a result of this proposed rule. Recall, the total number of IPFs is 1,354.

As shown in Table 17, 100 percent of these small Psychiatric and Substance Abuse hospitals will incur costs as a result of this proposed rule.

5. Does the impact on small entities meet the two-part threshold?

According to Table 17, this proposed rule will have a significant impact upon 2.6 percent impact of small Psychiatric and Substance Abuse hospitals. Costs for small Psychiatric and Substance Abuse hospitals are estimated to increase by $4,782.09 per IPF ($4,618.75 as a result of the IPFQR proposals, and $163.34 as a result of the regulatory review costs.) The $4,782 implies a significant impact threshold of $159,400 in annual revenue ($4,782/$159,400 = 0.03, or 3 percent). As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent.

Assuming the firm size distribution provided in Table 17, we expect 2.6 percent of small firms to fall below this significant impact threshold. We also believe this estimate to be an upper-bound since the cost increase from the proposed implementation of the IPF–PAI would scale based on the number of patients treated. As such, we anticipate that small Psychiatric and Substance Abuse hospitals will likely have a lower burden due to having fewer patient stays; and therefore, fewer IPF–PAI assessments to be completed on an annual basis. We believe that the threshold for significant economic impact on a substantial number of small entities will not be reached by the requirements in this proposed rule.

6. Significant Alternatives

Section 603(c) mandates that agencies shall contain a description of any significant alternatives to the proposed rule which accomplish the stated objectives of applicable statutes and

which minimize any significant economic impact of the proposed rule on small entities. As discussed in section IV.C. of this proposed rule, we propose to implement the IPF–PAI in the IPF Quality Reporting Program to comply with section 1886(s)(4)(E) of the Act, which requires each IPF participating in the IPF Quality Reporting Program to collect and submit to the Secretary certain standardized patient assessment data, using a standardized patient assessment instrument (PAI) implemented by the Secretary. At this time, we have not identified any viable alternative that would accomplish the stated objectives of section 1886(s)(4)(E) of the Act while further reducing the economic impact of the proposed rule on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds.

As discussed in section VII.C.2. of this proposed rule, the rates and policies set forth in this proposed rule will not have an adverse impact on the rural hospitals based on the data of the 171 rural excluded psychiatric units and 64 rural psychiatric hospitals in our database of 1,354 IPFs for which data were available. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandate Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This proposed rule does not mandate any requirements for State, local, or tribal governments, or for the private sector. This proposed rule will not impose a mandate that will result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This proposed rule does not impose substantial direct costs on state or local governments or preempt State law.

I. E.O. 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' This proposed rule, if finalized as proposed, is expected to be considered an Executive Order 14192 regulatory action. We estimate that this proposed rule will generate $6.31 million in annualized cost at a 7 percent discount rate, over a perpetual time horizon.

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 26, 2026.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 412 as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 412.424 is amended by adding paragraph (d)(3)(i)(D) to read as follows:

§ 412.424 Methodology for calculating the Federal per diem payment amount.

* * * * *

(d) * * *

(3) * * *

(i) * * *

(D) For discharges occurring in cost reporting periods beginning on or after October 1, 2026, an IPF's total outlier payments are limited to no more than 20 percent of its total IPF PPS payments.

* * * * *

■ 3. Section 412.433 is amended by—

■ a. Revising paragraphs (a) and (d); and

■ b. Adding paragraph (h).

The revisions and addition read as follows:

§ 412.433 Procedural requirements under the IPFQR Program.

(a) *Statutory authority.* Section 1886(s)(4) of the Act requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. Under section 1886(s)(4) of the Act, for an IPF paid under the IPF PPS that fails to submit data required for the quality measures and standardized patient assessment data selected by the Secretary in a form and manner and at a time specified by the Secretary, we reduce the otherwise applicable annual update to the standard Federal rate by 2.0 percentage points with respect to the applicable fiscal year.

* * * * *

(d) *Submission of IPFQR Program data.* In general, except as provided in paragraph (f) of this section, IPFs that participate in the IPFQR Program must submit to CMS data on measures selected under section 1886(s)(4)(D) of the Act and specified non-measure data, including standardized patient assessment data under section 1886(4)(E) of the Act, in a form and manner, and at a time specified by CMS.

* * * * *

(h) *Data Completion Threshold for the IPF–PAI.* IPFs must meet or exceed a data completeness threshold for standardized patient assessment data collected using the IPF–PAI to avoid receiving a 2 percentage point reduction to their annual payment update for a given fiscal year as set forth in paragraph (a) of this section, beginning with FY 2029 and for all subsequent payment updates. The threshold is set at 100 percent completion of standardized patient assessment data collected using the IPF–PAI on at least 80 percent of the assessments submitted through the CMS designated data submission.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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