Medicare Program; Fiscal Year 2026 Inpatient Psychiatric Facilities Prospective Payment System — Rate Update (CMS-1831-P)
Proposed Rule Summary

The Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2026 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) proposed rule (CMS-1831-P) on April 11, 2025. **The public comment period will end on June 10, 2025**. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals.

This proposed rule would update the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided IPFs for discharges occurring October 1, 2025, through September 30, 2026 (FY 2026). This rule includes a proposal to revise the payment adjustment factors for teaching status and for IPFs located in rural areas. This proposed rule would update a quality measure, remove four quality measures, and update and codify the Extraordinary Circumstances Exception (ECE) policy under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program as well as make requests for information (RFI) on the program's future.

Addenda that show payment rates and other relevant information for determination of FY 2026 IPF PPS rates are available at: Inpatient Psychiatric Facilities PPS Files | CMS. Wage index information is available at: IPF Wage Index | CMS.

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I. Background

Under the IPF PPS, facilities are paid based on a standardized federal per diem base rate adjusted by a series of patient-level and facility-level adjustments. The rule reviews in detail the statutory basis and regulatory history of the IPF PPS. The system was implemented in January 2005 and was updated annually based on a calendar year. Beginning with FY 2013, the IPF PPS has been on a federal FY updating cycle.

The base payment rate was initially based on national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. IPF payment rates have been updated based on statutory requirements in annual notices or rulemaking since then. Additional payment policies apply for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). The ECT per treatment payment rate is also subject to annual updates.

CMS updated the patient specific factors, the ED adjustment and payment for ECT for the first time since the IPF PPS was adopted in the FY 2025 IPF final rule based on an extensive regression analysis (89 FR 23154 through 23161 and 89 FR 64594 through 64601). The patient-level adjustments address age, Medicare Severity Diagnosis-Related Group (MS-DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay; and lower costs for later days of the stay.

Facility-level adjustments are for the area 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). Except for the adjustment for the presence of an ED, CMS did make changes to the facility level adjustments based on a revised regression analysis in the FY 2025 IPF rule but requested comment on future changes to these adjustments.

II. Provisions of the FY 2026 IPF PPS Payment Update

A. Proposed FY 2026 Market Basket and Productivity Adjustment

1. Market Basket Less Productivity

For FY 2026, CMS is proposing an inflation update of 3.2 percent, less 0.8 percentage points for productivity, or 2.4 percent, based on IHS Global Inc.'s 4th quarter 2024 forecast with historical data through the 3rd quarter of 2024. Productivity is based on a rolling 10-year average in economy-wide productivity.

IPFs that do not report quality data or fail to meet the quality data reporting requirements are subject to a 2.0 percentage point reduction in the update. For these IPFs, their FY 2026 payment rate update will be 0.4 percent (with other adjustments applied, as described below).

2. Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2021-based market basket.[1] For FY 2026, CMS is proposing a total labor-related share of 78.8 percent—75.7 percent for the operating costs plus 3.1 percent for the labor-related share of capital-related costs. Table 1 of the proposed rule shows how updated data changes the labor-related share:

Table 1: Comparison of FY 2025 and FY 2026 IPF Labor-Related Shares (LRS)

	FY 2025	FY 2026[1]
Wages and Salaries	53.6	53.7
Employee Benefits	14.1	14.1
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	**75.7**	**75.8**
Labor-related portion of capital (46%)	3.1	3.1
Total LRS	**78.8**	**78.9**

1. IHS Global Inc. 4th quarter 2024 forecast of the 2026-based IPF market basket.

B. Proposed Updates to the IPF PPS Rates for FY 2026

1. Increase in the ECT Payment per Treatment

CMS has been making a per treatment payment for ECT in addition to per diem and outliers since the inception of the IPF PPS in 2005. To establish the ECT per treatment payment, CMS has used the pre-scaled and pre-adjusted median cost for procedure code 90870 developed for the Hospital Outpatient Prospective Payment System (OPPS) in 2005 updated for inflation and budget neutrality.

For the FY 2025 IPF PPS, CMS revised the payment for ECT based on more recent OPPS costs. CMS developed the ECT payment per treatment add-on under the IPF PPS for FY 2025 using the pre-scaled and pre-adjusted 2024 OPPS geometric mean cost adjusted by the market basket update and the wage index budget neutrality factor. The FY 2025 ECT payment per treatment is $661.52.

[1] The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-Related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2021) and FY 2024.

2. Increase in IPF PPS Payment

CMS determines the FY 2026 proposed payment rates by applying the update factor of 2.4 percent (1.024), the wage index budget neutrality adjustment (1.0011) and the refinement standardization factor (0.9927) to FY 2025 rates. For hospitals that do not report quality data or meet the quality data reporting requirements, CMS determines the FY 2025 payment rate by applying the reduced update factor of 0.4 percent (1.004), the wage index budget neutrality adjustment (1.0011) and the refinement standardization factor (0.9927) to the full unreduced FY 2025 payment rates.

The table below compares the federal per diem base rate and the ECT payments per treatment for FY 2025 compared to those proposed for FY 2026.

	FY 2025	**FY 2026**
Federal per diem base rate	$876.53	$891.99
Labor share	*$690.71*	*$703.78*
Non-labor share	*$185.82*	*$188.21*
ECT payment per treatment	$661.52	$673.19
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$876.53	$874.57
Labor share	*$690.71*	*$690.04*
Non-labor share	*$185.82*	*$184.53*
ECT payment per treatment	$661.52	$660.04

Note: The update for FY 2025 for IPFs that do not submit quality data is applied to the full (unreduced) rate for FY 2025, not the actual rate they were paid in FY 2025.

C. Proposed Updates to the Patient-Level Adjustment Factors

Payment adjustments are made for the following patient-level characteristics: MS-DRG assignment based on a psychiatric principal diagnosis, selected comorbidities, patient age, and variable costs during different points in the patient stay. For FY 2025, CMS made changes to the patient-level changes based on an updated regression model for the first time since the IPF PPS was adopted in 2005.

1. MS–DRG Adjustment Factors

For FY 2026, CMS is proposing to make the existing payment adjustments for psychiatric diagnoses that group to one of the existing 19 IPF MS–DRGs listed in Addendum A of the proposed rule. 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, 2025, using the final IPPS FY 2026 ICD–10–CM/PCS code sets. The FY 2026 IPPS/LTCH PPS final rule will include tables of the changes to the ICD–10–CM/PCS code sets that underlie the proposed FY 2026 IPF MS–DRGs. Both the FY 2026 IPPS/LTCH PPS final rule and the tables of final changes to the ICD–10–CM/PCS code sets will be available on the CMS IPPS website: Acute Inpatient PPS | CMS

CMS discusses the Code First policy, which follows the ICD-10-CM Official Guidelines for Coding and Reporting. Under the Code First policy, when a primary (psychiatric) diagnosis code has a "code first" note, the provider would follow the instructions in the ICD-10-CM text to determine the proper sequencing of codes.

Annual updates to ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes are made annually April 1 and October 1. Effective April 1, 2025, CMS is making coding updates (including the Code First policy) sub-regulatory to reduce lead time for making routine coding updates to the Code First list, comorbidities, and ECT coding categories. The proposed FY 2026 Code First table is shown in Addendum B.

2. Comorbidity Adjustments

The intent of the comorbidity adjustments is to recognize the increased costs associated with 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 treatment during the stay.

CMS revised the comorbidity adjustment factors based on the results of the 2019-2021 regression analysis beginning in FY 2025. The proposed FY 2026 comorbidity codes based on updates to the ICD-10 code sets are shown in Addendum B.

3. Revisions to Patient Age Adjustments

In general, CMS has found that the cost per day increases with age. Older age groups are costlier than the under 45 age group. The differences in per diem cost increase for each successive age group and are statistically significant. CMS revised the age adjustments based on the 2019-2021 regression model. The patient age adjustments are shown in Addendum A.

4. Variable Per Diem Adjustments

Variable per diem adjustments recognize higher ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. CMS revised the variable per diem adjustments based on the results of the 2019-2021 regression analysis beginning with FY 2025 and is proposing to continue using those same adjustments for FY 2026 found in Addendum A of the proposed rule.

D. Proposed Updates to the Facility-Level Adjustments

Facility-level adjustments provided under the IPF PPS are for 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 facility-level adjustment factors currently in place for rural location and teaching status are the existing regression-derived factors that were adopted in 2005.

For the FY 2026 IPF PPS proposed rule, CMS performed an extensive regression analysis of the IPF facility-level adjustment holding constant the patient-level adjustments finalized for FY

2025. The proposed rule discusses the methodology CMS used in detail including all data sources, data trims and assumptions, calculation of the dependent variable (per diem costs standardized for geographic cost differences) and independent variables (patient and facility level characteristics).

In summary, CMS began with a base sample of IPF stays by Medicare FFS beneficiaries in the Medicare Provider and Analysis Review (MedPAR) database from the FY 2020 through FY 2022. MedPAR contained a total of 712,543 stays from 1,650 IPFs. After applying several data restrictions and exclusions to remove stays with missing and or aberrant data, the final sample used for the regression analysis contained 704,494 stays from 1,633 IPFs, which reflects the removal of 17 providers and 8,049 stays. The proposed rule indicates that the regression model can explain approximately 27.8 percent of the variation in per diem cost among IPF stays.

1. Wage Index Adjustment

CMS believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index is the best available to use as a proxy for an IPF specific wage index. Consistent with past practice, CMS proposes to use the FY 2026 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2026 IPF wage index.

CMS reiterates that it will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. As described earlier, the labor-related share of the national rate and ECT payment per treatment will change from 78.8 percent in FY 2025 to 78.9 percent in FY 2025, reflecting the labor-related share of the 2021-based IPF market basket for FY 2026. CMS also applies a cap on reductions to an IPF hospital's wage index of 5 percent from its wage index in a prior year. The 5 percent cap on reductions is applied budget neutral.

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. CMS adopted changes to the CBSAs based on the 2020 decennial census in the FY 2025 IPF final rule.

CMS proposes to make an FY 2026 IPF wage index budget neutrality adjustment, based on estimated aggregate IPF PPS payments for FY 2025 and FY 2026 using FY 2022 cost reports. The ratio of FY 2026 to FY 2025 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2026. CMS proposes a budget neutrality adjustment of 1.0011 (0.11 percent) associated with revisions to the wage index. This proposed budget neutrality adjustment will be revised based on later data in the final rule.

2. Adjustment for Rural Location

Since the inception of the IPF PPS, CMS has provided a 17-percent payment increase 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.

As noted in section I., CMS completed an analysis of more recent cost and claims information to update the patient and facility adjustments for FY 2025. However, to minimize the scope of changes that would impact providers in any single year, CMS did not use the updated regression-derived adjustment factor for IPFs located in a rural area for FY 2025. Based on the 2020 through 2022 regression analysis described in section II. D., CMS is proposing to increase the rural facility adjustment from 17 to 18 percent beginning in FY 2026.

Under the revised CBSA delineations adopted based on the 2020 decennial census, 54 counties designated as rural would become rural. CMS adopted a policy to phase-out the rural transition adjustment over 3 years for hospitals located in these counties beginning in FY 2025. The FY 2025 adjustment was 2/3 of the adjustment received in 2024. For 2026, CMS is proposing that hospitals in these counties would receive a rural adjustment of 1/3 of the amount received in 2024 and no adjustment in FY 2027.

3. Teaching Adjustment

As noted in section I., CMS completed an analysis of more recent cost and claims information to update the patient and facility adjustments for FY 2025. However, to minimize the scope of changes that would impact providers in any single year, CMS did not use the updated regression-derived adjustment factor for teaching IPFs in FY 2025. Based on the 2020 through 2022 regression analysis described in section II. D., CMS is proposing to increase the coefficient value from 0.5150 to 0.7981. The proposed coefficient value will recognize the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs.

The teaching adjustment formula follows, where ADC = average daily census.

$$(1 + Interns\ and\ Residents/ADC)\text{^}0.7981$$

For example, the teaching adjustment for an IPF with a ratio of interns and residents to ADC of 0.2 equals 1.098. This adjustment is applied to the federal per diem base rate.

Beginning with the 2005 IPF PPS, CMS established a cap on the number of full time equivalent (FTE) residents that hospitals may count. This policy limits the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. IPFs are subject to a cap on the number of FTE residents that trained in the IPF's most recent cost report filed before November 15, 2004.

The proposed rule indicates that section 4122 of the Consolidated Appropriations Act (CAA), 2023 provides for the distribution of at least 100 psychiatry or psychiatry subspecialty resident FTEs and provides for corresponding increases to IME payments under the IPPS. While this provision does not apply to IPFs, CMS is proposing to recognize FTE cap increases that are awarded under section 4122 of the CAA, 2023, either to an IPF hospital or to an IPPS hospital for FTEs that are allocated to the IPF subunit paid under the IPF PPS. This proposed policy is

consistent with longstanding policy of maintaining IPF PPS cap policies that align with IME cap policies under the IPPS.

4. Cost of Living Adjustment for Alaska and Hawaii

CMS applies cost of living adjustment (COLA) factors for Alaska and Hawaii to the non-labor related share of the IPF standardized amounts and updates them every 4 years consistent with the timing of when the IPPS labor share is updated. The COLAs were last updated in FY 2022 and have been used through FY 2025 as shown below:

COLA Factors: IPFs Located in Alaska and Hawaii

Area	FY 2022 through FY 2025
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22
City of Juneau and 80-kilometer (50-mile) radius by road	1.22
Rest of Alaska	1.24
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

CMS indicates that using the methodology to update the COLAs beginning in 2026 would result in a decrease to the adjustment factors of 0.04 in all areas of Alaska and 0.01 in the County of Hawaii. However, consistent with the FY 2026 IPPS proposed rule, CMS is not adopting these lower adjustment factors to allow CMS to consider whether any other data sources or methodology changes will account for the unique circumstances of hospitals located in Alaska and Hawaii.

5. Adjustment for IPFs with a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs, which is applied through the variable per diem adjustment. The adjustment applies to a psychiatric hospital, an IPPS-excluded psychiatric unit of an IPPS hospital, or a critical access hospital (CAH) with a qualifying ED. The adjustment is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the OPPS that are furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF, and the overhead cost of maintaining the ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay. While CMS did not update facility level adjustments in other circumstances based on the 2019-2021 regression analysis to minimize the number of changes affecting IPFs in a single year, CMS did update the adjustment factor from 1.31 to 1.53 for IPFs with qualifying EDs for

FY 2025. Those IPFs with a qualifying ED receive a variable per diem adjustment factor of 1.53 for day 1 beginning in FY 2025 based on the update regression analysis discussed earlier.

With one exception, this facility-level adjustment applies to all admissions to an IPF with a qualifying ED, regardless of whether the patient receives preadmission services in the hospital's ED. The exception is for cases 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. The adjustment is not made in this case because the costs associated with ED services are reflected in the MS-DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH. In these cases, the IPF receives the day 1 variable per diem adjustment of 1.27.

6. Refinement Standardization Factor

Consistent with section 1886(d)(5)(D) of the Act and § 412.424(c)(5), CMS is proposing to apply a refinement standardization factor for FY 2026 to maintain budget neutrality for the revised adjustment factors for teaching status and for IPFs located in rural areas. CMS outlines the 4-step process it proposes to determine a refinement standardization factor of 0.9927 (-0.73 percent) to the federal per diem base rates.

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS provides for outlier payments when an IPF's estimated total cost for a case exceeds a fixed loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. For qualifying cases, the outlier payment equals 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, and 60 percent of the difference for day 10 and after. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2026, CMS proposes to continue to set the fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS. CMS' uses data from the 2nd fiscal year that precedes the payment year to simulate payments for setting the fixed loss threshold (e.g., FY 2024 data for setting the FY 2026 outlier threshold). CMS is proposing to use the same methodology to determine the fixed loss threshold for FY 2026 that it has used dating back to FY 2008—except for FY 2022, FY 2023, where specific changes led to changes for those years.

Based on an analysis of the December 2024 update of FY 2024 IPF claims and the FY 2025 rate increases, CMS estimates that outlier payments for FY 2025 will be slightly higher than the target of 2.0 percent. For FY 2026, CMS proposes to increase the fixed loss threshold from $38,110 in FY 2025 to $39,360 in FY 2026. CMS will update the proposed outlier threshold in the final rule based on later data.

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

In estimating the total cost of a case for comparison to the fixed loss threshold amount, CMS multiplies the hospital's charges on the claim by the hospital's cost-to-charge ratio (CCR). CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is 3 times the standard deviation from the applicable (i.e., urban or rural) geometric mean CCR. The national median also applies to new IPFs and those for which the data are inaccurate or incomplete. Based on the most recent CCRs from the 2024 PSF, the proposed FY 2026 national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2026		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.3331	1.7585

CMS will update the proposed national median and ceiling CCRs in final rule based on later data.

III. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS proposes to (i) modify the reporting period and delay the first payment determination (until the FY 2029 payment determination) for the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge (IPF ED Visit) measure; (ii) remove the Facility Commitment to Health Equity measure, COVID HCP measure, and two Social Drivers of Health measures from the measure set; and (iii) make revisions to the extraordinary circumstance exception (ECE) policy. In addition, the agency issues three requests for information.

CMS estimates that, in total, compared to current burden estimates, the IPFQR Program proposals in this proposed rule would result in for 2026 a decrease in burden of 66,947 hours at a savings of $1,731,712 and for 2027 a decrease in burden of 67,215 hours at a savings of $1,746,474 across all IPFs.

CMS invites public comment on these proposals.

A. Background

CMS established the IPFQR program beginning in FY 2014, as required under section 1886(s)(4) of the Act. The IPFQR program follows many of the policies established for the Hospital Inpatient Quality Reporting Program but has a distinct set of quality measures. In addition, beginning for FY 2028, IPFs[2] participating in the IPFQR Program must collect and

[2] Psychiatric hospitals and psychiatric units within acute care and critical access hospitals that treat Medicare patients paid under the IPF PPS are subject to the IPFQR program. CMS uses the terms "facility" or IPF to refer to both inpatient psychiatric hospitals and psychiatric units.

report certain standardized patient assessment data using a standardized patient assessment instrument (PAI) developed by the Secretary.

Per statute, an IPF that does not meet the requirements of participation in the IPFQR program for a fiscal year is subject to a 2.0 percentage point reduction in the update factor for that year. The payment determination is the year in which an IPF would receive the 2 percentage point reduction to the annual update to the standard federal rate. The data submission period is prior to the payment determination and is the period during which IPFs are required to submit data on the specified quality measures for that determination year. Substantive changes to the IPFQR program are proposed and finalized through rulemaking.

For the FY 2025 payment determination, based upon compliance with the IPFQR program requirements, of the 1,514 IPFs eligible for the IPFQR program, 86 failed to report successfully and received a 2.0 percentage point reduction. An additional 40 facilities chose not to participate and were subject to the 2.0 percentage point reduction.

For more information about the program, see https://qualitynet.cms.gov/ipf/ipfqr and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS.

B. Proposal to Modify the Reporting Period of the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an IPF Discharge (IPF ED Visit) Measure

The IPF ED Visit measure was adopted into the IPFQR Program beginning with the FY 2027 payment determination to address a gap in the measure set regarding patient outcomes in the period following discharge from the IPF; that is the post-discharge use of ED visits that do not result in a hospital admission.[3] The reporting period for the measure is a one-year period and will be CY 2025 for the FY 2027 payment determination. When adopted, the measure was intended to complement the IPF Unplanned Readmission measure, which assesses hospital readmissions post-discharge from an IPF. The IPF Unplanned Readmission measure uses a 2-year reporting period.

Therefore, CMS proposes to change the 1-year reporting period for the IPF ED Visit measure to instead be a 2-year reporting period, consistent with the IPF Unplanned Readmission measure's reporting period. To align the measures, the 2-year reporting period would be from July 1st (4 years before the applicable FY payment determination) to June 30th (2 years before the applicable FY payment determination). This would mean: (i) the first reporting period for the IPF ED Visit measure would be quarter 3 of 2025 through quarter 2 of 2027 for the FY 2029 payment determination; (ii) the first payment determination for the measure would be the FY 2029 payment determination instead of the FY 2027 payment determination; and (iii) the measure would first be publicly reported in the January 2029 release on the Compare tool.

[3] FY 2025 IPF PPS final rule (89 FR 64650-64659)

C. Proposal to Remove the Facility Commitment to Health Equity (FCHE) Measure

The FCHE structural measure was adopted into the IPFQR program in the FY 2024 IPS PPS final rule[4] to provide IPF leadership with actionable health data to assist in eliminating health disparities. CMS proposes to remove the measure beginning with the FY 2026 payment determination on the basis of removal factor 8, which is that the costs associated with achieving a high score on the measure outweigh the benefits of its continued use in the program. The agency is refocusing on clinical outcomes measures and quality measures that address the topics of prevention, nutrition, and well-being. CMS believes the removal of the FCHE measure will allow IPFs to focus on those priority areas. If finalized, (i) IPFs that do not report their 2024 reporting data for the measure would not be considered noncompliant with the measure for the FY 2026 payment determination; and (ii) any data received for the measure by CMS would not be used for public reporting or payment purposes.

D. Proposal to Remove the COVID-19 Vaccination Among Healthcare Personnel (COVID HCP) Measure

The COVID HCP measure tracks vaccination status for employees, licensed independent practitioners, trainers/volunteers, and other contract personnel of an IPF and requires IPFs to report data for one week each month for each of the months in a quarter. CMS believes that with the end of the public health emergency period and decrease in COVID-19 deaths, the continued costs and burden to providers to track and report the measure outweigh the benefits of continued information collection on the measure.

Therefore, CMS proposes, beginning with the 2024 reporting period/FY 2026 payment determination, to remove the COVID HCP measure under removal factor 8 (the costs associated with the measure outweigh the benefits of its continued use). If finalized, (i) IPFs that do not report their 2024 reporting data for the measure would not be considered noncompliant with the measure for the FY 2026 payment determination; and (ii) any data received for the measure by CMS would not be used for public reporting or payment purposes.

E. Proposed Removal of Two Social Drivers of Health (SDOH) Measures

CMS proposes to remove, beginning with the 2024 reporting period/FY 2026 payment determination, to remove the Screening for SDOH measure[5] and the Screen Positive Rate for SDOH (Screen Positive) measure[6] based on removal factor 8 (the costs associated with the measures outweigh their continued use). CMS points to the burden to providers of screening patients, storing the data, training staff, and altering workflows. If finalized, (i) IPFs that do not report their 2024 reporting data for the measures would not be considered noncompliant with the measure for the FY 2026 payment determination; and (ii) any data received for either measure by CMS would not be used for public reporting or payment purposes.

[4] 88 FR 51100-51107
[5] Adopted at 88 FR 51107-51117.
[6] Adopted at 88 FR 51117-51122.

F. Summary of IPFQR Program Measures for FY 2028 Payment Determination and Subsequent Years

The IPFQR Program measure set for the FY 2028 payment determination is set forth in Table 5 of the rule (shown below with slight modifications for formatting and explanations).

IPFQR Measure Set for FY 2028 IPFQR Program

CBE #	Measure ID	Measure
Required Measures		
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 Unplanned Readmission	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
n/a	IPF ED Visit	Thirty-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge^
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
n/a	COVID HCP	COVID-19 Healthcare Personnel (HCP) Vaccination^^
n/a	Facility Commitment	Facility Commitment to Health Equity^^
n/a	Screening for SDOH	Screening for Social Drivers of Health^^
n/a	Screen Positive	Screen Positive Rate for Social Drivers of Health^^

*Measure is no longer endorsed by the CBE but was endorsed at time of adoption. Section 1886(s)(4)(D)(ii) of the Act authorizes the Secretary to specify a measure that is not endorsed by the CBE as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS 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.
**Reporting for PIX is voluntary for the FY 2027 payment determination and required beginning for the FY 2028 payment determination.
^The reporting period is proposed to be modified for this measure in section IV.B of the proposed rule.
^^Facility Commitment (FCHE), COVID HCP, Screen Positive, and Screening for SDOH are proposed for removal in sections IV.C, IV.D, and IV.E of the proposed rule.

G. IPFQR Program Extraordinary Circumstances Exception (ECE) Policy

Under the current ECE policy at §412.433(f), CMS grants exceptions from the quality data reporting requirements for extraordinary circumstances beyond the control of an IPF.

CMS proposes to update the ECE policy to (i) specify that an ECE could be in the form of an extension of a deadline for an IPF to comply with a reporting requirement if CMS determines that type of relief is appropriate, and (ii) further clarify the policy. The clarifications would specify that CMS may grant an ECE with respect to reporting requirements in the case of an extraordinary circumstance beyond the control of an IPF. An extraordinary circumstance would be defined as "an event beyond the control of an IPF (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year." CMS states that the process for IPFs to request and CMS to grant an ECE would remain the same as the current process.[7] CMS proposes that an IPF would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred (as opposed to the current 90 days) in order to align with CMS systems implementation requirements across quality reporting programs. In the preamble of the rule CMS clarifies its authority to grant an ECE at any time after the circumstance. As proposed, §412.433(f)(3) would state that CMS may grant an ECE to IPFs that have not made a request for one if CMS determines that a systemic problem with the CMS data collection system directly impacted the ability of the IPF to comply with the requirements or the circumstance has affected an entire region or locale. Any ECE granted would specify whether the IPF is (or IPFs are) exempted from reporting requirements or CMS has granted an extension for compliance.

H. RFIs on Future Changes to the IPFQR Program

1. RFI: Future Star Ratings for IPFs

CMS describes how star ratings are intended to help consumers more easily understand complex information about health care providers' quality of care and compare providers to help inform decision-making. The star ratings summarize provider performance using symbols. Although CMS publicly reports data on measures under the IPFQR Program on the Compare tool, there are no star ratings displayed for IPFs and IPFs are not included in hospital star ratings.

The agency is seeking feedback on the development of a 5-star methodology for IPFs to describe the quality of care offered by IPFs. CMS provides specific numbered questions (and notes the numbers are to aid in providing feedback). Some of the topics for comment include:

- Specific criteria CMS should use to select measures for an IPF star rating system, such as a measure's generalizability.
- Whether an IPF star rating system should be limited to or more heavily weight certain measures (such as process, structural, outcome or measures that address certain topics).

[7] The current process is available on CMS QualityNet at https://qualitynet.cms.gov/inpatient/iqr/participation#tab3.

- From the patient/family/caregiver perspective, the measures in the IPFQR Program that are most and least important for summarizing quality of care, as well as any measures that should be excluded or included for a star ratings system.
- Recommendations regarding whether and how the HBIPS-2 and HBIPS-3 measures (both of which are calculated and publicly reported as a rate per 1000 hours of patient care) should be included in a star ratings methodology.
- Feedback regarding inclusion of the PIX survey measure, such as whether it should be included as part of an overall star rating or used for a stand-alone patient experience star rating.
- Any measurement topics not currently addressed by an IPFQR measure that would be valuable for an IPF star rating.

2. RFI: Future Measures

CMS seeks comment on the importance, relevance, appropriateness, and applicability of future quality measure concepts of well-being and of nutrition. With respect to well-being, the agency requests input on the tools and measures that assess for overall health, happiness, and satisfaction in life. With respect to nutrition, the agency requests input on tools and frameworks that promote healthy eating habits, exercise, nutrition, or physical activity for optimal health.

3. RFI: Digital Quality Measurement: Approach to FHIR Patient Assessment Reporting in the IPFQR Program

IPFs participating in the IPFQR Program must collect and submit specified standardized patient assessment data using a new standardized patient assessment instrument beginning with FY 2028. CMS believes achieving interoperability is important and reiterates its goal to facilitate secure data sharing, access, and use of electronic health information. The agency is considering ways to advance reporting of data for the IPF patient assessment instrument (PAI) based on Fast Healthcare Interoperability Resources® (FHIR) standards.

The agency seeks information on how IPFs integrate technologies into existing systems and how the integration affects workflow, particularly to identify the challenges during the integration and to determine support that is needed. The agency lists many specific questions on which it is seeking feedback regarding the state of health IT use in IPFs. Some of those areas of inquiry include:

- The extent to which IPFs use health IT systems to maintain and exchange patient records; for IPFs that use electronic records, the types of health IT that are used to maintain patient records and whether the systems are certified by the ONC Health IT Certification Program.
- Whether patient assessment data is submitted directly to CMS or through a third party intermediary (TPI); how information is exchanged by the IPF with other providers or systems, and challenges faced with the electronic exchange of health information or with the IPF's current electronic devices (such as Internet access or connectivity).
- Steps taken by the IPF to implement health IT systems that are compliant with security and patient privacy requirements; and whether the IPF uses the SAFER Guides to self-assess EHR safety practices.

- Challenges faced when submitting quality measure data.
- Types of technical assistance, guidance, training, and resources that would be most beneficial for implementing FHIR-based technology for the submission of IPF-PAI and how quality improvement organizations could enhance the support.
- Whether the facility is using technology that utilizes APIs based on the FHIR standard and how the adoption of such technology could impact workflow or quality of care.
- Any other information that should be considered for adoption and integration of FHIR-based technologies and standardized data for patient assessment instruments.

CMS notes it issued the same RFI as this one in the FY 2026 IPPS/LTCH PPS proposed rule.

IV. Regulatory Impact Analysis

CMS estimates that payments to IPF providers for FY 2026 will increase by $70 million due to the 2.4 percent update to the payment rates. Not included in this estimate are any reduced payments associated with the required 2.0 percentage point reduction to the market basket increase factor for any IPF that fails to meet the IPFQR Program requirements.

Table 11 in the proposed rule, reproduced below, shows the estimated effects of the IPF PPS proposed rule policies by type of IPF using the December 2024 update of FY 2024 MedPAR claims data.

Facility by Type	Number of Facilities	Outlier	Refinement of Facility-Level Adjustments	Wage Index FY26, Labor-Related Share, and 5% Cap	Total Percent Change*
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,393	0.0	0.0	0.0	2.4
Total Urban	1,148	0.0	0.0	0.1	2.4
Urban unit	626	-0.1	0.4	0.1	2.8
Urban hospital	522	0.0	-0.5	0.0	1.9
Total Rural	245	0.0	0.2	-0.3	2.2
Rural unit	184	0.0	0.2	-0.3	2.2
Rural hospital	61	0.0	0.2	-0.4	2.2
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	112	-0.1	0.8	0.3	3.4
Non-Profit	98	0.0	-0.3	0.0	2.1
For-Profit	312	0.0	-0.7	-0.1	1.5

Facility by Type	Number of Facilities	Outlier	Refinement of Facility-Level Adjustments	Wage Index FY26, Labor-Related Share, and 5% Cap	Total Percent Change*
Rural Psychiatric Hospitals					
Government	28	-0.1	0.2	0.2	2.7
Non-Profit	13	-0.1	0.3	-0.9	1.7
For-Profit	20	0.0	0.1	-0.5	2.0
IPF Units					
Urban					
Government	91	-0.1	1.5	-0.2	3.6
Non-Profit	414	-0.1	0.3	0.3	3.0
For-Profit	121	0.0	-0.4	-0.2	1.8
Rural					
Government	42	0.0	0.2	-0.6	1.9
Non-Profit	103	0.0	0.3	0.0	2.7
For-Profit	39	0.0	0.1	-0.7	1.8
By Teaching Status:					
Non-teaching	1,189	0.0	-0.6	0.0	1.8
Less than 10% interns and residents to beds	101	-0.1	0.5	0.0	2.9
10% to 30% interns and residents to beds	77	-0.1	3.0	0.1	5.5
More than 30% interns and residents to beds	26	-0.1	10.3	-0.5	12.3
By Region:					
New England	94	-0.1	0.1	1.1	3.6
Mid-Atlantic	192	-0.1	0.3	-0.2	2.5
South Atlantic	221	0.0	0.4	-0.4	2.4
East North Central	220	0.0	-0.3	0.5	2.6
East South Central	138	0.0	-0.3	0.2	2.4
West North Central	91	-0.1	0.0	1.2	3.5
West South Central	215	0.0	-0.2	-0.5	1.6
Mountain	97	0.0	-0.3	0.3	2.4
Pacific	125	-0.1	-0.1	-0.8	1.4
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	91	0.0	-0.4	-0.2	1.8
Beds: 25-49	89	0.0	-0.7	0.4	2.1

Facility by Type	Number of Facilities	Outlier	Refinement of Facility-Level Adjustments	Wage Index FY26, Labor-Related Share, and 5% Cap	Total Percent Change*
Beds: 50-75	93	0.0	-0.4	0.1	2.1
Beds: 76 +	310	0.0	-0.4	-0.2	1.8
Psychiatric Units					
Beds: 0-24	409	0.0	-0.1	0.0	2.2
Beds: 25-49	231	0.0	0.6	0.1	3.1
Beds: 50-75	100	-0.1	0.6	0.2	3.2
Beds: 76 +	70	-0.1	0.6	0.0	2.9

*This column includes the impact of the updates in columns (3) through (5) above, and of the proposed IPF market basket update factor for FY 2026 (3.2 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act