Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2026

MEDICARE IPF PPS PROPOSED RULE

Overview and Resources

On April 3, 2026, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FFY) 2027 proposed payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) IPF payment rates and policies.

A link to the proposed rule and other resources related to the IPF PPS are available on the CMS website.

An online version of the proposed rule can be found here.

Program changes proposed by CMS would be effective for discharges on or after Oct. 1, 2026, unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate updates to be an increase of $50 million in aggregate payments to IPFs in FFY 2027 over FFY 2026.

Comments on this proposed rule are due to CMS by June 1, 2026 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1847-P."

IPF PPS Payment Rates

The table below lists the IPF federal per diem and electroconvulsive therapy (ECT) base rates proposed for FFY 2027 compared to the rates currently in effect:

	Final FFY 2026	Proposed FFY 2027	Percent Change
IPF Per Diem Base Rate	$892.87	$912.58	+2.21%
ECT Base Rate	$673.85	$688.73	

The following table provides details for the proposed updates to the IPF payment rates for FFY 2027.

Update Factor Components	IPF Base Rate Update
Market Basket (MB) Update	3.1%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 percentage points (PPTs)
Wage Index and Labor-Related Share Budget Neutrality	-0.09%
Net Rate Update	**+2.21%**

The Consolidated Appropriations Act (CAA) of 2023 includes a provision that CMS interprets as any revisions in payment adjustments implemented for the IPF PPS for FFY 2025 and onwards must be budget neutral. Due to CMS not proposing any updates to facility- or patient-level adjustments (besides wage index, which has its own budget neutrality factor) there is no proposed refinement standardization factor FFY 2027.

Facility and Patient Level Adjustments to the IPF Payment Rates

For FFY 2027, CMS proposed continuing to use the patient-level adjustment factors adopted for FFY 2025 and the facility-level adjustment factors adopted for FFY 2026.

Wage Index, Cost-of-Living Adjustment (COLA), Labor-Related Share, and Revised CBSA Delineations

The labor-related portions of the IPF per diem base rate and the ECT base rate are adjusted for differences in area wage levels using a wage index. CMS proposed to continue using the current year pre-floor, pre-reclassified inpatient PPS (IPPS) wage index for FFY 2027 to adjust payment rates for labor market differences.

CMS applies the wage index to the estimated labor-related portion of the IPF standard rate to adjust for differences in area wage levels. CMS proposed an increase to the labor-related share of the IPF per diem base rate and the ECT base rate from 79.0% in FFY 2026 to 79.1% for FFY 2027.

CMS proposed a wage index budget neutrality factor of 0.9991 for FFY 2027 to ensure that aggregate payments made under the IPF PPS are not greater or less than would otherwise be made if wage adjustments had not changed. This includes the budget neutrality associated with the 5% wage index cap, described below.

CMS applies a 5% cap on any decrease to the IPF wage index, compared with the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPF's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the IPF's capped wage index in the prior FFY. A new IPF is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPF would not have a wage index in the prior FFY.

A complete list of the proposed IPF wage indexes to be used for payment in FFY 2027 is available on the CMS website.

CMS is soliciting comments on creating an IPF-specific wage index using alternative data sources, such as Bureau of Labor Statistics data or IPF cost reports, for potential use in future years.

Patient Condition Medicare-Severity Diagnosis Related (MS-DRG) Adjustment

For FFY 2027, CMS proposed to continue to utilize the MS-DRG system used under the IPPS to classify Medicare patients treated in IPF, in a budget neutral manner, using the adjustment factors adopted for FFY 2025.

Similar to prior years, principal diagnoses codes (ICD-10-CM) that group to one of 19 MS-DRGs recognized under the IPF PPS would receive a DRG adjustment. Principal diagnoses that do not group to one of the designated MS-DRGs recognized under the IPF PPS would receive the federal per diem base rate and all other applicable adjustments but will not include a DRG adjustment in the payment.

The following table lists the 19 MS-DRGs that would continue to be eligible for a MS-DRG adjustment under the IPF PPS for FFY 2027 under this proposal.

MS-DRG	Description	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.12
057	Degenerative nervous system disorders w/o MCC	1.11
876	O.R. procedure w principal diagnoses of mental illness	1.29
880	Acute adjustment reaction & psychosocial dysfunction	1.08

881	Depressive neuroses	1.06
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.17
884	Organic disturbances & intellectual disabilities	1.08
885	Psychoses	1.00
886	Behavioral & developmental disorders	1.07
887	Other mental disorder diagnoses	1.00
894	Alcohol/drug abuse or dependence, left AMA	0.86
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.90
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.00
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.95
917	Poisoning and toxic effects of drugs w MCC	1.19
918	Poisoning and toxic effects of drugs w/out MCC	1.12
947	Signs and Symptoms w MCC	1.12
948	Signs and Symptoms w/out MCC	1.09

Patient Comorbid Condition Adjustment

For FFY 2027, CMS proposed to continue with the previously adopted comorbidity categories for which an adjustment to the per diem rate can be applied. For each claim, an IPF may receive one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one category.

The following table lists the comorbid condition payment adjustments that would continue for FFY 2027 under this proposal.

Description of Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Tracheostomy	1.09
Eating Disorders	1.09
Renal Failure, Acute	1.06
Renal Failure, Chronic	1.08
Oncology Treatment	1.44
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.17
Cardiac Conditions	1.04
Gangrene	1.12
Chronic Obstructive Pulmonary Disease and Sleep Apnea	1.09
Artificial Openings—Digestive and Urinary	1.07

Severe Musculoskeletal & Connective Tissue Diseases	1.05
Poisoning	1.16
Intensive Management for High-Risk Behavior	1.07

Patient Age Adjustment

CMS proposed to continue utilizing the patient age adjustments adopted for FFY 2025, which are based on the patient age at the time of admission.

Age	Adjustment Factor	Age	Adjustment Factor
Under 45	1.00	65 and under 70	1.09
45 and under 55	1.02	70 and under 80	1.11
55 and under 60	1.05	80 and over	1.13
60 and under 65	1.06		

Patient Variable Per Diem Adjustment

CMS proposed to continue to use the per diem rate adjustments adopted for FFY 2025, which are based on patient length-of-stay (LOS) using a variable per diem adjustment factor.

The following table lists the variable per diem adjustment factors for FFY 2027 under this proposal.

Day-of-Stay	Adjustment Factor	Day-of-Stay	Adjustment Factor
Day 1	1.28 (w/o ED) 1.54 (w/ ED)	Day 6	1.06
Day 2	1.20	Day 7	1.03
Day 3	1.15	Day 8	1.02
Day 4	1.12	Day 9	1.01
Day 5	1.08	Day 10+	1.00

Rural Adjustment

IPFs located in rural areas currently receive an adjustment to the per diem rate of 1.18. This adjustment is provided because a previous analysis by CMS determined that the per diem cost of rural IPFs was 18% higher than that of urban IPFs. CMS proposed to continue to apply this adjustment to rural IPFs for FFY 2027.

Teaching Adjustment

CMS proposed that IPFs with teaching programs would continue to receive an adjustment to the per diem rate to account for the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. Currently, CMS applies a teaching adjustment coefficient value at 0.7957, which is based on the number of full-time equivalent interns and residents training in the IPF and the IPF's average daily census. CMS proposed to continue to apply this coefficient to eligible hospitals for FFY 2027.

Emergency Department (ED) Adjustment

CMS proposed continuing the policy where IPFs with a qualifying ED would receive a variable per diem adjustment for day one of each stay. This adjustment accounts for the costs associated with maintaining

a full-service ED. The ED adjustment applies to all IPF admissions, regardless of whether a patient receives preadmission services in the hospital's ED. CMS proposed to maintain the 1.54 adjustment factor for FFY 2027. This adjustment would not be made when a patient is discharged from an acute care hospital or Critical Access Hospital (CAH) and admitted to the same hospital or CAH's psychiatric unit. In such cases, the IPF would continue to receive an adjustment factor of 1.28.

Outlier Payments

Outlier payments were established under the IPF PPS to provide additional payments for extremely costly cases. Outlier payments are made when 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. Costs are determined by multiplying the facility's overall cost-to-charge ratio (CCR) by the allowable charges for the case. Currently, when a case qualifies for an outlier payment CMS pays 80% of the difference between the estimated cost for the case and the adjusted threshold amount for the first through ninth day of the stay, and then 60% of the difference for the tenth day onwards. The varying 80% and 60% "loss sharing ratios" were established to discourage IPFs from increasing patient length of stay in order to receive outlier payments.

Using the current methodology to establish the target of 2% of total IPF PPS payments to be set aside for high-cost outliers the outlier threshold would be $42,720, an 8.5% increase over the FFY 2026 threshold of $39,360. To calculate this outlier threshold, CMS used FFY 2025 claims updated as of December 2025, excluding providers if their change in estimated average cost per day is outside three standard deviations from the mean.

Recent analysis by CMS suggests that a substantial share of outlier payments may be driven by higher facility-level costs rather than patient complexity. Due to this, CMS is concerned that the current outlier methodology limits outlier payments to too few IPF PPS stays and providers and therefore proposed to update the outlier payment policy. Under this proposed update, CMS would maintain the established target of 2% of total IPF PPS payments to be set aside for high-cost outliers but would also minimize the impact that a small number of high-cost IPFs would have on the outlier fixed dollar loss threshold amount. To achieve this, CMS proposed establishing a facility-level outlier payment cap for FFY 2027 and onwards. Under this policy, a provider's outlier payments would be limited to 20% of the facility's total IPF PPS payments and is estimated to affect approximately 3.6% of IPF providers. Under this approach, the estimated outlier threshold for FFY 2027 would be $37,820, a -3.9% reduction compared to the FFY 2026 threshold.

CMS seeks comment on this approach for interim payments as well as cost report settlement. CMS is also seeking comment on setting the cap at 20% versus an alternative percentage and implementing an exemption policy for IPFs that do not exceed a minimum threshold for annual stays.

CMS is further soliciting comments on the factors which contribute to higher costs at facilities that routinely receive a high share of outlier payments in an effort to identify if there are other factors, for which the IPF PPS does not adjust payments, that could explain the increased patient resource use and costs among these IPFs.

Updates to the IF CCR Ceiling

CMS applies a ceiling to IPFs' CCRs. If an individual IPF's CCR exceeds the appropriate urban or rural ceiling, the IPF's CCR is replaced with the appropriate national median CCR for that FFY, either urban or rural. The national urban and rural CCRs and the national urban and rural CCR ceilings for IPFs are updated annually, based on analysis of the most recent data that is available. The national median CCR is applied when:

- New IPFs have not yet submitted their first Medicare cost report;
- IPFs' overall CCR is in excess of three standard deviations above the corresponding national CCR ceiling for the current FFY; and/or
- Accurate data to calculate an overall CCR are not available for IPFs.

CMS proposed to continue to set the national CCR ceilings at three standard deviations above the mean CCR, and therefore the national CCR ceiling for FFY 2027 would be 2.4181 for rural IPFs and 1.8850 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2027, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS proposed a national median CCR of 0.5720 for rural IPFs and 0.4200 for urban IPFs, with both values being the same as adopted for FFY 2026. Calculations of both the proposed national CCR ceiling and national median CCR are based on current CBSA-based geographic designations.

IPF Quality Reporting (IPFQR) Program

IPFs that do not successfully participate in the IPFQR Program are subject to a 2 percentage point reduction to the market basket update for the applicable year. All currently adopted IPFQR measures, and their associated payment determination FFY, are listed in the table below.

Measure	NQF #	Payment Determination Year
Required Measures		
HBIPS-2—Hours of Physical Restraint Use	#0640	FFY 2015+
HBIPS-3—Hours of Seclusion Use	#0641	FFY 2015+
IMM-2—Influenza Immunization	#1659	FFY 2017+
TOB-3/3a Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	N/A	FFY 2018+
SUB-2/2a Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention	N/A	FFY 2018+
Transition record with specified elements received by discharged patients	N/A	FFY 2018+
Screening for Metabolic Disorders Measure	N/A	FFY 2018+
SUB-3/3a Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	N/A	FFY 2019+
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Facility	#2860	FFY 2019+
Medication Continuation Following Inpatient Psychiatric Discharge	#3205	FFY 2021+
Follow-Up After Psychiatric Hospitalization (FAPH)	N/A	FFY 2024+
30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge	N/A	FFY 2029+
Psychiatric Inpatient Experience (PIX) Survey	N/A	Voluntary FFY 2025–2027 Mandatory FFY 2028+

CMS proposed the removal of the following measures from the IPFQR program starting with the CY 2026 reporting period/FFY 2028 payment determinations:

- SUB-2/2a Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention
- TOB-3/3a Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge

CMS is soliciting comments on alternative ways of addressing nicotine use, as well as interventions and treatment for nicotine use, for patients treated in IPFs.

Implementation of the IPF-Patient Assessment Instrument (PAI)

The CAA of 2023 requires that any IPFs participating in the IPFQR must collect and submit certain standardized patient assessment data using a standardized PAI for rate year (RY) 2028 (FFY 2028) and each subsequent RY. For IPFs to meet this new data collection and reporting requirement, the Secretary must implement a standardized PAI which collections data from 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.

Based on responses from previous requests for information, as well as development by CMS and its contractors, CMS proposed to implement the IPF-PAI as the assessment instrument for the submission of standardized patient assessment data for all patients aged 18 or older. The initial version of the IPF-PAI is intended to meet the statutory obligation to collect these data by selecting a minimal set of assessment items on each of the aforementioned data categories. Future enhancements may include the addition, removal, or change of assessment items using results and feedback from this initial proposed IPF-PAI.

CMS proposed that all IPFs paid under the IPF PPS would be required to complete the IPF-PAI for all patients aged 18 years or older and should be administered at admission and discharge, unless otherwise specified. CMS seeks comment as to on the proposed age requirement for the IPF-PAI, specifically on the potential inclusion of adolescents in the population for the IPF-PAI.

The proposed assessment items based on the statutory categories, as well as assessment items related to administrative record matching and database management, are shown in the following table.

Assessment Category	Proposed Assessment Item
Functional status	Mobility: Chair/Bed-to-Chair Transfer
Cognitive function and mental status	Suicide Screening
Special services, treatments, and interventions	Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting (Psychiatric Treatments, Restrictive Interventions)
Medical conditions and comorbidities	Primary Medical Condition Category
Impairments	Hearing Speech Clarity Vision

Administrative: Assessment items required for record matching and database management	Legal Name of Patient Birth Date Sex Social Security and Medicare Numbers Facility Provider Numbers (National Provider Identifier, CMS Certification Number) Admission/Discharge Date Payer Information—Primary Payer Type of Record Assessment Reference Date Reason for Assessment Type of Admission/Type of Discharge IPF-PAI Completion Date

CMS proposed that mandatory reporting for the IPF-PAI would begin with a reporting period of Oct. 1, 2027–Dec. 31, 2027, regardless of payer, impacting the FFY 2029 payment determination. Beginning with the FFY 2030 payment determination, and for subsequent years, CMS proposed that IPFs must report data with respect to admissions and discharges that occur during the calendar year from Jan. 1 through Dec. 31 two years preceding the FFY payment determination year (for example, Jan. 1, 2028 through Dec. 31, 2028 for the FFY 2030 payment determination).

The IPF-PAI data is proposed to be submitted quarterly with a deadline of day 15 of the second month after the end of the calendar quarter and would use the Assessment Reference Date (ARD) to determine which quarter the admission or discharge falls within. The Admission ARD would be not later than 3 days after the admission and the Discharge ARD would be the day of discharge. Table 8 of the proposed rule shows the proposed data submission deadlines and associated payment determination years for the IPF-PAI.

An IPF would need to complete 100% of the IPF-PAI assessment items on 80% of the IPF-PAIs submitted to satisfy the IPFQR program data reporting requirements. IPFs that fail to do so would be deemed non-compliant with the IPFQR program and would be subject to a two PPT reduction to their annual percentage update. CMS also states that this 80% threshold may increase in future rulemaking, as they have done with PAIs used in other post-acute settings.

CMS proposed that to submit data for the IPF-PAI, providers would need to use one of two tools in order to satisfy the IPF-PAI data submission requirements: a CMS developed web-based application or Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs). For the web-based application, CMS plans to make it available in spring or summer 2027, prior to the start of the proposed reporting period to allow time for IPFs to gain familiarity with the application and for CMS to provide training. CMS proposed to use the two FHIR® APIs built from the HL7 FHIR® specification, based on FHIR v4.0.1. Any future changes to these systems and submission process for the IPF-PAI would be done through future rulemaking.

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