STRATEGIC HEALTH CARE

FY 2027 Inpatient Psychiatric Facilities PPS Final Rule

Summary of the Most Consequential Changes

CMS-1847-F | Effective October 1, 2026, except where otherwise noted

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Executive Summary

CMS finalized a 2.3 percent FY 2027 IPF PPS payment update, producing an estimated $60 million aggregate increase in Medicare payments. The Federal per diem base rate rises to $912.40 and the electroconvulsive therapy (ECT) payment rises to $688.59. However, the actual change for an individual facility will vary because of wage-index and other facility-level adjustments.

The rule also makes two structural changes with effects beyond FY 2027. First, CMS establishes a facility-level cap under which outlier payments may not exceed 20 percent of an IPF's total IPF PPS payments. CMS delayed this policy until FY 2028 and exempted facilities with fewer than 50 stays during the cost-reporting year. Second, CMS adopts the standardized IPF Patient Assessment Instrument (IPF-PAI), which will require all-payer admission and discharge data for adult patients. Reporting is voluntary beginning October 1, 2027 and mandatory beginning July 1, 2028, with the first payment consequences in FY 2030.

To reduce current reporting burden, CMS removes two chart-abstracted quality measures beginning with the CY 2026 reporting period/FY 2028 payment determination: SUB-2/2a and TOB-3/3a. The measure removals offset much of the estimated administrative burden associated with the new IPF-PAI, although CMS estimates a small net increase in annual compliance costs after all policies are fully implemented.

Reference pages: PDF pp. 1-3, 69-72, 80-89, 93-103, 147-165, and 180-182.

1. FY 2027 Payment Rates Increase, but Facility-Level Results Will Vary

CMS finalized a 3.2 percent IPF market-basket increase, reduced by a 0.9 percentage-point productivity adjustment, yielding a 2.3 percent payment-rate update. CMS did not adopt a forecast-error correction sought by commenters. After application of the 0.9989 wage-index budget-neutrality factor, the published base rates increase by approximately 2.2 percent:

- Federal per diem base rate: $892.87 to $912.40.
- ECT payment per treatment: $673.85 to $688.59.
- For IPFs that fail to satisfy IPF Quality Reporting Program requirements, the annual update is reduced by 2 percentage points, leaving a 0.3 percent update; the resulting rates are $894.56 per diem and $675.13 per ECT treatment.

CMS estimates that the payment update will increase aggregate FY 2027 IPF PPS payments by approximately $60 million: about $80 million from the market-basket increase, offset by about $20 million from the productivity adjustment. The rule does not create a uniform 2.3 percent increase for every facility. Wage-index effects, rural status, teaching status and other adjustments change the actual facility-level result.

The impact analysis estimates an average 2.3 percent increase across all IPFs, but approximately 2.7 percent for rural IPFs and 2.2 percent for urban IPFs. Urban psychiatric units are estimated at 2.6 percent compared with 1.8 percent for urban freestanding psychiatric hospitals. Regional averages range from approximately 1.3 percent in the East South Central region to 3.4 percent in the Mid-Atlantic region. These differences make facility-specific modeling more important than relying on the national headline update.

The labor-related share decreases slightly from 79.0 percent to 78.9 percent, and CMS applies the FY 2027 wage index with a budget-neutrality factor of 0.9989. CMS also continues the permanent 5 percent cap on year-over-year decreases in an IPF's wage index, which limits abrupt reductions but does not prevent other payment components from changing.

Reference pages: PDF pp. 18-25, 35-43, 186, and 188-191.

2. Outlier Policy Changes: Higher FY 2027 Threshold and a New FY 2028 Facility Cap

For FY 2027, CMS increases the fixed-dollar-loss threshold from $39,360 to $40,750 to keep estimated outlier payments at 2 percent of aggregate IPF PPS payments. A higher threshold means a case must generate greater estimated losses before qualifying for an outlier payment, which may reduce outlier eligibility for some high-cost cases even though aggregate outlier spending remains targeted at 2 percent.

The more consequential structural change is a new provider-level limit on outlier payments. For cost-reporting periods beginning on or after October 1, 2027, an IPF with at least 50 IPF PPS stays may not receive outlier payments exceeding 20 percent of its total IPF PPS payments. Facilities with fewer than 50 stays during the cost-reporting year are exempt.

CMS will apply the cap on an interim basis to claims beginning in FY 2028 and finalize it annually through cost-report settlement. Once the cap is reached, the facility will no longer receive additional outlier payments for otherwise qualifying high-cost cases. CMS adopted this policy because a small group of facilities receives a disproportionately high share of outlier payments, which CMS believes contributes to growth in the national fixed-dollar-loss threshold and makes outlier payments less accessible to other facilities.

The delayed effective date and low-volume exception are meaningful changes from the proposed rule. They provide an additional year for affected facilities to model exposure and protect very small IPFs from volatility caused by a limited number of unusually expensive stays. Facilities with 50 or more annual stays and outlier payments approaching 20 percent of total IPF PPS revenue should evaluate the potential effect on FY 2028 cash flow and cost-report settlement.

Reference pages: PDF pp. 51-72.

3. CMS Adopts the Standardized IPF Patient Assessment Instrument

CMS adopts the IPF-PAI as a new component of the IPF Quality Reporting Program. The instrument applies to every patient age 18 or older in an IPF, regardless of payer. This all-payer scope is broader than Medicare-only reporting and will require IPFs to integrate standardized assessment collection into routine admission and discharge workflows across their adult patient population.

The initial IPF-PAI covers the statutory categories of functional status; cognitive function and mental status; special services, treatments and interventions; medical conditions and comorbidities; impairments; and administrative data needed for record management. The finalized instrument includes items addressing mobility, suicide screening, primary medical condition, hearing, speech clarity, vision, admission and discharge type, and special psychiatric services and interventions. CMS emphasizes that the IPF-PAI is not intended to replace the facility's clinical psychiatric assessment, diagnosis or treatment-planning process.

CMS modified the proposed instrument to reduce burden. It removed nine proposed assessment items and reduced the estimated completion time for the combined admission and discharge process from 14.7 minutes to 12 minutes per patient. Mobility is collected at admission only. Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting is collected at discharge only, using a lookback covering the entire stay. CMS did not finalize collection of Social Security numbers, and a Medicare number is required only when Medicare is the primary payer.

For stays of fewer than three calendar days, an IPF will not complete a separate discharge assessment. Instead, the facility will complete selected discharge items as part of the admission assessment; that record will count as both an admission and a discharge assessment for compliance purposes. For longer stays, separate admission and discharge assessments remain required. The admission assessment reference date may be no later than three days after admission, and the discharge assessment reference date is the date of discharge.

The IPF-PAI is strategically important because the Consolidated Appropriations Act of 2023 requires CMS to use standardized patient-assessment information when revising the IPF PPS payment methodology for FY 2031. The instrument therefore creates the data infrastructure for potential future case-mix and payment-system refinements, not merely an additional quality-reporting requirement.

Reference pages: PDF pp. 5-6, 91-103, 146-160, and 180-182.

4. IPF-PAI Implementation Is Phased, with First Payment Consequences in FY 2030

CMS substantially delayed and softened the proposed implementation schedule. The final timeline is:

- October 1, 2027 through June 30, 2028: three voluntary reporting quarters (Q4 2027 and Q1-Q2 2028).
- July 1, 2028: mandatory reporting begins for Q3 CY 2028.
- Q3 and Q4 CY 2028 data: first used for the FY 2030 payment determination.
- CY 2029 data: used for the FY 2031 payment determination.
- CY 2030 data: used for the FY 2032 payment determination, when the compliance threshold increases.

IPF-PAI data are reported quarterly, generally by the 15th day of the second month after the close of the quarter. CMS recommends rolling submissions rather than waiting until the deadline so facilities can use iQIES reports to identify incomplete records and monitor compliance.

For Q3-Q4 CY 2028 and CY 2029, at least 50 percent of submitted IPF-PAIs must contain responses for 100 percent of all required items. Beginning with CY 2030, that threshold increases to 70 percent. An IPF that fails the applicable completeness threshold will be treated as noncompliant with the IPF Quality Reporting Program and will receive a 2 percentage-point reduction to its annual payment update. CMS

lowered the initial threshold from the proposed 80 percent and postponed the first payment consequence from FY 2029 to FY 2030.

Facilities may submit through either of two pathways: the free CMS Patient Assessment Reporting Interoperability Tool (PARIT), or HL7 FHIR application programming interfaces integrated into an EHR or vendor solution. Both methods transmit data to iQIES and require CMS identity and access controls. CMS intends to provide implementation guides, testing tools and training before the voluntary period. The free web option is particularly important for IPFs without sophisticated EHR or interoperability capabilities, although manual entry may create substantial staffing demands.

Reference pages: PDF pp. 147-165 and 203-204.

5. Two Chart-Abstracted Quality Measures Are Removed

CMS removes the Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention measure (SUB-2/2a), and the Tobacco Use Treatment Provided or Offered at Discharge measure (TOB-3/3a), beginning with the CY 2026 reporting period/FY 2028 payment determination and subsequent years.

CMS concluded that the administrative costs of both measures outweigh their continued benefit. SUB-2/2a is substantially duplicative of the broader SUB-3/3a measure, which remains in the program and covers patients screening positive for alcohol or other substance-use disorders. TOB-3/3a requires resource-intensive chart abstraction and showed stable performance without evidence that it was continuing to drive improvement. CMS did not adopt an immediate replacement tobacco measure but stated that it may consider future IPF-PAI items or less burdensome tobacco and nicotine measures.

Removal from the quality-reporting measure set does not change an IPF's obligation to provide clinically appropriate alcohol, substance-use and tobacco-cessation services. It does, however, eliminate the specific chart-abstraction and submission requirements and associated payment-compliance risk for these two measures.

CMS estimates that eliminating the two measures will reduce annual information-collection burden by approximately 476,238 hours and $26.2 million. The new IPF-PAI is estimated to add approximately 419,778 hours and $27.3 million annually once fully mandatory. Taken together, CMS estimates a net annual reduction of 56,460 burden hours but a net cost increase of approximately $1.08 million, reflecting the higher-cost clinical staff expected to participate in IPF-PAI completion.

Reference pages: PDF pp. 74-89 and 180-182.

Document scope: *This summary focuses on the provisions most likely to affect IPF payment, operations, reporting burden and future payment-system development. It does not reproduce every technical update in the final rule.*