



## **ChatGPT Executive Summary of CMS' FY 2027 Inpatient Psychiatric Facilities (IPF) PPS proposed rule**

**April 3, 2026**

Here is a two-page, policy-focused synthesis of the FY 2027 Inpatient Psychiatric Facilities (IPF) PPS proposed rule. The biggest story is not the annual rate update. It is that CMS is using this rule to rebalance outlier payments, launch a standardized psychiatric assessment infrastructure, and trim older chart-abstracted quality measures.

### **Executive takeaway**

This rule has four major policy signals.

1. A modest payment increase, but not a major financial reset. CMS proposes a 3.1% IPF market basket increase, reduced by a 0.8 percentage point productivity adjustment, for a 2.3% payment rate update. It would raise the federal per diem base rate from \$892.87 to \$912.58 and generate an estimated \$50 million increase in FY 2027 IPF payments overall.
2. CMS is targeting outlier concentration much more aggressively. The proposed rule would impose a facility-level cap so that total outlier payments could not exceed 20% of a facility's total IPF PPS payments. CMS says a relatively small number of very high-cost IPFs are driving a disproportionate share of outlier payments, and it wants to spread outlier protection more broadly across the sector.
3. The most important structural change is the proposed IPF patient assessment instrument (IPF-PAI). Starting with FY 2028, IPFs would have to collect and submit standardized assessment data using a common instrument. CMS proposes using it for all patients age 18 and older, at admission and discharge, and the proposal explicitly moves toward interoperable submission infrastructure, including FHIR-based exchange.
4. CMS is pruning older QRP measures it sees as lower value relative to burden. It proposes to remove Alcohol Use Brief Intervention (SUB-2/2a) and Tobacco Use Treatment at Discharge (TOB-3/3a) beginning with the CY 2026 reporting period/FY 2028 payment determination. CMS's rationale is largely that the burden of these chart-abstracted measures now outweighs their benefit, especially where another substance-use measure remains in place.

### **1. Payment update: positive, but not the main story**

#### What changed

CMS proposes to update the IPF PPS federal per diem base rate from \$892.87 to \$912.58 and the ECT payment per treatment from \$673.85 to \$688.73. The update reflects a proposed 3.1% market basket increase, less a 0.8 percentage point productivity adjustment, for a net 2.3% rate update. CMS estimates the total payment effect at about +\$50 million for FY 2027.

## Why this matters

This is a conventional annual update, not a redesign of the underlying IPF payment model. The rule does not attempt to solve broader workforce or psychiatric capacity pressures through base payment. The immediate financial effect is modestly positive, but narrow.

## What to be concerned about

The headline increase is limited, and facilities that fail QRP requirements still face a 2.0 percentage point reduction to the annual update. CMS calculates that non-reporting IPFs would receive only a 0.3% payment rate update, with a proposed FY 2027 federal per diem base rate of \$894.74 instead of \$912.58.

## **2. Outlier policy: one of the most important policy changes in the rule**

### What changed

CMS proposes a 20% facility-level cap on outlier payments, meaning an IPF's total outlier payments could not exceed 20% of its total IPF PPS payments. CMS would codify the policy for cost reporting periods beginning on or after October 1, 2026.

### Why CMS is doing this

CMS says outlier payments are too concentrated in a small number of facilities. Its analysis found that 47.8% of all simulated outlier payments were attributable to about 37 IPFs with outlier payments exceeding 20% of total IPF PPS payments. CMS argues that this concentration forces the fixed-loss threshold too high, making it harder for the broader field to qualify for outlier protection when they treat unusually expensive patients.

### What this changes in practice

With the 20% cap, CMS estimates the fixed dollar loss threshold would be about \$37,820, down from what it otherwise would be and closer to the FY 2026 level of \$39,360. CMS estimates this would increase the number of providers receiving outlier payments from 379 to 419, and about 1.9% of IPF stays would qualify for outlier payments, averaging roughly \$1,012 each.

### What to be concerned about

This creates clear winners and losers. Facilities that have relied heavily on very large outlier revenue streams are directly exposed. On the other hand, many IPFs that previously could not reach the higher threshold may gain access to outlier protection. From a policy standpoint, CMS is signaling that outlier payments should protect against exceptional cases, not function as a quasi-base payment stream for a small subset of facilities.

## **3. IPF-PAI: the most consequential long-term operational change**

### What changed

CMS proposes to implement a standardized IPF patient assessment instrument (IPF-PAI) under the IPF Quality Reporting Program, as required by the Consolidated Appropriations Act, 2023. The statute requires IPFs to collect and submit standardized patient assessment data for FY 2028 and subsequent years.

### What the instrument would cover

The statute requires the assessment to collect information on functional status; cognitive function and mental status; special services, treatments, and interventions; medical conditions and comorbidities; impairments; and other categories the Secretary deems appropriate. CMS says the IPF-PAI must be standardized across providers, meaning the same questions, response options, standards, and definitions.

### What CMS is proposing operationally

CMS proposes that IPFs complete the IPF-PAI for all patients age 18 and older, with assessment items collected at admission and discharge. It estimates that completing both assessments for a patient would take about 14.7 minutes. CMS also proposes that IPFs collect and submit these admission and discharge assessments for all such patients regardless of payer, beginning October 1, 2027, for FY 2028 payment purposes.

### Why this matters

This is the biggest infrastructure change in the rule. It gives CMS a standardized psychiatric patient dataset that can support future quality measurement, care comparison, and potentially later payment refinement. It is also a clear interoperability move: CMS is discussing FHIR-based exchange and says if a facility does not submit through the proposed FHIR API route, it would need to use the web app submission route instead.

### What to be concerned about

The immediate issue is burden and implementation readiness. CMS estimates the IPF-PAI would add about 514,228 burden hours at a cost of \$33.4 million, and after accounting for offsetting savings from measure removals, the QRP changes still yield a net annual burden increase of 37,990 hours and \$7.22 million beginning with the CY 2028 reporting period. Strategically, though, the bigger issue is that CMS is building data infrastructure it can later use for broader psychiatric policy and payment reform.

## **4. Quality Reporting Program measure removals: burden reduction, but selective**

### **A. Alcohol Use Brief Intervention (SUB-2/2a)**

#### What changed

CMS proposes to remove SUB-2/2a beginning with the CY 2026 reporting period/FY 2028 payment determination.

#### Why CMS is doing this

CMS says the measure meets two removal rationales: the cost of continued use outweighs the benefit, and the measure can be replaced by a more broadly applicable measure, since SUB-3/3a remains in the program and addresses alcohol and other substance use disorder treatment while reducing duplication. Both measures require chart-abstracted data collection.

### What to be concerned about

This is a burden-reduction move, not a retreat from substance-use quality oversight altogether. CMS is narrowing the measure set, not abandoning the topic. The practical implication is that facilities get some administrative relief, but quality expectations around substance-use treatment still remain through other measures.

## B. Tobacco Use Treatment at Discharge (TOB-3/3a)

### What changed

CMS also proposes to remove TOB-3/3a beginning with the CY 2026 reporting period/FY 2028 payment determination.

### Why CMS is doing this

CMS says the measure's costs now outweigh its benefits. It notes TOB-3 is chart-abstracted and that internal analysis found median performance scores of only 0.58 to 0.63 between 2023 and 2025, with no meaningful improvement over time. CMS concludes the measure is no longer driving facilities to improve their offering of these interventions.

### What to be concerned about

Again, this is a burden reduction move, but it may also signal CMS's willingness to retire older, manual measures that are resource-intensive and have plateaued in performance value. That is important because it shows where CMS may be heading more broadly: fewer chart-abstracted measures, more standardized assessment and interoperable data collection.

## **5. Reporting and compliance implications: more data, same penalty leverage**

### What changed

The IPF QRP would now combine two opposing forces: removal of two older measures and implementation of the new IPF-PAI. CMS estimates each of the two removed measures would save about 238,119 hours and \$13.1 million, but the IPF-PAI more than offsets those savings on an ongoing basis.

### Why this matters

This is not simple deregulation. CMS is replacing older manual reporting with a more standardized and scalable data architecture. Facilities that view the measure removals as pure burden relief may underestimate the significance of the new assessment and submission requirements.

## What to be concerned about

The 2.0 percentage point QRP penalty still applies, and now it will attach not just to quality measure reporting but also to standardized patient assessment data submission selected by the Secretary. That means IPFs will need to treat IPF-PAI implementation as core payment compliance, not just a documentation project.

### **Bottom line**

This rule is best understood as a modest payment update paired with a substantial policy shift in data collection and outlier design. The most immediate financial issue is the proposed 20% outlier cap, which will directly affect a small but important subset of high-outlier facilities while broadening access to outlier protection for others. The most important long-term issue is the proposed IPF-PAI, because it creates a standardized psychiatric data platform across facilities and payers. The main burden-reduction story is the removal of SUB-2/2a and TOB-3/3a, but those savings are more than offset by the new assessment regime.