DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1831–F]

RIN 0938–AV46

Medicare Program; FY 2026 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

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

ACTION: Final rule.

SUMMARY: This final rule updates 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 final rule also revises the payment adjustment factors for teaching status and for IPFs located in rural areas. These changes will be effective for IPF discharges occurring during the fiscal year beginning October 1, 2025, through September 30, 2026. We are finalizing changes to measures used in the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program, updating and codifying the Extraordinary Circumstances Exception policy, and summarizing comments received through requests for information regarding future changes to the IPFQR Program.

DATES: These regulations are effective October 1, 2025.

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 Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program.

SUPPLEMENTARY INFORMATION:

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

Addendum A to this final rule summarizes the fiscal year (FY) 2026 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 final rule shows the complete listing of ICD–10 Clinical Modification (CM) and Procedure Coding System (PCS) codes, the FY 2026 IPF PPS comorbidity adjustment, and electroconvulsive therapy (ECT) procedure codes. Addenda A and B to this final rule are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/tools-and-worksheets.*

Tables setting forth the FY 2026 Wage Index for Urban Areas Based on Core Based Statistical Area (CBSA) Labor Market Areas, the FY 2026 Wage Index Based on CBSA Labor Market Areas for Rural Areas, and the FY 2026 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 final rule updates 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) 2026, (beginning October 1, 2025, through September 30, 2026). This rule also revises the payment adjustment factors for teaching status and for IPFs located in rural areas. Lastly, this final rule modifies a quality measure, removes four quality measures, and updates and codifies the Extraordinary Circumstances Exception (ECE) policy under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program.

B. Summary of the Major Provisions

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

For the IPF PPS, we are finalizing our proposals to:

- Revise the facility-level IPF PPS adjustment factors for teaching status and for IPFs located in rural areas.
- 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 updates:

++ The IPF PPS Federal per diem base rate from $876.53 to $892.87.

++ The IPF PPS Federal per diem base rate for providers who failed to report quality data to $875.44.

++ The electroconvulsive therapy (ECT) payment per treatment from $661.52 to $673.85.

++ The ECT payment per treatment for providers who failed to report quality data to $660.70.

++ The labor-related share from 78.8 percent to 79.0 percent.

++ The wage index budget neutrality factor to 1.0011. This final rule applies a refinement standardization factor of 0.9927.

++ The fixed dollar loss threshold amount from $38,110 to $39,360, to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

2. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

For the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program, we are finalizing our proposals to modify the reporting period of the 30-Day Risk-Standardized All Cause Emergency Department (ED) Visit Following an IPF Discharge measure, remove the Facility Commitment to Health Equity measure, remove the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, remove the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures, and update and codify changes to the Extraordinary Circumstances Exception (ECE) policy. In addition, we are summarizing comments received on three topics through requests for information on a potential future star rating system for IPFs, future measure concepts for the IPFQR Program, and on using the Fast Healthcare Interoperability Resources® (FHIR®) standard for electronic exchange of healthcare information for patient assessment reporting.

C. Summary of Impacts

Provision description	Total transfers & cost reductions
FY 2026 IPF PPS payment update	The overall economic impact of this final rule is an estimated $70 million in increased payments to IPFs during FY 2026.

Provision description	Total transfers & cost reductions
IPFQR Program update, including measure removals	We estimate a cost reduction of $1,746,474 ($1,731,712 in CY 2026 and a further $14,761 in CY 2027) for facilities and patients due to the policies we are finalizing for the IPFQR Program.

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 IPFQR 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 IPFQR 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 final 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 2025 IPF PPS final rule (89 FR 64582), appeared in the **Federal Register** on August 7, 2024. The FY 2025 IPF PPS final rule updated the patient-level adjustments and the ED adjustment as well as increased the ECT per treatment payment amount for FY 2025, 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 2024 IPF PPS final rule (88 FR 51054). In revising the IPF PPS patient-level adjustment factors, 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 patient 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 2025 IPF PPS proposed rule (89 FR 23154 through 23161) and our FY 2025 IPF PPS final rule (89 FR 64594 through

64601). For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

As required by section 1886(s)(5)(D)(iii) of the Act, revisions to the IPF PPS payment rates implemented pursuant to section 1886(s)(5)(D)(i) of the Act must be budget neutral. Therefore, we finalized a refinement standardization factor for the FY 2025 IPF PPS payment rates to maintain budget neutrality for FY 2025. The application of the FY 2025 standardization factor is described in detail in our FY 2025 IPF PPS proposed rule (89 FR 23194) and our FY 2025 IPF PPS final rule (89 FR 64640 and 64641).

III. Analysis of and Responses to the Public Comments

We received 55 public comments that pertain to proposed IPF PPS payment policies, requests for information, and the proposed updates to the IPFQR Program. Comments were from inpatient psychiatric facilities, health systems, national and state level provider and patient advocacy organizations, health information technology providers, and individuals. We reviewed each comment and grouped related comments, after which we placed them in categories based on subject matter or section(s) of the regulation affected. Summaries of the public comments received and our responses to those comments are provided in the appropriate sections in the preamble of this final rule.

In addition, we received a few comments that were out of the scope of the FY 2026 IPF PPS proposed rule. We appreciate these comments but note that, because they fall outside the scope of this rulemaking, we do not address them in this rule. We may consider these comments as we continue to develop policies for future rulemaking, as applicable.

IV. Provisions of the FY 2026 IPF PPS Final Rule and Responses to Comments

A. FY 2026 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. FY 2026 IPF Market Basket Update

For FY 2026 (beginning October 1, 2025, and ending September 30, 2026), we proposed 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 proposed to estimate the market basket update for the IPF PPS based on the most recent forecast available at the time of rulemaking from IHS Global Inc. (IGI).[1] IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets and productivity adjustment. For the proposed rule, based on IGI's fourth quarter 2024 forecast with historical data through the third quarter of 2024, the proposed 2021-based IPF market basket increase factor for FY 2026 was 3.2 percent. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the FY 2026 IPF market basket update in this final rule.

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 (MFP) (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. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act was published by BLS as private nonfarm business MFP. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business TFP. However, as mentioned previously, the data and methods are unchanged. We refer readers to *www.bls.gov* 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.* In addition, in the FY 2022 IPF PPS final rule (86 FR 42611), we noted that effective with FY 2022 and forward, CMS changed the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment.

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 the FY 2026 IPF PPS proposed rule, based on IGI's fourth quarter 2024 forecast, the proposed productivity adjustment for

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

FY 2026 (the 10-year moving average change of TFP for the period ending FY 2026) was projected to be 0.8 percentage point. Accordingly, we proposed to reduce the proposed 3.2 percent IPF market basket increase by the proposed 0.8 percentage point productivity adjustment, as mandated by the Act. This resulted in a proposed FY 2026 IPF PPS payment rate update of 2.4 percent (3.2 percent − 0.8 percentage point = 2.4 percent). We also proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2026 IPF market basket increase and productivity adjustment for the final rule.

We solicited comments on the proposed IPF market basket increase and productivity adjustment for FY 2026. The following is a summary of the comments we received and our responses.

Comment: Several commenters expressed appreciation for the FY 2026 IPF payment update; however, some commenters stated that the proposed payment update is inadequate to address the current cost pressures IPFs are facing. A commenter highlighted that from 2022 to 2024, general inflation rose by 14.1 percent while Medicare IPF payment rates increased only 5.1 percent, effectively creating a payment cut in real terms. Another commenter provided data showing that hospital employee compensation grew by 45 percent from 2014 to 2023, while IPF PPS updates provided only a 23.5 percent increase during the same period. Commenters explained that this has created an unsustainable financial environment where Medicare payments have consistently failed to keep pace with the actual cost of caring for patients.

Commenters stated that workforce shortages and escalating labor costs represent the most significant challenge facing IPFs, with labor constituting approximately 80 percent of the IPF PPS market basket according to CMS data. A commenter reported that advertised salaries for registered nurses have grown 26.6 percent faster than the rate of inflation over the past 4 years, while hospitals have been forced to dramatically increase wages, bonuses, and contract labor rates to maintain critical staffing. A couple of commenters stated that rural facilities face particularly acute challenges because their IPFs rely heavily on traveling clinicians and contract staff due to severe workforce shortages in underserved areas. This commenter stated that rural facilities also face higher per-patient infrastructure costs due to lower patient volumes, limited access to community-based alternatives that result in longer patient stays, and transportation barriers that require additional investment in discharge planning and patient support services. Several commenters stated that IPFs are facing significant increases in pharmaceutical and supply costs that further strain their operating budgets, citing a Department of Health and Human Services report showing that prices for nearly 2,000 drugs increased an average of 15.2 percent from 2017 through 2023, notably faster than general inflation. The commenters indicated that drug shortages have compounded these challenges, with medications commonly used in psychiatric care—including clonazepam, oxazepam, and ketamine—experiencing supply disruptions that force facilities to seek more expensive alternatives and disrupt patient care protocols.

A commenter stated the IPF market basket is flawed due to CMS's use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket. The commenter stated that the ECI might not fully capture growth in employment and labor costs, as it does not account for changes driven by shifts between different categories of labor such as between staff and contract employees.

Several commenters stated that the inadequate payment update threatens the long-term sustainability of inpatient psychiatric services and could force facilities to reduce capacity or close altogether. A commenter added that Medicare Advantage is having even further negative impacts on IPFs by reimbursing for IPF services at rates below cost. The commenter explained that since their patient mix is close to 50 percent covered by Medicare fee-for-service (FFS) and Medicare Advantage, they are less able to mitigate losses by increasing rates on commercial payors to offset those losses. Commenters urged CMS to adopt a higher market basket update that reflects the true cost of providing inpatient psychiatric care in the current economic environment noting that the Medicare Advantage plans have a forecasted increase for 2026 of about 5 percent. Several organizations specifically requested that CMS utilize more recent cost data in developing the final rule.

Response: We appreciate the commenters' concern regarding inflationary pressure facing IPFs and the proposed FY 2026 market basket update. As stated in the FY 2024 IPF final rule (88 FR 541057) and FY 2025 IPF final rule (89 FR 64586), the 2021-based IPF market basket is a fixed-weight, Laspeyres-type index that measures price changes over time. Since the inception of the IPF PPS, the IPF payment rates (with the exception of statutorily-mandated updates) have been updated by a projection of a market basket percentage increase—consistent with other CMS PPS updates (including IPPS, SNF, and HH). The market basket is designed to measure price inflation for IPF providers and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services (such as the quantity of labor used).

Additionally, we acknowledge that the market basket updates may differ from other overall inflation indexes such as the topline CPI; however, we would reiterate that these topline indexes are not comparable since they measure different mixes of products, services, or wages than the IPF market basket. Additionally, the market basket updates appropriately differ from other payment updates (such as projected increase in the average per capita payments to Medicare Advantage organizations) that are not consistent in concept with the statutory requirement as they would reflect anticipated volume and intensity of services.

As is our general practice, we proposed in the FY 2026 IPF proposed rule that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2026 IPF market basket update for the final rule. The projection of the 2021-based IPF market basket is based on the most recent forecast from IGI—a nationally recognized economic and financial forecasting firm with which we contract to forecast the price proxies of the market baskets. We also note that when developing its forecast for labor prices, IGI considers overall labor market conditions (including rise in contract labor employment due to tight labor market conditions) as well as trends in contract labor wages, which both have an impact on wage pressures for workers employed directly by the hospital.

For this final rule, based on the more recent IGI second quarter 2025 forecast with historical data through the first quarter of 2025, the projected 2021-based IPF market basket increase factor for FY 2026 is 3.2 percent, which is unchanged from the projected FY 2026 market basket increase factor in the proposed rule. We note that while there are multiple offsetting factors contributing to differences in the forecasts underlying the proposed and final rules, the final FY 2026 productivity-adjusted IPF market basket

update is slightly higher due to economic uncertainty.

We rebased and revised the IPF market basket in the FY 2024 IPF final rule (88 FR 51057) and did not receive any comments related to the use of the ECIs in the IPF market basket. We continue to believe the ECI is an appropriate index to measure the price changes for Compensation costs. While the ECI reflects the price changes for employed staff only, we believe those price changes accurately reflect the labor price trends for those occupations, regardless of whether they are employed or contracted staff. Additionally, separating the compensation category by occupation enables us to capture any cost weight changes associated with employing versus contracting labor when the index weights are updated. We will continue to monitor the trends in the ECI as well as the increased use of contract labor. We welcome any additional publicly available data that commenters can provide regarding alternative price indexes.

Comment: Several commenters expressed concerns regarding the ongoing application of the productivity adjustment to IPFs. The commenters highlighted that CMS identified a lag in hospital productivity compared to the BLS estimate of private nonfarm business productivity growth. Commenters stated that under these circumstances, expecting an increase in IPF productivity in FY 2026 is unreasonable.

A commenter further expressed concerns with the mandated productivity adjustment by stating that private nonfarm business TFP productivity measures are unsuitable for hospitals. They stated that while TFP outputs in private businesses are based on quantities and prices of goods/services, hospital outputs, such as visit/procedure volumes, reflect community disease burdens rather than productivity. Additionally, the commenter explained that hospitals cannot adjust their prices like private businesses due to fixed reimbursements and negotiated rates with insurers. This commenter also stated that TFP does not account for the unique challenges faced by hospitals, including unpredictable patient volumes, rising costs, varying acuity levels, and regulatory burdens unfamiliar to other industries. Finally, commenters stated that hospital services are labor-intensive, making sustained productivity gains difficult. Commenters explained that, similar to education and social assistance sectors, hospitals have lower productivity rates. Commenters further noted that CMS recognizes hospitals achieve only one-third of the productivity gains of the private sector, citing a June 2022 memorandum from CMS. This memo stated that ''over the period 1990–2019, the average growth rate of hospital [productivity] using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business [productivity] of 0.8 percent.'' [2] The memo also indicated that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remained reasonable compared to an assumed productivity growth rate in the private nonfarm business sector of 1.0 percent.

A commenter questioned the increase of the FY 2026 productivity cut to 0.8 percent from 0.5 percent in FY 2025 despite being based on a 10-year moving average, which should smooth out fluctuations. They mentioned an inability to fully analyze projections due to CMS's lack of transparency but suggested that excluding a low-TFP growth period in 2016 from the updated 10-year moving average may unjustifiably increase the productivity adjustment. The commenter also claimed that the productivity adjustment is only applied if it reduces Medicare payments, never to increase them. They provided an example from FY 2021, where a −0.1 percent productivity factor forecast would have raised the hospital market basket by 0.1 percentage point, but CMS set it at 0, citing a mandate to reduce, not increase, the market basket percentage increase based on productivity changes. This practice leads to cumulative yearly reductions and asymmetric treatment of productivity declines, resulting in underfunding for hospitals.

Several commenters acknowledged the Affordable Care Act's requirement for the productivity adjustment but requested CMS use its ''special exceptions and adjustments'' authority to eliminate or modify the productivity adjustment for FY 2026. Some commenters requested that CMS carefully monitor the impact of these productivity adjustments on the IPF hospital sector, provide feedback to Congress as appropriate, and reduce the productivity adjustment.

Response: 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) to the IPF PPS market basket update. As required by statute, the FY 2026 productivity adjustment is derived based on the 10-year moving average growth in economy-wide private nonfarm business total factor productivity for the period ending FY 2026. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, we are required pursuant to section 1886(b)(3)(B)(xi)(II) of the Act to apply the specific productivity adjustment described here.

We have always made available on the CMS website the general method for calculating the productivity adjustment. This includes providing a link to the most recent BLS historical TFP data (*https://www.bls.gov/productivity/*), which allows interested parties to obtain historical TFP annual index levels for 1987 through 2024. We also provided the IGI projection model (*https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf*), which is used to derive annual TFP growth rates for 2025 and 2026. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2026 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2026, relative to the 40-quarter moving average projected level for the period ending September 30, 2025. We believe our methodology for the productivity adjustment is consistent with section 1886(b)(3)(B)(xi)(II) of the Act, which states that the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period), which is used to derive annual TFP growth rates for 2025 and 2026. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2026 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2026, relative to the 40-quarter moving average projected level for the period ending September 30, 2025.

At the time of this final rule, the FY 2026 productivity adjustment reflects BLS historical TFP data through 2024 (released on March 21, 2025) and IGI's forecasted TFP growth for 2025 and 2026. The average annual growth rate of historical TFP published by BLS for 2017 through 2024 is currently 0.9 percent and IGI is projecting average

[2] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, ''Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019.'' (*cms.gov*).

TFP growth of about 0.0 percent for 2025 and 2026 based on IGI's second-quarter 2025 forecast. Combining the historical and projected TFP data over the entire 10-year time period results in a compound annual growth rate of TFP of 0.7 percent for 2026. The productivity adjustment (based on the 10-year period ending FY 2026) for this final rule is 0.1 percentage point lower than in the proposed rule and primarily reflects the incorporation of a revised outlook from IGI that has lower projected economic growth over 2025 and 2026. The 0.7 percentage point productivity adjustment in the FY 2026 final rule is larger than the productivity adjustment in prior final rules for FY 2023 and FY 2024 mainly due to the incorporation of updated BLS historical data.

In response to commenters' concerns about the productivity adjustment only being applied if it reduces the payment update, we note that the productivity adjustment was established under the Affordable Care Act with a specific policy intent to encourage efficiency improvements in healthcare delivery by linking Medicare payment updates to economy-wide productivity gains. The statutory language in section 1886(s)(2)(A) of the Act requires that the Secretary reduce (not increase) the market basket percentage increase by changes in economy-wide productivity, therefore, only positive productivity adjustments are applied.

Comment: Several commenters noted concerns about CMS's estimation of the IPF market basket updates since the COVID–19 PHE, stating that it has resulted in several consecutive years of underpayments to IPF providers, with data showing that market basket updates for fiscal years 2021 through 2024 have understated the IPF base rate by 4.2 to 5.1 percentage points. The commenters stated that the pattern of forecast errors stems directly from economic disruption caused by the COVID–19 PHE, which created inflationary pressures that existing forecasting models failed to capture, representing a departure from historically more balanced forecasting performance. Some commenters stated that these under forecasts are built into the IPF base payment and because future updates are based on current payment levels, missed forecasts become permanently established in standard payment rates and continue to compound over time, creating an ever-widening gap between actual costs and reimbursement levels that disadvantages IPFs and inhibits their ability to address behavioral health needs in their communities. Several commenters urged CMS to take corrective measures including one-time adjustments ranging from 3.6 to 4.2 percentage points to account for cumulative forecast errors and requested that CMS use special exceptions and adjustments authority to eliminate productivity cuts and implement base rate corrections that would provide IPFs with stability needed to maintain access to patient care despite ongoing financial challenges.

Response: We appreciate the concerns of commenters; however, we did not propose and are not finalizing a forecast error adjustment for the IPF PPS for FY 2026. The IPF market basket updates are set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2026 market basket update in this final rule reflects historical data through the first quarter of CY 2025 and forecasted data through the third quarter of CY 2026.

While there is no precedent to adjust for market basket forecast error in the IPF payment update, a forecast error can be calculated by comparing the actual market basket increase for a given year less than the forecasted market basket increase. Due to the uncertainty regarding future price trends, forecast errors can be both positive and negative. The forecast error has been both positive and negative during past years, and over longer periods of time the cumulative forecast has not deviated significantly from the historical measures. Only considering the forecast error for years when the IPF market basket update was lower than the actual market basket update does not consider the full experience and impact of forecast error.

Final Decision: After consideration of the comments received, we are finalizing our proposal to update IPF PPS payment rates using the latest available productivity-adjusted market basket increase factor. Based on IGI's second quarter 2025 forecast, the 2021-based IPF market basket percentage increase for FY 2026 is 3.2 percent and the projected FY 2026 productivity adjustment is 0.7 percentage point. Therefore, the final FY 2026 IPF market basket update is equal to 2.5 percent (3.2 percent market basket percentage increase reduced by the 0.7 percentage point productivity adjustment).

3. FY 2026 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 will 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 proposed 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 proposed 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. 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 2026. Based on IGI's fourth quarter 2024 forecast of the 2021-based IPF market basket, the sum of the FY 2026 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 75.8 percent. We proposed, 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 2026, we proposed to take 46 percent of 6.7 percent to determine a labor-related share of Capital-Related costs for FY 2026 of 3.1 percent. Therefore, we proposed a total labor-related share for FY 2026 of 78.9 percent (the sum of 75.8 percent for the labor-related share of operating costs and 3.1 percent for the labor-related share of Capital-Related costs). We also proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2026 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).

We solicited comments on the proposed labor-related share for FY 2026. The following is a summary of the comments we received and our responses.

Comment: A commenter expressed support for the proposed increase in the labor-related share for FY 2026. They also stated that CMS should consider a shorter period than 5 years for the next rebasing and revising of the IPF market basket and revision to the standard payment conversion factor labor share since the current labor share is based on FY 2021 cost reports and may not fully reflect the increase weight of labor in the overall index that hospitals experienced due to the COVID–19 PHE and labor shortages.

Response: We appreciate the commenter's support for the FY 2026 IPF labor-related share. We proposed to use the FY 2026 relative importance values for the labor-related cost categories from the 2021-based IPF market basket because it accounts for more recent data regarding price pressures and cost structure of IPFs. This methodology is consistent with the determination of the labor-related share since the implementation of the IPF PPS. As stated in the FY 2026 IPF proposed rule, we also proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2026 labor-related share for the final rule. Based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the FY 2026 labor-related share for the final rule is 79.0 percent, which is 0.1 percentage point higher than the proposed rule.

We appreciate the commenter's request for us to consider a shorter period than 5 years for the next rebasing. We generally rebase the IPF market basket every 5 years, in part because the cost weights obtained from the Medicare cost reports did not indicate much of a change in the weights over shorter intervals. However, we recognize the commenter's concern and the potential impact of the PHE on the cost weights. Therefore, we have been regularly monitoring the Medicare cost report data to assess whether a rebasing is technically appropriate, and we will continue to do so in the future. As done historically, a rebasing of the IPF market basket would be proposed in rulemaking and subject to public comments.

Final Decision: After consideration of the comments, we are finalizing a FY 2026 labor-related share based on the latest available data. Based on IGI's second quarter 2025 forecast of the 2021-based IPF market basket, the sum of the FY 2026 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 75.9 percent. Since the relative importance for Capital-Related costs is 6.7 percent of the 2021-based IPF market basket for FY 2026, we take 46 percent of 6.7 percent to determine a labor-related share of Capital-Related costs for FY 2026 of 3.1 percent. Therefore, the total labor-related share for FY 2026 is 79.0 percent (the sum of 75.9 percent for the labor-related share of operating costs and 3.1 percent for the labor-related share of Capital-Related costs).

Table 1 shows the final FY 2026 labor-related share and the final FY 2025 labor-related share using the 2021-based IPF market basket relative importance.

TABLE 1—FY 2026 FINAL IPF LABOR-RELATED SHARE AND FY 2025 IPF LABOR-RELATED SHARE

	Relative importance, labor-related share FY 2025 [1]	Relative importance, labor-related share FY 2026 [2]
Wages and Salaries	53.6	53.7
Employee Benefits	14.1	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	75.7	75.9
Labor-related portion of Capital-Related (.46)	3.1	3.1
Total Labor-Related Share	78.8	79.0

[1] Based on the 2nd quarter 2024 IGI forecast of the 2021-based IPF market basket.
[2] Based on the 2nd quarter 2025 IGI forecast of the 2021-based IPF market basket.

B. Updates to the IPF PPS Rates for FY Beginning October 1, 2025

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/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.*

As discussed in sections IV.D.5. and IV.D.6. of this final rule, we proposed to revise the facility-level adjustment factors for FY 2026 pursuant to section 1886(s)(5)(D)(i) of the Act. Section 1886(s)(5)(D)(iii) of the Act requires that revisions to IPF payment rates implemented pursuant to section 1886(s)(5)(D)(i) of the Act must be made budget-neutrally. Therefore, as discussed in section IV.D.9. of this final rule, we proposed to apply a standardization factor to the FY 2026 base rate that takes these refinements of facility-level adjustments into account to keep total IPF PPS payments budget neutral.

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.

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).

We last updated the ECT payment amount per treatment for FY 2025. 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. These IPF stays with ECT treatment, which accounted for only 1.7 percent of all IPF stays in 2022 (down from 6.0 percent in 2002), were approximately three times more costly than IPF stays without ECT treatment. We noted that on average, IPF stays with ECT cost $44,687.50 compared to $15,432.30 for IPF stays without ECT treatment in 2022, with notable increases in per-day costs and ancillary expenses. While our standard payment update methodologies would have resulted in only minor adjustments, the analysis indicated that the updates to the ECT payment rates since 2005 had not kept pace with rising costs.

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. We stated that the change to the ECT per treatment amount aligned payments more closely with the actual cost of providing ECT. We noted that the increase to the ECT per treatment amount would be associated with a minor decrease to the IPF per diem base rate as a result of the refinement standardization factor, and it would increase payments to facilities providing ECT. 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).

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

The current (FY 2025) Federal per diem base rate is $876.53 and the ECT payment per treatment is $661.52. For the final FY 2026 Federal per diem base rate, we applied the final IPF market basket update of 2.5 percent (that is, the final 2021-based IPF market basket percentage increase for FY 2026 of 3.2 percent reduced by the final productivity adjustment of 0.7 percentage point), the final wage index budget neutrality factor of 1.0011 (as discussed in section IV.D.4.c. of this final rule), and the final refinement standardization factor of 0.9927 (as discussed in section IV.D.9. of this final rule) to the FY 2025 Federal per diem base rate of $876.53, yielding a final Federal per diem base rate of $892.87 for FY 2026. We applied the final IPF market basket update of 2.5 percent, the final wage index budget neutrality factor of 1.0011, and the final refinement standardization factor of 0.9927 to the final FY 2025 ECT payment per treatment of $661.52, yielding a final ECT payment per treatment of $673.85 for FY 2026.

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 final annual update to the Federal per diem base rate and the final ECT payment per treatment as follows:

- For IPFs that fail to report required data under the IPFQR Program, we will apply a 0.5 percent payment rate update—that is, the final IPF market basket increase for FY 2026 of 3.2 percent reduced by the final productivity adjustment of 0.7 percentage point for an update of 2.5 percent, and further reduced by 2.0 percentage points in accordance with section 1886(s)(4)(A)(i) of the Act. We will also apply the refinement standardization factor of 0.9927 and the wage index budget neutrality factor of 1.0011 to the FY 2025 Federal per diem base rate of $876.53, yielding a Federal per diem base rate of $875.44 for FY 2026.
- For IPFs that fail to report required data under the IPFQR Program, we will apply a 0.5 percent payment rate update, the 0.9927 refinement standardization factor, and the 1.0011 wage index budget neutrality factor to the FY 2025 ECT payment per treatment of $661.52, yielding an ECT payment per treatment of $660.70 for FY 2026.

C. 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 current (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 2026, we proposed to use the existing regression-derived patient-level adjustment factors established for FY 2025. We did not propose any changes to the patient-level adjustment factors for FY 2026; 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. 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. 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 2026, we proposed 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. We did not receive any comments on this proposal, and we are finalizing it as proposed. Addendum A is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.* Psychiatric principal diagnoses that do not group to one of the 19 designated MS–DRGs will still receive the Federal per diem base rate and all other applicable adjustments, but the payment will 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 final 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, which underlie the FY 2026 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.

In the FY 2026 IPF PPS proposed rule, we did not describe any code first changes effective for April 1, 2025, and we did not receive any comments about coding updates for the IPF PPS code first list. For this FY 2026 IPF PPS final rule, we are removing one ICD–10–CM diagnosis code and adding eight ICD–10–CM diagnosis codes to the IPF PPS code first list effective for October 1, 2025. The final FY 2026 Code First table is shown in Addendum B on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-forService Payment/InpatientPsychFacilPPS/tools.html.*

b. 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. Specifically, we removed 3 existing comorbidity categories, revised 2 existing comorbidity categories, and added 1 new comorbidity category. We finalized 15 comorbidity categories for FY 2025.

We did not propose any changes to the comorbidity adjustment factors, and we are retaining the existing comorbidity adjustment factors for FY 2026. The final FY 2026 comorbidity adjustment factors are found in Addendum A, available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/InpatientPsychFacilPPS/tools.html.*

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 IV.C.2.a of this final 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). In the FY 2026 IPF PPS proposed rule, we explained that for April 1, 2025, we added two ICD–10–PCS procedure codes to the Oncology Treatment Procedures list. We did not receive any comments on the April 1, 2025, coding changes.

For this FY 2026 IPF PPS final rule, we are adding 12 ICD–10–CM diagnosis codes to the Poisoning code list, removing 4 ICD–10–PCS procedure codes to the Oncology Treatment Procedure code list, and adding 2 ICD–10–CM diagnosis codes to the Oncology Treatment Diagnosis code list. The final FY 2026 comorbidity codes are shown in Addenda B, available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-*

ServicePayment/InpatientPsych FacilPPS/tools.html.

c. 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 2026, we proposed to use the patient age adjustments currently in effect for FY 2025.

We did not propose any changes to the patient age adjustment factors, and we are retaining the existing patient age adjustment factors for FY 2026, as shown in Addendum A of this final rule (see *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientPsychFacilPPS/tools.html*).

d. 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 IV.D.8. of this final 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 2026, we proposed to use the variable per diem adjustment factors currently in effect in FY 2025.

We did not propose any changes to the variable per diem adjustment factors, and we are retaining the existing variable per diem adjustment factors for FY 2026 as shown in Addendum A of this final rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientPsychFacilPPS/tools.html*).

D. Updates to the IPF PPS Facility-Level Adjustments

1. Overview of the IPF PPS Facility-Level Adjustment Factors

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 facility-level adjustment factors currently in place for rural location and teaching status are the existing regression-derived factors established in the RY 2005 IPF final rule. As discussed in the following sections, we proposed annual updates to the FY 2026 IPF PPS wage index. In addition, we proposed to update the facility-level adjustment factors for rural location and teaching status for FY 2026 to reflect more recent cost and claims data.

2. History of IPF PPS Cost and Claims Analyses

In the FY 2023 IPF PPS proposed rule (87 FR 19428 and 19429), we briefly discussed past analyses and areas of interest for future refinement, about which we previously solicited comments. At the same time, CMS also released a technical report posted to the CMS website [3] accompanying the rule, summarizing these analyses. In that same proposed rule, we described the results of the agency's latest analysis of the IPF PPS and solicited comments on certain topics from the report. We summarized the considerations and findings related to our analyses of the IPF PPS adjustment factors in the FY 2023 IPF PPS final rule (46864 through 46865).

In the FY 2024 IPF PPS proposed rule (88 FR 21269 through 21272), we requested information from the public to inform revisions to the IPF PPS required by the CAA, 2023. Specifically, we sought information about which data and information would be most appropriate and useful for the purposes of refining IPF PPS payments. We requested information related to the specific types of data and information mentioned in the CAA, 2023. We also solicited comments on the reporting of ancillary charges, such as labs and drugs, on IPF claims.

In response to those requests for information in the FY 2024 IPF PPS proposed rule, commenters offered a number of suggestions for further analysis, including recommendations to consider adjusting payment for patients with sleep apnea, violent behavior, and patients that transfer from an acute care unit.

In the FY 2025 IPF PPS proposed rule, we discussed our latest regression analysis results and the methodology we used to calculate proposed revisions to the patient-level adjustment factors (89 FR 23154 through 23161). In that same proposed rule (89 FR 23161 through 23172), we also discussed the analyses that we conducted and our findings, as related to patient-level adjustment factors, in response to the comments we received on the FY 2024 IPF PPS proposed rule.

As we have previously noted in the FY 2025 IPF PPS proposed rule (89 FR 23154), the primary goal in refining the IPF PPS payment adjustment factors is to pay each IPF an appropriate amount for the efficient delivery of care to Medicare beneficiaries. The system must be able to account adequately for each IPF's case-mix to allow for both fair distribution of Medicare payments and access to adequate care for those beneficiaries who require more costly care. As required by section 1886(s)(5)(D)(iii) of the Act, revisions to the IPF PPS adjustment factors made pursuant to section 1886(s)(5)(D)(i) of the Act must be budget neutral. As discussed in section IV.D.9 of this final rule, we are applying a refinement standardization factor to the final IPF PPS payment rates to maintain budget neutrality for FY 2026.

3. Development of the Revised Regression for Facility-Level Refinements

In the FY 2026 IPF PPS proposed rule, we explained that we performed an extensive regression analysis of the relationship between the per diem costs and certain patient- and facility-level characteristics to analyze those characteristics associated with statistically significant cost differences. As discussed in section IV.C of this final rule, we finalized revisions to the IPF PPS patient-level adjustments in the FY 2025 IPF PPS final rule (89 FR 64593 through 64614). As a result, we used a constrained regression model for FY 2026 to hold the patient-level adjustments at the level finalized for FY 2025. We discuss the results of this constrained regression analysis in

[3] *https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf.*

section IV.D.3.e of this final rule. We further discuss policies related to the revisions to the IPF PPS facility-level adjustment factors based on this regression analysis in sections IV.D.5 and IV.D.6 of this final rule.

For this FY 2026 IPF PPS final rule, we calculated a per diem cost (including routine and ancillary components) and identified patient and facility characteristics for each Medicare inpatient psychiatric stay using information from MedPAR files, Common Working File (CWF) inpatient claims, Medicare hospital cost reports, and other data sources for FY 2020 through FY 2022. We refer readers to the FY 2025 IPF PPS final rule for a discussion of the impact of the COVID–19 PHE and the benefits of using a combined set of data for the accuracy of the results (89 FR 64594).

We began with a base sample of IPF stays by Medicare FFS beneficiaries in MedPAR from FY 2020 through FY 2022, which contain a total of 712,543 stays from 1,650 IPFs. We applied several data restrictions and exclusions to remove stays with missing and or aberrant data. The final sample used for the regression analysis contained 704,472 stays from 1,633 IPFs, which reflects the removal of 17 providers and 8,071 stays.

In preparing the cost regression sample and analysis, we incorporated more recent input data and refined our data processing method, as described in this section. We estimated a baseline regression using the constrained model and conducted sensitivity analysis to confirm the robustness of our results.

a. Data Sources

For the regression analysis, our primary data sources include the annual MedPAR files, which provide stay-level summaries of IPF stays, and Medicare hospital cost reports, which contain provider-level data on costs, utilization, and other financial information. Additionally, we used the Common Working File (CWF) claims data, the Provider of Services (POS) files, and the Provider Specific File (PSF) to identify provider and patient characteristics and to construct variables in the regression model.

More specifically, we used the following sources of data:

- *MedPAR Files:* The annual MedPAR file compiles final action claims records for IPF stays discharged during the fiscal year. Each MedPAR record provides a summary of clinical characteristics, service utilization, facility billings, and Medicare coverage for an inpatient hospital stay. We use MedPAR to identify all IPF stays by Medicare FFS beneficiaries during the fiscal year, along with key variables such as MS–DRG, principal and secondary diagnosis, length of stay, patient age, admission source, provider charges by revenue center, and other patient and provider attributes. For the FY 2026 final rule cost regression, we used MedPAR files for FY 2020 through FY 2022.
- *Hospital Cost Reports:* Medicare hospital cost reports (CMS Form 2552–10; OMB control number 0938–0050) provide the key inputs for estimating the per diem cost of IPF stays, specifically the facility's routine per diem cost and Cost-to-Charge Ratios (CCRs) for detailed cost centers for each Federal FY. We also use hospital cost reports to obtain key facility characteristics, including teaching status, bed counts, and ownership type. For providers whose own fiscal periods align with the FY, we directly match their FY 2020–FY 2022 hospital cost reports to the corresponding MedPAR stays. For providers whose own fiscal periods differ from the FY, we use multiple years of hospital cost reports data and proportionally allocate and align them to the FY basis for FY 2020 through FY 2022 before linking them to other data sources. This allocation and alignment is discussed in greater detail later in this section of this final rule.
- *Common Working File (CWF) Inpatient Claims Data:* We use detailed claims data from the CWF to supplement MedPAR stay records, specifically obtaining data on covered charges by detailed revenue center and utilization of ECT treatments during each IPF stay. To promote internal consistency, we use the CWF claims data with the same final action week as the corresponding MedPAR record.
- *Provider of Services (POS) File:* The POS file contains facility characteristics such as name, address, and types of services provided. For the regression analysis for this FY 2026 IPF PPS final rule, we primarily use the POS file to identify providers' Federal Information Processing Series (FIPS) codes, which determine each provider's designated Core-Based Statistical Area (CBSA). The CBSA is then used to match providers with the corresponding geographic cost adjustment factor. Additionally, we use the POS file as a secondary source for provider ownership type.
- *Provider Specific Data for Public Use Files for the IPF PPS:* We use the Provider Specific File (PSF) to identify providers' COLA factors and other facility-level characteristics, including whether a facility has a qualified Emergency Department (ED).
- *IPF Market Baskets:* We used the historical IPF market basket increases and labor-related shares for the FY 2020–FY 2022 period.
- *IPF PPS Wage Index:* We use the IPF PPS wage index, along with COLA and labor-related share, to calculate the geographic cost adjustment factor, which accounts for regional cost differences among providers in each year. In this analysis, we used the FY 2024 IPF PPS wage index to adjust IPF costs in FY 2020, and FY 2025 IPF PPS wage index to adjust IPF costs in FY 2021 and FY 2022.

b. Trims and Assumptions

For the FY 2026 final rule regression analysis, we used a combined set of FY 2020 through FY 2022 MedPAR data, consistent with the approach we adopted for the FY 2025 IPF PPS proposed and final rules to revise the patient-level adjustment factors. Our analysis demonstrated that combining multiple years of data yields the most stable and consistent result. We continue to believe that using a 3-year combined set of data in the regression analysis helps smooth the impact of utilization changes driven by the COVID–19 PHE, as well as significant changes in staffing and labor costs that commenters noted in response to the FY 2023 and FY 2024 IPF PPS proposed rules. This data set best reflects the current cost of care as impacted by the COVID–19 PHE, which has an ongoing impact on IPF cost and utilization trends. Our approach mitigates the effect of these impacts in any single year by expanding the set of data.

Within the MedPAR dataset, we included inpatient hospital stays that met the following criteria:

- Hospital CMS Certification Number (CCN) contains ''40'', ''41'', ''42'', ''43'', or ''44'' in the third and fourth positions (freestanding psychiatric hospitals), a special unit code of ''S'' in the third position (psychiatric unit in an acute care hospital), a special unit code of ''M'' in the third position (psychiatric unit in a critical access hospital), or a special unit code of ''SA'', ''SB'', ''SC'', ''SD'', or ''SE'' in the third and fourth positions (psychiatric unit in a long-term care hospital (LTCH), rehabilitation hospital, or children's hospital).
- Beneficiary primary payer code is ''M'', ''N'', or blank, indicating that Medicare is the primary payer.
- Group Health Organization (GHO) paid code is zero or blank, indicating that a GHO has not paid the facility for the stay.

• National Claims History (NCH) claim type code is ''60,'' indicating a fee-for-service (FFS) inpatient claim.

• Covered charge and covered days (or Medicare utilization days) are greater than zero.[1]

For the FY 2020 through FY 2022 sample period, a total of 712,543 patient stays from 1,650 unique providers in MedPAR met these selection criteria. That includes 284,176 stays from 1,587 providers in FY 2020, 231,668 stays from 1,546 providers in FY 2021, and 196,699 stays from 1,522 providers in FY 2022.

Using this base sample, we applied a series of additional trimming steps to remove stays with missing or outlier cost data. A detailed description of how we estimate IPF per diem costs is provided in section IV.D.3.c of this-final rule. We removed the following:

• Stays with missing routine per diem cost data or missing provider hospital cost reports for the FY 2020–FY 2022 period. This step removed 240 stays from the sample, which came from 13 unique providers.

• Stays with extraordinarily high or low costs per day. Specifically, we removed 2,345 stays whose routine per diem costs fell outside the mean plus or minus 3.00 standard deviations of the natural logarithm of routine per diem costs in the combined 3-year sample. We also removed an additional 1,631 stays with total per diem costs that fell outside the mean plus or minus 3.00 standard deviations of the natural logarithm of total per diem costs in the combined 3-year sample. (All cost estimates were adjusted for geographic differences and year-over-year inflation.) In total, this trimming step removed 3,976 stays with extraordinarily high or low costs per day from 323 providers across the 3-year sample.[2]

Finally, we excluded all stays with an MS–DRG that is not recognized by the IPF PPS, which removed 3,855 stays from 954 providers from the remaining sample.

After these trimming steps, our final cost regression sample included 704,472 IPF stays by Medicare FFS beneficiaries from 1,633 unique IPF providers in MedPAR FY 2020 through FY 2022. This final sample consists of 280,959 stays from 1,569 providers in FY 2020, 229,125 stays from 1,521 providers in FY 2021, and 194,388 stays from 1,491 providers in FY 2022.

c. Calculation of the Dependent Variable

The regression model for this FY 2026 IPF PPS final rule uses the natural logarithm of the total per diem cost, adjusted for geographic differences and inflation, as the dependent variable. Total per diem costs are calculated as the sum of routine per diem costs and ancillary per diem costs, with both components including operating and capital costs.

• Routine per diem costs are derived from facility-level average routine cost per day reported in provider hospital cost reports as total inpatient routine costs divided by total inpatient days (Worksheet D–1, Part II, column 1, Line 41 divided by Line 9)[3] and assigned to individual patient stays within the facility.

• Ancillary per diem costs are calculated by applying the cost center cost-to-charge ratio (CCR) from the cost report to the covered charges from ancillary departments on CWF inpatient claims, then dividing by the number of Medicare covered days of the stay (available in MedPAR).

The total per diem costs (or costs per day) are further adjusted for geographic cost differences using IPF wage indices (for the labor-related share portion) and COLA factors (for the non-labor-related share portion for IPFs located in Alaska and Hawaii). Cost estimates are also adjusted for annual inflation based on the historical growth rates of the 2021-based IPF market basket.

To promote consistency, accuracy, and comparability of our data, we apply a series of methodological steps when calculating the dependent variable as follows:

(1) Addressing Variation in Cost Report Reporting Periods

Because providers can select their own fiscal/reporting periods for hospital cost reports, there is a lack of uniformity in the time periods covered by the raw cost report data from different providers. For example, within each annual HCRIS file, roughly 40 percent of the reports have a January through December cost reporting period (Calendar Year), 30 percent have a July through June cost reporting period, 15 percent have an October through September cost reporting period (Federal fiscal year (FFY), and the remaining 15 percent cover various other cost reporting periods. Moreover, some providers change their fiscal/reporting periods mid-year (sometimes due to an ownership change), resulting in shorter or longer hospital cost reports and, in some cases, multiple hospital cost reports within a single year.

To address this lack of uniformity in provider reporting periods and enhance data accuracy and consistency, we apply a re-allocation procedure to align all provider hospital cost reports data to the FFY basis before matching them to MedPAR stays. First, we allocate each provider's annual cost report data across the months, assuming uniform values per month within the reporting period. Then we regroup the monthly data to align with the FFY for each provider and calculate annual averages. When data for some months are missing, we use available partial-year data to extrapolate and construct the annual estimate.

For example, suppose a provider uses the CY as its cost reporting period. Its reported average routine per diem cost was $900 in CY 2019, $950 in CY 2020, $1000 in CY 2021, and $1100 in CY 2022. Its CCR for laboratory services is 0.30 in CY 2019, 0.25 in CY 2020, 0.32 in CY 2021, and 0.28 in CY 2022. Using the reallocation method, this provider's average routine per diem costs were $937.50 for FY 2020 (= 3/12*$900 + 9/12*$950), $987.50 for FY 2021, and $1,075.00 for FY 2022. Its CCR for laboratory services were 0.2625 for FY 2020, 0.3025 for FY 2021, and 0.2900 for FY 2022.

(2) Obtaining CCRs for Ancillary Cost Estimation

To estimate the costs of non-routine services provided during IPF stays, we group the cost centers from hospital cost reports and the revenue centers from CWF claims into 25 ''ancillary departments'': Pharmacy, Laboratory, Emergency Room, Medical/Surgical Supplies, Cardiology, Radiology, Magnetic Resonance Imaging (MRI), Physical Therapy, Occupational Therapy, Inhalation Therapy, Speech Pathology, Anesthesia, Operating Room, Intensive Care Unit (ICU), Coronary Care Unit (CCU), End Stage Renal Disease (ESRD), Professional Fees, Clinic Visit, Outpatient Services, Durable Medical Equipment (DME), Used DME, Blood, Blood Storage and Processing, Lithotripsy, and Other Services.[4]

For each ancillary department, we calculate each provider's CCR using the provider's cost report, Worksheet D. Specifically, we take ancillary department costs (Worksheet D–3, Column 3), subtract any positive inpatient pass-through costs (Worksheet D, Part IV, Column 11), and divide the result by ancillary department charges (Worksheet D–3, Column 2).[5]

To address extreme values and missing data in CCRs, we apply winsorization and imputation. For extreme values, we examine the distribution of CCR data (after aligning to FFY) for each ancillary department across providers from FY 2020 through FY 2022 and winsorize values at the 2nd and 98th percentiles. In addition,

we consider all CCRs lower than 0.01 or higher than 10.0 as improbable and recode them to 0.01 or 10.0, respectively.

After adjusting for extreme values, we impute missing CCRs using available data, prioritizing provider-specific information. (A CCR is considered missing only if the provider had charges from the ancillary department on MedPAR and CWF claims for that year but did not report a CCR.) If a provider's CCR for an ancillary department is missing for a given year but available in other years, we use the weighted average of the provider's CCRs for that ancillary department from other years (weights based on the provider's stay counts in those years) to fill in the missing value. If those data are unavailable, we use the provider's all-ancillary CCR for that year, the weighted average of the provider's all-ancillary CCRs from other years, or the median CCR for that ancillary department from other providers of the same type (freestanding or unit-based) for that year, in descending order of preference. For ancillary departments such as ICU and CCU, where CCRs are rarely reported despite the presence of service charges on claims, we use the median all-ancillary CCR from other providers of the same type to fill in missing values.

(3) Accounting for Geographic Differences and Inflation

To account for geographic differences in costs, we construct a geographic adjustment factor using the formula:

*Geographic cost adjustment factor = IPF wage index * labor-related share + COLA for AK and HI * (1-labor-related share).*

We adjust the labor-related portion of per diem costs using the IPF wage index to account for regional differences in labor costs, while the non-labor portion is adjusted using COLA factors for IPFs in Alaska and Hawaii. Because the IPF wage index reflects local cost differences with a lag, we adjust for that timing discrepancy by applying more recent IPF wage indexes to the FY 2020–FY 2022 MedPAR stays. (We remind readers that the IPF PPS wage index is based on the pre-floor, pre-reclassified IPPS hospital wage index, which in turn is derived from hospital cost reports data from approximately 3–4 years prior. For example, the FY 2025 IPF PPS wage index reflects cost data from local labor markets around 2021–2022.) For this analysis, we used the FY 2024 IPF PPS wage index to adjust IPF costs in FY 2020, and FY 2025 IPF PPS wage index to adjust IPF costs in FY 2021 and FY 2022.

Finally, to promote comparability across the 3 years, we adjust cost estimates for year-over-year inflation using historical IPF market basket increases and labor-related shares, converting all cost estimates into 2022 dollars.

We calculated routine per diem cost, ancillary per diem cost, and the total per diem using the approach discussed in this section for all IPF stays in our FY 2020–FY 2022 MedPAR sample. We then excluded stays with missing routine costs and outlier routine or total per diem costs, based on the approach described earlier in section IV.D.3.b of this final rule.

Among the 704,472 stays in the final FY 2020–FY 2022 cost regression sample, the median total per diem cost was $1,135 in 2022 dollars, with a range of $355 to $4,201 and a mean of $1,205 (the standard deviation was $539). Consistent with our approach in the FY 2025 IPF PPS final rule (89 FR 64596), the stays with zero ancillary charges were retained in the sample.

d. Independent Variables

The independent variables in the regression model represent patient-level and facility-level characteristics that influence the cost of an IPF stay. Some of these variables are adjustment-related, meaning that they are used for payment adjustments, while others are control variables, which are used to account for variation in the dependent variable associated with factors outside the adjustment factors in the payment model.

(1) Adjustment-Related Variables

Patient-level adjustment-related variables in the model include MS–DRG, comorbidity categories, patient age, and length of stay. Because we did not propose any changes to these patient-level adjustment factors in the FY 2026 IPF PPS proposed rule, we constrained their coefficients to their corresponding FY 2025 adjustment factor values in the regression, instead of estimating them in the model.

Facility-level adjustment-related variables in the model include the facility's teaching status and whether the facility is located in a rural area. (A facility's rural status in each year is determined based on its CBSA designation.) We refer readers to sections IV.D.4. and IV.D.5. of this-final rule for a more detailed explanation of the payment adjustment for rural location. In sections III.D.5. and III.D.6. of the proposed rule, we proposed to revise the IPF PPS payment adjustment factors for these two facility-level characteristics based on the estimated coefficients of these variables in the constrained regression.

(2) Control Variables

As we noted in the FY 2025 IPF PPS proposed and final rules (89 FR 23157; and 89 FR 64596 and 64597, respectively), the original regression model included a control variable for the presence of ECT because ECT is paid on a per-treatment basis under the IPF PPS. We continue to observe that IPF stays with ECT have significantly higher costs per day. For FY 2026 we will continue paying for ECT on a per-treatment basis; therefore, we included a control variable to account for the additional costs associated with ECT, which will continue to be paid outside the regression model.

Similarly, we included a control variable for stays with positive covered ED-related charges. To address the costs of maintaining an ED and providing ED services, IPF PPS pays facilities with a qualified ED an additional 26 percent of the payment rate for the first day of the stay. To prevent ED adjustment from serving as an incentive for unnecessary ED use, all stays in facilities with qualifying EDs receive the payment, except in cases when the admission source code is ''D,'' indicating that the patient was transferred from the inpatient part of the same facility. (In such cases, the ED costs would have already been covered under the preceding claim.) The 26 percent ED adjustment, updated in the FY 2025 IPF PPS final rule (89 FR 64635 and 64636), was calculated in a way that accounts for the percentage of stays with ED charges and different admission sources, and that calculation was performed outside the cost regression framework. Since our regression model includes all costs associated with each IPF stay, including ED costs, we included a control variable for stays with positive covered ED charges to control for the additional costs associated with ED services in this FY 2026 IPF PPS final rule.

Lastly, we included control variables for the data year. Since the model uses a combined set of data from 3 years, we adjusted cost estimates for year-over-year inflation using historical IPF market basket increases and labor-related shares. However, external factors beyond this inflation adjustment may have influenced cost differences across the 3 years included in our sample. These factors, such as the impact of the COVID–19 PHE, may affect cost variation in our sample period. To account for these additional year-related factors, we continued to include a set of

year controls in the FY 2026 IPF PPS final rule regression model.

e. Regression Results

We estimated the constrained regression using ordinary least squares (OLS) on 704,472 IPF stays from FY 2020 to FY 2022, clustering standard errors at the provider level. Table 2 presents the estimation results, along with the number and percentage of stays associated with each independent variable. The regression model has an R-squared value of 0.27799, meaning that the independent variables included in the regression (facility characteristics and control variables) were able to explain approximately 27.8 percent of the variation in per diem costs among IPF stays. We note that the R-squared value of our regression model is comparable to the R-squared values of prior models used for the IPF PPS (for example, see the R-squared value of 0.32340 in the FY 2025 IPF PPS final rule (89 FR 64597) and the finding that the payment model explained 33 percent of the variation in per diem cost among IPFs in the RY 2005 IPF PPS final rule (69 FR 66957)).

Except for the teaching variable, each of the adjustment factors presented in Table 2 is the exponentiated regression coefficient from our regression model, which as we previously noted uses the natural logarithm of per diem total cost as the dependent variable. We present the exponentiated regression results, as these most directly translate to the way that IPF PPS adjustment factors are calculated for payment purposes. That is, the exponentiated adjustment factors presented in this-final rule represent a percentage increase or decrease in per diem cost for IPF stays with each characteristic. In the case of the teaching variable, the result presented is the un-exponentiated regression coefficient. As discussed in section IV.D.6. of this final rule, the current IPF PPS teaching adjustment is calculated as 1 + a facility's ratio of interns and residents to its average daily census, raised to the power of 0.5150. The coefficient for teaching status presented in Table 2 can be interpreted in the same way.

Lastly, we consider regression factors to be statistically significant when the p-value is less than or equal to the significance level of 0.05 (*), 0.01 (**), and 0.001 (***), as notated in the Table 2 presented in this final rule.

We discuss the changes to the adjustment factors for IPFs located in rural areas and for teaching status in sections IV.D.5. and IV.D.6. of this final rule, respectively, and the refinement standardization factor in section IV.D.9. of this final rule.

TABLE 2—IPF PPS PER DIEM COST REGRESSION RESULTS WITH DATA FROM FY 2020 THROUGH FY 2022

Variable Description	Number of stays FY2020–FY2022	Percentage of Stays FY2020–FY2022	FY2025 adjustment factor	Estimated adjustment factor	Statistical significance
Total	704,472	100.0	.....	.....	.....
Provider: Rural	88,437	12.6	1.17	1.18	***
Provider: Teaching Status, log(1 + FTE Residents/Average Daily Census)	146,175	20.7	0.5150	0.7957	***
Control Variable: Stay Has ECT treatment	11,269	1.6	N/A	1.31	***
Control Variable: Stay Has Positive Covered ED Charge	227,647	32.3	N/A	1.46	***
Control Variable: Stay Discharged in FY2020	280,959	39.9	N/A	1.00	.....
Control Variable: Stay Discharged in FY2021	229,125	32.5	N/A	1.01	**
Control Variable: Stay Discharged in FY2022	194,388	27.6	N/A	1.03	***
MS–DRG 056: Degenerative Nervous System Disorders w MCC	4,251	0.6	1.12	.....	.....
MS–DRG 057: Degenerative Nervous System Disorders w/out MCC	33,401	4.7	1.11	.....	.....
MS–DRG 876: OR Procedures with Principal Diagnosis of Mental Health	671	0.1	1.29	.....	.....
MS–DRG 880: Acute Adjustment Reaction and Psychosocial Dysfunction	6,996	1.0	1.08	.....	.....
MS–DRG 881: Depressive Neuroses	19,756	2.8	1.06	.....	.....
MS–DRG 882: Neuroses Except Depressive	8,944	1.3	1.02	.....	.....
MS–DRG 883: Disorders of Personality and Impulse Control	5,067	0.7	1.17	.....	.....
MS–DRG 884: Organic Disturbances and Intellectual Disability	48,587	6.9	1.08	.....	.....
MS–DRG 885: Psychosis	529,855	75.2	1.00	.....	.....
MS–DRG 886: Behavioral and Developmental Disorders	1,340	0.2	1.07	.....	.....
MS–DRG 887: Other Mental Disorder Diagnoses	309	0.0	1.00	.....	.....
MS–DRG 894: Alcohol, Drug Abuse or Dependence, Left AMA	2,631	0.4	0.86	.....	.....
MS–DRG 895: Alcohol, Drug Abuse or Dependence w Rehab Therapy	10,346	1.5	0.90	.....	.....
MS–DRG 896: Alcohol, Drug Abuse or Dependence w/out rehab therapy w MCC	920	0.1	1.00	.....	.....
MS–DRG 897: Alcohol, Drug Abuse or Dependence w/out rehab therapy w/out MCC	29,884	4.2	0.95	.....	.....
MS–DRG 917: Poisoning and Toxic Effects of Drugs w MCC	128	0.0	1.19	.....	.....
MS–DRG 918: Poisoning and Toxic Effects of Drugs w/out MCC	742	0.1	1.12	.....	.....
MS–DRG 947: Signs and Symptoms w MCC	56	0.0	1.12	.....	.....
MS–DRG 948: Signs and Symptoms w/out MCC	588	0.1	1.09	.....	.....
Comorbidity: Artificial Openings—Digestive & Urinary	3,217	0.5	1.07	.....	.....
Comorbidity: Cardiac Conditions	19,478	2.8	1.04	.....	.....
Comorbidity: Chronic Obstructive Pulmonary Disease and Sleep Apnea	40,003	5.7	1.09	.....	.....
Comorbidity: Developmental Disabilities	24,782	3.5	1.04	.....	.....
Comorbidity: Eating Disorders	2,577	0.4	1.09	.....	.....
Comorbidity: Gangrene	207	0.0	1.12	.....	.....
Comorbidity: Oncology Treatment	10	0.0	1.44	.....	.....
Comorbidity: Poisoning	5,436	0.8	1.16	.....	.....
Comorbidity: Renal Failure, Acute	17,466	2.5	1.06	.....	.....
Comorbidity: Renal Failure, Chronic	42,544	6.0	1.08	.....	.....

TABLE 2—IPF PPS PER DIEM COST REGRESSION RESULTS WITH DATA FROM FY 2020 THROUGH FY 2022—Continued

Variable Description	Number of stays FY2020–FY2022	Percentage of Stays FY2020–FY2022	FY2025 adjustment factor	Estimated adjustment factor	Statistical significance
Comorbidity: Severe Musculoskeletal & Connective Tissue Disease	3,765	0.5	1.05		
Comorbidity: Severe Protein Malnutrition	4,907	0.7	1.17		
Comorbidity: Tracheostomy	260	0.0	1.09		
Comorbidity: Uncontrolled Diabetes	20,001	2.8	1.05		
Comorbidity: Intensive Management for High-Risk Behavior	18,815	2.7	1.07		
Ages: Under 45	208,334	29.6	1.00		
Ages: 45 and under 55 years	102,694	14.6	1.02		
Ages: 55 and under 60 years	61,728	8.8	1.05		
Ages: 60 and under 65 years	58,702	8.3	1.06		
Ages: 65 and under 70 years	83,972	11.9	1.09		
Ages: 70 and under 80 years	113,411	16.1	1.11		
Ages: 80 years and over	75,631	10.7	1.13		
Length of stay—1 day	15,429	2.2	1.28		
Length of stay—2 days	24,436	3.5	1.20		
Length of stay—3 days	36,245	5.1	1.15		
Length of stay—4 days	41,061	5.8	1.12		
Length of stay—5 days	46,857	6.7	1.08		
Length of stay—6 days	50,853	7.2	1.06		
Length of stay—7 days	54,636	7.8	1.03		
Length of stay—8 days	44,677	6.3	1.02		
Length of stay—9 days	36,935	5.2	1.01		
Length of stay—10 days	33,644	4.8	1.00		
Length of stay—11 days	30,418	4.3	1.00		
Length of stay—12 days	28,017	4.0	1.00		
Length of stay—13 days	28,089	4.0	1.00		
Length of stay—14 days	30,556	4.3	1.00		
Length of stay—15 days	21,953	3.1	1.00		
Length of stay—16 days	16,502	2.3	1.00		
Length of stay—17 days	14,126	2.0	1.00		
Length of stay—18 days	12,300	1.7%	1.00		
Length of stay—19 days	11,467	1.6	1.00		
Length of stay—20 days	11,702	1.7	1.00		
Length of stay—21 days	11,018	1.6	1.00		
Length of stay—22 days or longer	103,551	14.7	1.00		

4. 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. For FY 2026, we proposed to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index.

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.

In the FY 2026 IPF PPS proposed rule, we proposed 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 IV.A.3 of this final rule, the final labor-related share of the IPF PPS national base rate and ECT payment per treatment is 79.0 percent in FY 2026. This percentage reflects the labor-related share relative importance of the 2021-based IPF market basket for FY 2026 and is 0.2 percentage point higher than the FY 2025 labor-related share.

The following is a summary of the comments we received on the proposed wage index adjustment and our responses.

Comment: A commenter recommended CMS apply the wage index 5-percent cap in a non-budget neutral manner.

Response: We did not propose any new policies this year pertaining to the 5-percent cap, and accordingly, we are not finalizing any new policies in this final rule. In accordance with our longstanding policy under the IPF PPS, we updated the wage index in such a way that total estimated payments to IPFs for FY 2026 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 applied the wage index cap in a budget-neutral manner in accordance with this overall budget neutrality policy for the IPF PPS wage index so that wage index changes do not increase aggregate Medicare spending. In the FY 2023 IPF PPS proposed rule (87 FR 19423 through 19425), we noted that applying a 5-percent cap on all wage index decreases would have a very small effect on the wage index budget neutrality factor for FY 2023. We explained that we anticipate that in the absence of proposed policy changes, most providers will not experience year to-year wage index declines greater than 5 percent in any given year and that we expect the impact to the wage index budget neutrality factor in future years will continue to be minimal.

Comment: Two commenters requested CMS revise the IPF wage index methodology. Specifically, the commenters suggested CMS revise the policy so that the post-reclassification and post-floor hospital IPPS wage index is used to calculate the wage index for IPFs. The commenter stated that the continued use of the pre-reclassification and pre-floor hospital inpatient wage index is unreasonable because it places IPFs at a disadvantage in the labor markets in which they operate relative to hospitals in the same markets. In addition, a commenter urged CMS to apply an out-migration adjustment to IPFs to account for the employment of hospital employees who reside in one county but commute to work in a county with a higher wage index.

Response: We appreciate the commenters' recommendations. We did not propose the specific policies suggested by commenters, but we will take these recommendations into consideration to potentially inform future rulemaking. We do not believe that the continued use of the pre-reclassification and pre-floor hospital inpatient wage index for FY 2026 is unreasonable or that this policy puts IPFs at a disadvantage relative to hospitals in the labor markets in which they operate. As we have previously discussed in the RY 2007 final rule (71 FR 27066), we believe that the actual location of an IPF (as opposed to the location of affiliated providers) is most appropriate for determining the wage adjustment because the prevailing wages in the area in which the IPF is located influence the cost of a case. In that same RY 2007 final rule (71 FR 27066), we also stated that we believe the ''rural floor'' is required only for the acute care hospital payment system because section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) applies specifically to acute care hospitals and not excluded hospitals and excluded units. As we have previously discussed, the IPF wage index is intended to be a relative measure of the value of labor in prescribed labor market areas (87 FR 46857). There are a variety of reasons why our longstanding IPF wage index policy have not applied floors or reclassifications, which, as we previously noted, are not applied to the IPF wage index by statute. For example, applying floors and reclassifications to the IPF wage index would significantly increase administrative burden, both for IPFs and for CMS, associated with IPFs reclassifying from one CBSA to another, and it would significantly increase the

complexity of the methodology. Furthermore, because floors and reclassifications would be applied budget-neutrally under the wage index, these policies would increase the wage index for some IPFs while reducing IPF PPS payments for all other IPFs, which would upset the long-settled expectations with which IPFs across the country have been operating. For these reasons, we believe using the pre-floor, pre-reclassified IPPS hospital wage index is the most appropriate data to use as a proxy for an IPF wage index. We appreciate the commenter's suggestion to apply an out-migration adjustment to IPFs to account for employment of hospital staff who commute to work in counties with a higher wage index. However, we note that the out-migration adjustment is applied to the IPPS hospital wage index under section 1886(d)(13) of the Act, which is a statutory provision that specifically applies to subsection (d) hospitals paid under the IPPS. As discussed in the prior paragraph, we do not believe it is appropriate for the IPF PPS to apply an out-migration adjustment that is not statutorily required, because such a policy would increase administrative burden and have distributional impacts on IPFs.

Final Decision: After consideration of the comments received, we are finalizing our proposal for FY 2026 to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index. We will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. The labor-related share of the national rate and ECT payment per treatment will change from 78.8 percent in FY 2025 to 79.0 percent in FY 2026. This percentage reflects the labor-related share of the 2021-based IPF market basket for FY 2026 (see section IV.A.3 of this final rule).

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 IV.D.5.c of this final rule. We also applied the permanent 5-percent cap on wage index decreases described at § 412.424(d)(1)(i).

c. 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 2026, we are continuing 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 2026 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 will use the following steps to ensure that the rates reflect the FY 2026 update to the wage indexes (based on FY 2022 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1: Simulate estimated IPF PPS payments, using the FY 2025 IPF wage index values (available on the CMS website) and labor-related share (as published in the FY 2025 IPF PPS final rule (89 FR 64582)).

Step 2: Simulate estimated IPF PPS payments using the FY 2026 IPF wage index values (available on the CMS website), and the FY 2026 labor-related share (based on the latest available data as discussed previously).

Step 3: Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2026 budget neutral wage adjustment factor of 1.0011.

Step 4: Apply the FY 2026 budget neutral wage adjustment factor from step 3 to the FY 2025 IPF PPS Federal per diem base rate after the application of the final IPF market basket increase reduced by the final productivity adjustment described in section IV.A.2 of this final rule to determine the final FY 2026 IPF PPS Federal per diem base rate. As discussed in section IV.D.9 of this final rule, we are also applying a refinement standardization factor to determine the FY 2026 IPF PPS Federal per diem base rate.

5. Adjustment for Rural Location

a. Background

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 as defined at § 412.64(b)(1)(ii)(C) for FY 2025. See the RY 2005 IPF PPS final rule (69 FR 66954) for a complete discussion of the adjustment for rural locations.

b. Adjustment for Rural Location

As discussed in section IV.D.3. of this FY 2026 IPF PPS final rule, we have completed analysis of more recent cost and claims data, which indicate that revisions to the facility-level IPF PPS payment adjustment factors would be appropriate.

In the FY 2025 IPF PPS proposed rule, we included a request for information (RFI) regarding a potential revision to the payment adjustment for rural location (89 FR 23194 and 23195); we refer readers to section V.A. of the FY 2025 IPF PPS final rule (89 FR 64641) for summaries of the comments we received, and our responses. In the FY 2026 IPF PPS proposed rule, we explained that we took the comments received into consideration for development of the proposed FY 2026 revision of the payment adjustment for rural location.

As discussed in section IV.D.3. of this FY 2026 IPF PPS final rule, we proposed to derive updated IPF PPS facility-level adjustment factors for FY 2026 using a regression analysis of data from the FY 2020 through 2022 MedPAR data files and Medicare cost report data from the FY 2020 through 2022 Hospital Cost Report Information System (HCRIS). More information about the data used for the impact simulations is found in section VII.C. of this FY 2026 IPF PPS final rule.

For FY 2026, we proposed to increase the rural adjustment to 18 percent. Our regression analysis described in section IV.D.3 of this final rule indicates that this revised adjustment more accurately represents the difference in costs between urban and rural IPFs. As discussed in section IV.D.9 of this final rule, we proposed to implement this revision to the rural adjustment budget-neutrally. A detailed discussion of the distributional impacts of this change is found in section VII.C. of this final rule.

We solicited comments on the proposed revision to the payment adjustment for rural location. Lastly, we proposed that if more recent data become available, we would consider using such data to determine the final FY 2026 adjustment factor for rural location. As discussed in section IV.D.3 of this final rule, our updated regression analysis for this final rule incorporated more recent claims data. The regression analysis of this updated data yields an FY 2026 adjustment factor for rural location of 18 percent; this result is consistent with the rural adjustment factor we proposed for FY 2026.

The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the update of the adjustment factor for rural location. A commenter appreciated this update to reflect more recent data, completing the updates of both patient-level and facility-level adjustment factors in FY 2025 and in this final rule.

A commenter advocated for a larger increase to 20 percent or more to be implemented with new funding; another suggested that the proposed update to 18 percent be implemented non-budget neutrally to avoid lowering payments for urban facilities. Commenters also suggested exploring policy alternatives like a low-volume adjustment, a small facility supplemental payment, or extension of the rural designation and payment adjustment to all safety net facilities.

Response: We appreciate the commenters' support for updating the adjustment factor for rural location. We share the commenters' concerns regarding protecting access to inpatient psychiatric care in rural areas but note that our regression analysis does not support an adjustment of 20 percent. We additionally note that section 1886(s)(5)(D)(iii) of the Act requires that revisions to the IPF PPS payment rates implemented pursuant to section 1886(s)(5)(D)(i) of the Act be made budget neutrally. We thank commenters for their policy suggestions for improving the IPF PPS and will take these suggestions into consideration as we continue to analyze and revise the IPF PPS in future years.

Final Decision: After consideration of the comments, we are finalizing an increase in the rural adjustment to 18 percent as proposed. Our regression analysis described in section IV.D.3 of this final rule indicates that this increased adjustment more accurately represents the difference in costs between urban and rural IPFs. This revision to the rural adjustment will be implemented budget-neutrally, as proposed. A detailed discussion of the distributional impacts of this change is found in section VII.C. of this final rule.

c. Continuation 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 will receive one-third of the rural adjustment that was applicable in FY 2024. For FY 2027, these IPFs will not receive a rural adjustment.

6. Teaching Adjustment

a. Background

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 is 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 this final rule at section IV.D.6.c.

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 IV.D.6.c. of this final rule, we proposed to make 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).

b. Revision to the IPF PPS Teaching Adjustment

As we previously described in section IV.D.3.e. of this final rule, we have completed analysis of more recent cost and claims data, which indicate that revisions to the facility-level IPF PPS payment adjustment factors would be appropriate. Accordingly, we proposed to revise the IPF PPS teaching adjustment for FY 2026 based on these results.

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 V.A. of the FY 2025 IPF PPS final rule (89 FR 64641) for summaries of the comments we received, and our responses. In general, commenters were supportive of increasing the IPF teaching adjustment based on the more recent analysis presented in that FY 2025 proposed rule. In the FY 2026 IPF PPS proposed rule, we explained that we took these previous comments into consideration when we developed our proposal for the FY 2026 revision of the payment adjustment for teaching status.

For FY 2026, we proposed to increase the teaching adjustment to 0.7981, based on the results of our latest regression model (90 FR 18494, 18510). We explained that this un-exponentiated regression coefficient for the teaching status variable was found to be statistically significant at the 0.001 level. We stated that in accordance with our longstanding methodology, we would convert this cost effect 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. In the FY 2026 IPF PPS proposed rule, we stated that we believe increasing the teaching adjustment from 0.5150 to 0.7981 would more appropriately adjust IPF PPS payments for IPFs that have qualified teaching programs and would address the estimated higher indirect operating costs for teaching IPFs (90 FR 18494, 18511). As discussed in section IV.D.9 of this final rule, we proposed to implement this revision to the teaching adjustment budget-neutrally. A detailed discussion of the distributional impacts of this change is found in section VII.C. of this final rule.

We solicited comments on this proposed revision to the payment adjustment for teaching status. Lastly, we proposed that, if more recent data were to become available, we would consider using such data to determine the final FY 2026 adjustment factor for teaching status. The following is a summary of the comments we received and our responses.

Comment: Commenters were supportive of CMS's proposal to increase the IPF PPS teaching status adjustment from 0.5150 to 0.7981. A commenter noted that the teaching adjustment presently in use was derived from 2002 data and stated their support for an update using more recent data.

Response: We appreciate these comments in support of an update to the teaching status adjustment. As discussed in section IV.D.3.e. of this FY 2026 IPF PPS final rule, we note that we have revised our regression model for FY 2026 based on the latest available

cost and claims data, as proposed. We believe the results of our latest regression model best address the estimated higher indirect operating costs for teaching IPFs and will most appropriately adjust IPF PPS payments for IPFs that have qualified teaching programs.

Comment: Some commenters who expressed support for the update to the teaching adjustment nevertheless expressed concerns about payment stability. A commenter stated that the proposed increase to the adjustment for teaching could lead to large swings in payment. A commenter stated that the proposed changes to the teaching and rural adjustment factors together would necessitate an adjustment of nearly three-quarters of 1 percentage point, for budget neutrality. These commenters suggested the adjustment be phased in over 2 years to mitigate negative distributional impacts on payments to non-teaching hospitals.

Response: We thank the commenters for the suggestion to phase in the proposed increase to the teaching adjustment over 2 years. Given the requirement under section 1886(s)(5)(D)(3) of the Act to apply revisions to the IPF PPS budget-neutrally, we estimate that the proposed increase to the teaching adjustment would result in distributional impacts across IPFs. However, we note that the total effect of the proposed facility-level revisions (to the adjustments for both rural location and teaching status) is a reduction of only $6.56 to the final FY 2026 IPF PPS Federal per diem base rate, which we believe IPFs have historically been able to adapt to in a single year.

Moreover, our analysis indicates that the largest decrease any provider will experience as a result of the increase in the teaching adjustment is 0.6 percent. By comparison, we have historically considered a 5 percent decrease (in a provider's wage index, for example), to be a level at which a policy limiting the decrease should be considered. We do not agree that the effect of the increase in the teaching adjustment on the base rate is substantial enough to warrant phasing in over 2 years. Additionally, we note that our latest analysis shows that IPFs with teaching programs have significantly higher costs than our current teaching adjustment recognizes. We believe that implementing the full revised teaching adjustment in FY 2026 would best support teaching facilities by more appropriately aligning IPF PPS payment with the level of resources involved in the delivery of care to Medicare beneficiaries.

Comment: Several commenters called for additional measures to expand the workforce in psychiatry and other clinicians providing mental health services. A few commenters broadly advocated for more training programs, training slots, and funding. Another commenter recommended that CMS consider complementary strategies that would support development of the IPF workforce at non-teaching hospitals, which could include incentive payments or launching a demonstration project at non-teaching hospitals to support new psychiatry residency rotations or training for non-physician practitioners.

Response: We appreciate the commenters' suggestions; however, these comments are out of scope with regard to the current IPF PPS proposal. We will consider these suggestions to potentially inform future rulemaking.

Final Decision: After consideration of the comments we received, we are finalizing a teaching adjustment of 0.7957 for FY 2026 based on the latest available data. In accordance with our longstanding methodology, we will convert this cost effect 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. This revision to the rural adjustment will be implemented budget-neutrally.

c. Update to IPF PPS Resident Caps

As we described earlier in this FY 2026 IPF PPS final rule, the IPF PPS teaching adjustment includes a policy of capping the number of FTE residents that an IPF can include in the calculation of its teaching adjustment. As previously noted, we established this policy to limit the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment, in keeping with CMS's statutory responsibility under the requirements of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33). In the RY 2005 IPF PPS final rule (69 FR 66955), we noted that the IPF PPS statute did not require us to impose resident FTE caps, but we recognized that if we imposed no limits on the teaching adjustment under the IPF PPS, teaching programs in those facilities could grow and receive payments in a manner that would be inconsistent with the methodology for teaching hospitals paid under the IPPS. In addition, we were concerned that if a teaching hospital had a distinct part psychiatric unit and had a number of FTE residents above the amount recognized for reimbursement under the limits established by the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), the hospital could potentially circumvent those limits by assigning residents to train in the IPF. We explained that after carefully reviewing the public comments, we decided to adopt a cap on the number of FTE residents that may be counted under the IPF PPS for the teaching adjustment. We stated that we made this decision in order to (1) exercise our statutory responsibility under the BBA to prevent any erosion of the resident caps established under the IPPS that could result from the perverse incentives created by the facility adjustment for teaching under the IPF PPS; and (2) avoid creating incentives to artificially expand residency training in IPFs, and ensure that the resident base used to determine payments is related to the care needs in IPF institutions.

Since the establishment of the IPF PPS, there have been numerous statutory resident cap increases, which have impacted GME payments as well as IME payments under the IPPS. These statutory resident cap increases have generally not been applicable to IPF hospitals or subunits, because caps are awarded to IPPS hospitals which receive both direct GME payments and indirect medical education (IME) payments under the IPPS.

Section 4122 of the CAA, 2023 provided for the distribution of at least 100 resident FTEs to be distributed for hospitals with a psychiatry or psychiatry subspecialty residency, which the CAA, 2023 defines as a residency in psychiatry as accredited by the Accreditation Council for Graduate Medical Education for the purpose of preventing, diagnosing, and treating mental health disorders. Hospitals with a psychiatry or psychiatry subspecialty residency could include not only acute care hospitals paid under the IPPS, but also freestanding psychiatric hospitals paid under the IPF PPS.

The CAA, 2023 also included a provision for IME payments under the IPPS, which stated that for discharges occurring on or after July 1, 2026, insofar as an additional payment amount under section 4122 is attributable to resident positions distributed to a hospital that is identified under subsection (h)(10), the indirect teaching adjustment factor would be computed in the same manner as provided under section 1886(d)(5)(B)(ii) with respect to such resident positions (in other words, utilizing 1.35 as the value of ''c'' in the adjustment formula). We note that IPF hospitals paid under the IPF PPS are not considered a hospital under subsection (h)(10) and do not receive IME

payments paid under the IPPS, under section 1886(d)(5)(B) of the Act.

Historically, the IPF PPS teaching adjustment at § 412.424 has not recognized permanent resident cap increases, which, as we noted earlier, have historically impacted GME payments and IME payments under the IPPS. However, current regulations at § 412.424(d)(1)(iii)(D) allow for an adjustment to an IPF's resident FTE cap for a new approved GME program. When we initially established this regulation in the RY 2005 IPF PPS final rule (69 FR 66955 and 66956), we explained that for new teaching IPFs and for teaching IPFs that start new programs, we were adopting the policy that was applied under the BBA for IPPS teaching hospitals that start new teaching programs as specified in § 413.79(e)(1). We noted that under § 412.105(f)(1)(vi) concerning IME payments under the IPPS, hospitals that have shared residency rotational relationships may elect to apply their respective IME resident caps on an aggregate basis via a Medicare GME affiliation agreement. We explained that our intent was not to affect affiliation agreements and rotational arrangements for hospitals that have residents that train in more than one hospital. We did not implement a provision concerning affiliation agreements specifically pertaining to the FTE caps used in the teaching adjustment under the IPF PPS.

We also stated that we believe these policies fairly balance our responsibilities under the statute to assure appropriate enforcement of the BBA and the overall limits on payment adjustments for teaching hospitals with the greater precision that can be achieved by adjusting payments for teaching IPFs. We also stated that we believe that we have designed a cap that balances the need for limits with the unique conditions of teaching programs in freestanding psychiatric hospitals and in distinct part psychiatric units. We noted in our RY 2005 IPF PPS final rule establishing the teaching adjustment, however, that we would monitor the impact of these policies closely and consider changes in the future when appropriate (69 FR 66954 through 66957).

In summary, the 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 but makes no provisions pertaining to the indirect operating costs for IPFs with teaching programs. For FY 2026, we proposed to recognize resident FTE cap increases that are awarded under section 4122 of the CAA, 2023, either to an IPF hospital or to an IPPS hospital for resident FTEs that are allocated to the IPF subunit paid under the IPF PPS. Specifically, we proposed that such resident FTE cap increases would align with our current IPF PPS teaching regulation at § 412.424(d)(1)(iii)(D), which allows for increases to IPF resident FTE caps for a new approved graduate medical education program. As we previously noted, we established the teaching cap policy under the IPF PPS to maintain alignment with the requirements of the BBA that applied to IME payments under the IPPS, and we have noted that § 412.424(d)(1)(iii)(D) is intended to achieve the same purpose. We stated that we believe this proposal would be consistent with our current regulation and our longstanding policy of maintaining IPF PPS teaching cap policies that align with IME cap policies under the IPPS. We further stated that we believe this proposal would continue to appropriately limit the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We solicited comments on the proposed update to the IPF PPS teaching policy.

The following is a summary of the comments we received and our responses.

Comment: Commenters broadly supported our proposal to recognize resident FTE cap increases awarded under section 4122 of the CAA, 2023, either to an IPF hospital or to an IPPS hospital for resident FTEs that are allocated to the IPF subunit paid under the IPF PPS. Commenters stated that this proposal would support the development of the IPF clinical workforce and would increase IPFs' capacity to meet patient needs. Commenters expressed that this proposal is especially important due to the shortage of psychiatrists nationwide.

Response: We appreciate the support of commenters. We agree with commenters about the importance of supporting the clinical workforce for IPF hospitals and units. We agree that IPF patients have unique needs, and we believe this proposed policy would help IPFs to better meet those needs.

Comment: Several commenters requested that CMS make changes to the Medicare cost report to allow IPFs to increase their resident caps. A commenter requested that CMS work with the Medicare Administrative Contractors to ensure that adjusted FTEs align with the program's slots awarded under section 4122. A commenter further noted that hospitals are instructed to reduce their IME applications for section 4122 slots for any portion of an FTE that is working in an IPF hospital or unit.

Response: We thank commenters for their careful consideration of the proposal. We will issue revised instructions and guidance to the Medicare Administrative Contractors in the near future. We intend to make updates to Worksheet E–3, Part II of the Medicare Hospital Cost Report (CMS–2552–10, OMB No. 0938–0050) to enable IPFs to document the additional FTEs awarded under section 4122 of the CAA, 2023, that are allocated to an IPF hospital or IPF unit that is paid under the IPF PPS. We are clarifying that we will not include FTE increases that are awarded under section 4122 of the CAA, 2023, in an IPF's teaching cap if those FTE increases are included in any IME cap increases for the same hospital.

Comment: Several commenters suggested that we adopt the same policy with respect to FTE cap slots awarded under section 126 of the CAA, 2021. A commenter stated that in the first three rounds of section 126 awards, CMS distributed 139.72 DGME slots and 90.78 IME slots to teaching hospitals that applied for funding to expand psychiatry and psychiatric subspecialty programs, even though the statute did not specify that the slots must be awarded for psychiatry residencies.

Response: We appreciate the commenters' suggestion, but we note that we did not propose to recognize slots awarded under section 126 of the CAA, 2021. As commenters pointed out, section 4122 of the CAA, 2023, is uniquely focused on psychiatry and psychiatric subspecialty residency slots. We are not finalizing any change to the FTE teaching adjustment policy with regard to section 126 of the CAA, 2021, but we will take these comments into consideration to potentially inform future rulemaking.

Comment: Some commenters suggested that CMS should reconsider its cap policy for the IPF teaching adjustment, noting that CMS has broad authority to determine the application of caps to the IPF PPS teaching adjustment.

Response: As we previously noted, we established the teaching cap policy under the IPF PPS to maintain alignment with the requirements of the BBA that applied to IME payments under the IPPS. We believe that the current policy fairly balances our responsibilities under the statute to assure appropriate enforcement of the BBA and the overall limits on payment adjustments for teaching hospitals with the greater precision that can be achieved by adjusting payments for teaching IPFs. We will continue to

monitor the impact of these policies closely and may consider changes in the future if appropriate.

Final Decision: After consideration of the comments, we are finalizing our proposal to recognize resident FTE cap increases awarded under section 4122 of the CAA, 2023, either to an IPF hospital or to an IPPS hospital for resident FTEs that are allocated to the IPF subunit paid under the IPF PPS.

7. 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).

Generally, under our existing methodology, we update the 2009 COLA factors published by the U.S. Office of Personnel Management (OPM) by a comparison of the growth in the Consumer Price Indices (CPIs) for the areas of Urban Alaska and Urban Hawaii, relative to the growth in the CPI for the average U.S. city as published by the Bureau of Labor Statistics (BLS). Using the respective CPI commodities index and CPI services index and using the approximate commodities/services shares obtained from the IPPS market basket, we create reweighted CPIs for each of the respective areas to reflect the underlying composition of the IPPS market basket nonlabor-related share. Lastly, we apply a 25 percent cap, which was incorporated into our methodology to reflect the statutory cap used to calculate OPM's COLA factors. For a complete discussion, we refer readers to the FY 2015 IPF PPS final rule (79 FR 45958 through 45960) as well as the FY 2022 IPF PPS final rule (86 FR 42621 and 42622).

Table 3 lists the COLA factors for IPFs located in Alaska and Hawaii as calculated under our current methodology, using updated CPI data through 2024 and the approximate 60 percent commodities/40 percent services shares obtained from the 2023-based IPPS market basket.

TABLE 3—IPF PPS COST-OF-LIVING ADJUSTMENT FACTORS: IPFs LOCATED IN ALASKA AND HAWAII

Area	FY 2022 through FY 2025 COLA factors	Updated COLA factors under current methodology	Difference
Alaska:			
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22	1.18	−0.04
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22	1.18	−0.04
City of Juneau and 80-kilometer (50-mile) radius by road	1.22	1.18	−0.04
Rest of Alaska	1.24	1.20	−0.04
Hawaii:			
City and County of Honolulu	1.25	1.25	0
County of Hawaii	1.22	1.21	−0.01
County of Kauai	1.25	1.25	0
County of Maui and County of Kalawao	1.25	1.25	0

In the FY 2026 IPF PPS proposed rule, we stated that we believe it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. We explained that we believe it would be appropriate to maintain the current COLA factors to allow CMS to consider whether any other data sources or methodology changes may improve the adjustment we make to hospital payments that accounts for the unique circumstances of hospitals located in Alaska and Hawaii. Therefore, we proposed to continue to use 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.

Comment: A commenter suggested reevaluating the COLA factors for IPFs located in Alaska and Hawaii annually due to the rise in cost of living and economic instability. The commenter also suggested the formation of a committee to inform future rate adjustments.

Response: We appreciate the commenter's suggestions; however, we did not propose the specific policies suggested by the commenter. As discussed earlier in this section, we believe it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. At this time, we continue to believe our current methodology for calculating the COLA factors for IPFs located in Alaska and Hawaii is appropriate.

Final Decision: After consideration of the public comments received, we are maintaining the current (FY 2025) IPF PPS COLA factors as proposed, for FY 2026. For a complete discussion of the final FY 2026 COLA factors, including a summary of comments received under the IPPS, we refer readers to the FY 2026 IPPS/LTCH final rule, published elsewhere in the **Federal Register**.

Table 4 lists the final FY 2026 COLA factors. The final IPF PPS COLA factors for FY 2026 are also shown in Addendum A to this final rule, which is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

TABLE 4—FINAL FY 2026 COST OF LIVING ADJUSTMENT (COLA) FACTORS: IPFS LOCATED IN ALASKA AND HAWAII

Area	Final COLA
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

8. 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.

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 of this final rule. 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 2026, we proposed 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).

Lastly, we note that following display of the FY 2026 IPF PPS proposed rule with comment period, we identified a typographical error in the preamble text regarding the FY 2025 adjustment factor for IPFs with qualifying EDs. On page 18513, in the first column, in the last paragraph, we made a typographical error and stated the current (FY 2025) adjustment factor was updated ''from 1.31 to 1.53'' instead of ''from 1.31 to 1.54''. We note that the correct FY 2025 adjustment factor for IPFs with qualifying EDs (that is, 1.54) is stated on page 18506, in Table 2; and in Addendum A of the FY 2026 IPF PPS proposed rule with comment period.

We did not receive any comments on the proposal to maintain the existing ED adjustment factor for FY 2026, and we are finalizing it as proposed.

9. Refinement Standardization Factor

Section 1886(s)(5)(D)(iii) of the Act provides that revisions in payment implemented pursuant to section 1886(s)(5)(D)(i) for a rate year shall result in the same estimated amount of aggregate expenditures under Title XVIII of the Act for psychiatric hospitals and psychiatric units furnished in the RY as would have been made under this Title for such care in such rate year if such revisions had not been implemented. We interpret this to mean that revisions in payment adjustments implemented for FY 2026 (and for any subsequent fiscal year) must be budget neutral.

Historically, we have maintained budget neutrality in the IPF PPS using the application of a standardization factor, which is codified in our regulations at § 412.424(c)(5) to account for the overall positive effects resulting from the facility-level and patient-level adjustments. As discussed in section IV.B.1 of this final rule, section 124(a)(1) of the BBRA required 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 standardization factor by setting the total estimated IPF PPS payments, taking into account all of the adjustment factors under the IPF PPS, to be equal to the total estimated payments that would have been made using TEFRA 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).

We believe the budget neutrality requirement of section 1886(s)(5)(D)(iii) of the Act is consistent with our longstanding methodology for maintaining budget neutrality under the IPF PPS pursuant to section 124(a)(1) of the BBRA. We note that for the FY 2025 IPF PPS rule (89 FR 64640 and 64641), we applied a refinement standardization factor to the FY 2024 IPF Federal per diem base rate and ECT per treatment amount to maintain budget neutrality for the change in the patient-level adjustment factors, ED adjustment, and ECT per treatment amount finalized in the FY 2025 IPF PPS rule.

Therefore, for FY 2026, we proposed to apply a refinement standardization factor in accordance with our existing policy at § 412.424(c)(5). Under this policy, we would update IPF PPS adjustment factors for teaching status and for IPFs located in rural areas, as finalized in this FY 2026 IPF PPS final rule, in such a way that total estimated payments to IPFs for FY 2026 are the same with or without the changes (that is, in a budget neutral manner) by

applying a refinement standardization factor to the IPF PPS rates. We proposed to use the following steps to ensure that the rates reflect the final FY 2026 update to the facility-level adjustment factors (as previously discussed in sections IVII.D.5 and IV.D.6. of this final rule and summarized in Addendum A) in a budget neutral manner:

Step 1: Simulate estimated IPF PPS payments using the FY 2025 IPF facility-level adjustment factor values (available on the CMS website).

Step 2: Simulate estimated IPF PPS payments using the final FY 2026 IPF facility-level adjustment factor values (see Addendum A of this final rule, which is available on the CMS website).

Step 3: Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the final FY 2026 refinement standardization factor of 0.9927.

Step 4: Apply the FY 2026 refinement standardization factor from step 3 to the FY 2025 IPF PPS Federal per diem base rate and ECT per treatment amount, after the application of the wage index budget neutrality factor and the IPF market basket increase reduced by the productivity adjustment described in section IV.A. of this final rule to determine the final FY 2026 IPF PPS Federal per diem base rate and FY 2026 ECT payment amount per treatment.

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

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 additional payments 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 additional payments reduce the financial losses that would otherwise be incurred in treating patients who require costlier care; therefore, reduce the incentives for IPFs to under-serve these patients. We make outlier payments 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, 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.

2. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we proposed 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 proposed to maintain the established 2 percent outlier policy for FY 2026.

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 proposed to update the IPF outlier threshold amount for FY 2026 using FY 2024 claims data and the same 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). For this FY 2026 IPF PPS rulemaking, consistent with our longstanding practice, based on an analysis of the latest available data (the December 2024 update of FY 2024 IPF claims) and rate increases, 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. Based on an analysis of these updated data, we estimated that IPF outlier payments as a percentage of total estimated payments would be slightly higher than 2.0 percent in FY 2025. Therefore, we proposed to update the outlier threshold amount to $39,360 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2026. The proposed update would be an increase from the FY 2025 threshold of $38,110. Lastly, we proposed that if more recent data become available for the FY 2026 IPF PPS final rule, we would consider using such data to determine the final outlier fixed dollar loss threshold amount for FY 2026.

We solicited comments on the proposed update to the outlier fixed dollar loss threshold amount. The following is a summary of the comments we received and our responses.

Comment: A commenter expressed concern about CMS's proposal to raise the IPF outlier fixed-loss threshold to $39,360 for FY 2026. The commenter stated the proposed threshold is too high and will reduce the number of cases qualifying for outlier payment relief. The commenter expressed concern about the impact on facilities that treat the most medically complex or violent psychiatric patients, as this creates significant financial risk for these specialized providers.

Response: The proposed increase in the IPF outlier fixed-loss threshold from $38,110 to $39,360 is intended to maintain budget neutrality by ensuring outlier payments remain at approximately 2.0 percent of total IPF payments as required by statute, reflect cost inflation to account for general cost increases in healthcare delivery, and preserve program integrity by maintaining the outlier payment system's role in protecting facilities from truly extraordinary costs. We carefully calibrate the threshold annually using the most recent available cost and claims data, with the 2.0 percent target for outlier payments representing a balance between

providing adequate protection for high-cost cases while maintaining overall payment system stability, supported by historical data analysis to achieve the statutory target. Our analysis indicates that the proposed threshold maintains the appropriate balance between outlier payment availability and budget neutrality, and while the proportion of cases receiving outlier payments may decrease, the total outlier payment pool remains consistent with statutory requirements, with the threshold adjustment reflecting actual cost trends in IPF services.

Comment: Two commenters noted concern that the increase in the outlier fixed loss threshold exceeds the proposed 2.4 percent update to IPF rates, creating a disparity that could negatively impact facilities. The commenters specifically requested that CMS consider adopting an alternative methodology used in FY 2022 and FY 2023, which involved removing IPFs with extremely high or low costs per day (3+ standard deviations from the mean) to create a more homogeneous dataset, as this approach previously helped mitigate increases in the fixed loss threshold and could serve as an effective means of reducing the proposed threshold increase for FY 2026.

Response: While the commenters correctly reference our use of statistical trimming methodology in prior years, it is important to clarify that the approach used in FY 2023 (87 FR 46862)—which involved excluding providers whose change in estimated average cost per day fell outside 3 standard deviations from the mean—was implemented as a targeted response to extraordinary data distortions caused by the COVID–19 PHE, rather than as a routine alternative methodology. Specifically, we observed that some providers had significant increases in their charges during the pandemic period, resulting in higher than normal estimated costs per day that would skew outlier payment estimates, and the statistical trim was applied to improve the validity of the data used for ratesetting under these exceptional circumstances. Our longstanding methodology for updating the outlier fixed-loss threshold continues to rely on using the best available data to maintain outlier payments at 2 percent of total IPF PPS payments, and any deviations from this established approach are carefully considered based on specific data quality concerns rather than as standard practice. We will continue to monitor the IPF PPS outlier policy and propose the application of appropriate statistical methods when necessary to ensure the integrity of the outlier policy while maintaining the balance between protecting facilities from extraordinarily costly cases and ensuring adequacy of the Federal per diem base rate for non-outlier cases.

Final Decision: After consideration of the comments received, we are finalizing our proposal to update the fixed dollar loss threshold amount used under the IPF PPS outlier policy. For this FY 2026 IPF PPS rulemaking, consistent with our longstanding practice, based on an analysis of the latest available data (the March 2025 update of FY 2024 IPF claims) and rate increases, 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. Based on an analysis of these updated data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 2.1 percent in FY 2025. Therefore, we are finalizing an update to the outlier threshold amount to $39,360 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2026.

3. 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 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 2026, we proposed to continue following this methodology. Lastly, we proposed 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 2026.

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 2026 is 2.4373 for rural IPFs and 1.8305 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 proposed to update the FY 2026 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 2026, to be used in each of the three situations listed previously, using the most recent CCRs entered in the CY 2024 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).

V. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

A. Background and Statutory Authority

The Inpatient Psychiatric Facilities Quality Reporting (IPFQR) 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 final rule for a detailed discussion of entities covered under the IPF PPS).[4] [5] 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 IPFQR Program. We have codified procedural requirements and reconsideration and appeals procedures for IPFQR Program decisions in our regulations at 42 CFR 412.433 and 412.434. Consistent with previous IPFQR 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 1886(s)(4)(E) of the Act requires IPFs participating in the IPFQR 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. In the FY 2025 IPF PPS proposed rule, we solicited public comment on the principles and approach that CMS should consider when developing the IPF–PAI (89 FR 23200 through 89 FR 23204), which we summarized in the final rule (89 FR 64642 through 64649).

B. Modification of the Reporting Period of the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an IPF Discharge Measure, Beginning With the FY 2029 Payment Determination

1. Background

In the FY 2025 IPF PPS final rule, we adopted the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge measure (IPF ED Visit measure) for the IPFQR Program beginning with the FY 2027 payment determination (89 FR 64650 through 89 FR 64659). The measure was adopted with a calendar year (CY) reporting period starting with the CY 2025 reporting period for the FY 2027 payment determination (89 FR 64659).[6] We adopted this measure to address a gap in existing IPFQR Program measures related to patient outcomes in the period following discharge from the IPF (89 FR 64651). While the Thirty Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization measure (IPF Unplanned Readmission measure), adopted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57241 through 57246), assesses hospital readmissions, it does not assess another type of post-discharge use of acute care: ED visits that do not result in a hospital admission. Therefore, we adopted the IPF ED Visit measure to fill this gap and to provide IPFs and patients with a more complete picture of acute care among IPF patients after discharge from the IPF (89 FR 64650 through 64659).

2. Modification of the Reporting Period of the IPF ED Visit Measure To Begin Q3 CY 2025–Q2 CY 2027 Reporting Period/FY 2029 Payment Determination

We intended for the IPF ED Visit measure to complement the IPF Unplanned Readmission measure to the extent possible (89 FR 64652 through 64653). Our rationale was that maintaining similarities between these two measures—the same timeframe (that is, the 30 days post-discharge from an IPF), the same definitions of index admission, and same patient populations—would provide IPFs and patients with a more complete picture of acute care among IPF patients after discharge. However, the IPF Unplanned Readmission measure uses a 2-year reporting period, which differs from the 1-year reporting period we finalized for the IPF ED Visit measure. To fully align the measures so that the same cohort of patients can be compared, it is necessary to modify the reporting period of the IPF ED Visit Measure.

For the reasons discussed in the FY 2026 IPF PPS proposed rule, we proposed to modify the current 1-year reporting period for the IPF ED Visit measure to a 2-year reporting period (90 FR 18515 through 18516). We proposed that this 2-year reporting period would run from July 1st, 4 years prior to the applicable fiscal year payment determination, to June 30th, 2 years prior to the applicable fiscal year payment determination. The proposed 2-year reporting period for the IPF ED Visit measure would align with the IPF Unplanned Readmission measure. The proposal would modify the first reporting period for the measure to Quarter (Q)3 CY 2025–Q2 CY 2027 for the FY 2029 payment determination.[7] The proposed 2-year reporting period would allow the IPF ED Visit measure to better complement the IPF Unplanned Readmission measure, resulting in more meaningful IPFQR Program measure data for providers and consumers.

Because the data used to calculate the IPF ED Visit measure are available on Medicare claims and enrollment data, this measure requires no additional data collection or submission by IPFs (89 FR 64667). We did not propose any other changes to the measure. We noted the IPF ED Visit measure for the FY 2029 payment determination, which would reflect a Q3 CY 2025–Q2 CY 2027 reporting period, would first be publicly reported in the January 2029 release on the Compare tool on *medicare.gov* (*https://www.medicare.gov/care-compare/*) or their successor websites.

We invited public comments on our proposal to modify the reporting period of the IPF ED Visit Measure. The following is a summary of the comments we received and our responses.

Comment: Several commenters expressed support for this proposal, agreeing with CMS on the importance of aligning the reporting periods for related measures. Some commenters supported the expansion to a 2-year reporting period, with one noting that a longer reporting period helps smooth out temporary fluctuations that might happen over a shorter time period.

[4] 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 IPFQR 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).

[5] For the IPFQR Program, we refer to the year in which an IPF would receive the 2-percentage point reduction to the annual update to the standard Federal rate as the *payment determination* year. An IPF generally meets IPFQR Program requirements by submitting data on specified quality measures in a specified time and manner during a *data submission period* that occurs prior to the payment determination year. These data reflect a period prior to the data submission period during which the IPF furnished care to patients; this period is known as the *reporting period,* sometimes also referred to as the *performance period.* For example, for a measure for which CY 2026 is the reporting period which is required to be submitted in CY 2027 and affects FY 2028 payment determination, if an IPF did not submit the data for this measure as specified during CY 2027 (and meets all other IPFQR Program requirements for the FY 2028 payment determination) we would reduce by 2-percentage points that IPF's update for the FY 2028 payment determination year.

[6] We note that we used ''performance period'' in the FY 2025 IPF PPS final rule to refer to the reporting period.

[7] As finalized in prior rulemaking (89 FR 64659), the IPF ED Visit measure would have been used in the FY 2027 payment determination. With modification of the reporting period, we proposed the first year that this measure would be used in the payment determination to change to FY 2029.

Other commenters described the proposal as sensible and reasonable.

Response: We thank the commenters for their support.

Comment: One comment stated concerns about the proposed 2-year reporting period, specifically that the data become outdated, which makes it more challenging for IPFs to make changes in response to measure performance. The commenter recommended that CMS consider modifying the IPF Unplanned Readmission—and not finalizing modifications to the IPF ED Visit measure—so that both measures follow a 12-month reporting cycle, beginning July 1 and ending June 30 the following year.

Response: We acknowledge that timeliness can be a limitation of claims-based measures. When the IPF Unplanned Readmission measure was developed, the measure developers established that 24 months of data were needed for the measure to be statistically reliable—that is, having sufficient observations in the reporting period for the measure to provide stable estimates, and not be subject to fluctuation due to normal variation in patient outcomes.[8] The IPF ED Visit measure was tested with a 24 month observation period in order to be comparable to the IPF Unplanned Readmission measure.[9] Because using a shorter reporting period with fewer observations would reduce reliability, we sought to balance sufficient measure reliability with some delay in this information being publicly reported.

Final Decision: After consideration of the comments we received, we are finalizing our proposal to modify the reporting period for the IPF ED Visit measure as proposed.

C. Removal of the Facility Commitment to Health Equity Measure Beginning With the CY 2024 Reporting Period/FY 2026 Payment Determination

We refer readers to the FY 2024 IPF PPS final rule where we adopted the Facility Commitment to Health Equity structural measure (hereafter referred to as FCHE measure) into the IPFQR Program (88 FR 51100 through 51107). In the FY 2026 IPF PPS proposed rule, we proposed to remove the FCHE measure beginning with the FY 2026 payment determination due to the costs associated with achieving a high score on the measure outweighing the benefit of its continued use in the program (90 FR 18516). As we explained in the proposed rule, when CMS first adopted the FCHE measure, we intended the collection of data described in the five domains of this measure to provide IPF leadership with meaningful and actionable health data to drive quality improvements to eliminate health disparities. Based on feedback received from IPFs as well as a re-focus on clinical outcomes measures, for which the FCHE measure, as a structural measure, does not directly measure clinical outcomes, we believed that the burden of collecting this measure may outweigh the benefits. We stated that removal of this measure would alleviate an estimated annual burden of approximately 267 hours, at a cost of $11,978, across all participating IPFs (88 FR 51151). These values were based on the estimated burden at the time the measure was proposed. Elsewhere in the proposed rule, in section V.B.3, we stated the updated burden estimate of 267 hours at a cost of $14,761, across all participating IPFs.

The IPFQR Program strives to minimize burden while maintaining a parsimonious set of the most meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. Removing this measure from the IPFQR Program is effective toward accomplishing this intent. In the proposed rule, we stated a re-focus on measurable clinical outcomes as well as identifying quality measures on topics of prevention, nutrition, and well-being, and as such we referred readers to our request for comment on our Request for Information on Future Measures for the IPFQR Program in section IV.H.2. (90 FR 18516). The IPFQR Program continues to incentivize the improvement of care quality and health outcomes for all patients through measurement and transparency with other measures. It may be costly for IPFs to continue reporting on the FCHE measure and achieve high performance scores, and removal of this measure would make room to enhance the program's focus on measurable clinical outcomes and for IPF leadership to focus on other priority quality and safety areas. We acknowledge that some IPFs may have expended resources to implement some or all of the activities described in the FCHE measure attestation statements in order to be able to attest ''yes'' for measure reporting purposes, however, IPFs that had already implemented such activities prior to adoption of the measure would have been able to attest ''yes'' without expending similar resources.

We stated that, if finalized, IPFs that do not report their CY 2024 reporting period data for the FCHE measure to CMS would not be considered noncompliant with the measure for purposes of their FY 2026 payment determination (that is, IPFs that do not report CY 2024 reporting period data would not be penalized for FY 2026 payments due to this measure). Any FCHE measure data received by CMS would not be used for public reporting or payment purposes.

We stated that, if not finalized, IPFs that do not report their CY 2024 reporting data for the FCHE measure to CMS would be considered noncompliant with the measure for their FY 2026 payment determination, and would receive a letter of noncompliance after August 1, 2025, at which time the required 30 day reconsideration period would begin. Payment adjustments for noncompliance with IPFQR Program requirements would apply to FY 2026 fee-for-service claims as previously finalized.

We invited public comments on our proposal to remove the FCHE structural measure from the IPFQR Program beginning with the FY 2026 payment determination. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported the removal of the FCHE measure. Several commenters described burden related to data collection for this measure. Several commenters stated that the measure had limitations and noted that it was redundant with some accreditation requirements from other programs.

Response: We thank the commenters for their support.

Comment: A few commenters disagreed that the cost of the FCHE measure outweighed the benefit, stating that facility attention to social factors is linked to clinical outcomes, and the focus areas of this measure are likely to prevent downstream costs.

Response: We appreciate commenters' input regarding the burden associated with reporting on the FCHE measure. We agree with commenters that the reporting burden associated with structural measures is typically small; however, costs are multi-faceted and include administrative costs to IPFs, maintaining information collection systems, and analyzing reported data. We are identifying ways to reduce overall provider burden of participating in the IPFQR Program, while continuing to hold IPFs accountable for measurable aspects of care and patient safety. At this time, we remain focused on identifying measures that balance feasibility, costs, and impact, while aligning with national priorities. For the reasons discussed in the FY 2026 IPF

[8] CMS. Internal Analysis. November 2015.

[9] *https://p4qm.org/measures/4190.*

PPS proposed rule (90 FR 18516), we have determined that the multi-faceted costs associated with this measure outweigh the benefits of its continued use in the program at this time.

Comment: A commenter stated that this measure generates meaningful and useful health data that facilities can use to drive quality improvement. A commenter stated that it would be difficult to advance CMS' goals of improving overall well-being and whole-person care without identifying and addressing social needs and health disparities. A few commenters stated that removing this measure would reverse or undermine progress made on improving outcomes for all patients.

Response: We acknowledge commenters that stated that the types of activities specified for attesting affirmatively on various domains for the FCHE measure—for example, strategic planning to address health equity, collecting information on patient demographics and/or social drivers of health, and using these data to inform quality improvement—support high-quality care and improved outcomes for patients. Removal of this measure does not preclude IPFs from collecting health information on topics that they deem important to their patient populations or quality improvement activities. Despite removal of this measure, IPFs will still be able to collect data that is important to their patient care initiatives and reflects the unique needs of their specific patient population.

We acknowledge commenters' concern about the impacts of this measure removal. The IPFQR Program strives to hold IPFs accountable for high-quality healthcare delivery to all beneficiaries, and to focus on measures that are clinically important and meaningful to patients. We regularly review measures in our quality reporting programs, and we remain focused on identifying measures that balance feasibility, burden, and impact. As part of this regular reassessment of the balance of measures in our programs, we have assessed the overall costs of this measure as outweighing the benefits of retaining it in the IPFQR Program at this time.

Final Decision: After consideration of the comments we received, we are finalizing, as proposed, our proposal to remove the FCHE structural measure.

D. Removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel Measure Beginning With the CY 2024 Reporting Period/FY 2026 Payment Determination

We refer readers to the FY 2022 IPF PPS final rule where we adopted the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure into the IPFQR Program (86 FR 42633 through 42640) and the FY 2024 IPF PPS final rule where we modified the COVID–19 Vaccination Coverage Among HCP measure to account for updated vaccine guidance (88 FR 51128 through 51133).

As discussed in the FY 2026 IPF PPS proposed rule (90 FR 18516 through 18517), we proposed to remove the COVID–19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/FY 2026 payment determination under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program (§ 412.433(e)(3)(i)(H)). We noted that reporting on this measure currently requires reporting data on COVID–19 vaccination coverage among HCP for 1 week each month for each of the 3 months in a quarter. This requires IPFs to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers, and other contract personnel and log in to the National Healthcare Safety Network (NHSN) to report the data monthly either manually in the NHSN or by uploading a comma-separated value (CSV) file (86 FR 42636). The estimated burden of collecting this information annually across all 1,596 IPFs is between $721,392 and $841,730 annually. We referred readers to section V.B.3. of the proposed rule for more details on this estimated burden calculation.

When we first adopted the COVID–19 Vaccination Coverage Among HCP measure, the United States was in a PHE with millions of cases and over 550,000 COVID–19 deaths (86 FR 42633). While preventing the spread of COVID–19 remains a public health goal, the PHE ended on May 11, 2023.[10] In addition, the number of deaths due to COVID–19 in the U.S. has decreased since the adoption of this measure. In March 2021, when this measure was being proposed, the United States was averaging over 5,000 deaths per week. In April 2023, the last full month of the PHE, weekly number of deaths due to COVID–19 averaged around 1,300.[11] With the end of the PHE and the decrease in COVID–19 deaths, we believe the continued costs and burden to providers of tracking and monthly reporting on this measure outweigh the benefit of continued information collection on COVID–19 vaccination coverage among HCP. As it may be costly for IPFs to continue to report on the COVID–19 Vaccination Coverage Among HCP measure, removal of this measure would allow the IPFQR Program to focus on goals such as measuring clinical outcomes.

We stated that, if finalized, IPFs that do not report their CY 2024 reporting period data for the COVID–19 HCP Vaccination measure to CMS would not be considered noncompliant with the measures for purposes of their FY 2026 payment determination (that is, IPFs that do not report CY 2024 reporting period data would not be penalized for FY 2026 payments due to this measure). Any COVID–19 HCP Vaccination measure data received by CMS would not be used for public reporting or payment purposes.

We also stated that, if not finalized, IPFs that do not report their CY 2024 reporting data for the COVID–19 HCP Vaccination measure to CMS would be considered noncompliant with the measure for their FY 2026 payment determination, and would receive a letter of noncompliance after August 1, at which time the required 30 day reconsideration period would begin. Payment adjustments would apply to FY 2026 payment determination as previously finalized.

We invited public comment on our proposal to remove the COVID–19 Vaccination Coverage Among HCP measure from the IPFQR Program beginning with the FY 2026 payment determination. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported the removal of this measure. Commenters stated that tracking and reporting for this measure is burdensome, especially given the changes in measure definition over time. A few commenters described the administrative challenges with the up-to-date definition used in this measure, which has changed over time. These commenters stated that the current definition made data collection difficult. A few commenters stated that the measure no longer reflects facility performance or quality of care. A few commenters stated that removal of this measure will allow their staff to spend more time on activities or areas that more directly contribute to improved care for patients or for safety and protection of the IPF workforce. A few commenters noted practical concerns around continuing to require this measure, such as the vaccination no

[10] *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.*

[11] Provisional COVID–19 Deaths, by Week, in The United States, Reported to CDC. Accessed on March 27, 2025 via *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00.*

longer being required for HCP at their facility.

Response: We thank commenters for their support.

Comment: A commenter stated that this measure's definition, data collection, and public reporting represent a point-in-time count of a numerator, and do not accurately depict vaccination coverage. This commenter supported the removal of this measure.

Response: We thank the commenter for their support.

Comment: A commenter opposed the removal of this measure, stating that this measure is important to sustaining infection control practices and protecting IPF patients.

Response: We acknowledge that vaccination of healthcare personnel against COVID–19 may be one component of infection control in IPFs, but we do not believe that the removal of this measure of vaccination rates will inhibit IPFs' abilities to protect IPF patients, as well as IPF healthcare personnel. We remind readers the COVID–19 Vaccination Coverage Among HCP measure was never a vaccine mandate (86 FR 42638; 88 FR 51133), and we note that IPFs may continue to encourage and monitor HCP vaccination against COVID–19 and/or other infectious diseases as part of their policies to meet the infection control conditions of participation at 42 CFR 482.42. The goal of this measure removal is to alleviate the burden associated with tracking and reporting COVID–19 HCP vaccination rates for the IPFQR Program.

Final Decision: After consideration of the comments we received, we are finalizing our proposal to remove the COVID–19 Vaccination Coverage Among HCP measure as proposed.

E. Removal of two Social Drivers of Health Measures Beginning With the CY 2024 Voluntary Reporting Period

We proposed to remove two social drivers of health process measures from the IPFQR Program beginning with the CY 2024 voluntary reporting period: Screening for Social Drivers of Health measure (Screening for SDOH) (adopted at 88 FR 51107 through 51117); and Screen Positive Rate for Social Drivers of Health measure (Screen Positive) (adopted at 88 FR 51117 through 51121) in the FY 2026 IPF PPS proposed rule (90 FR 18517).

In the proposed rule, we proposed to remove the Screening for SDOH and Screen Positive measures beginning with the CY 2024 voluntary reporting period under removal Factor 8, the costs associated with the measure outweigh the benefit of its continued use in the program (90 FR 18517). We have previously heard from some IPFs concerned with the costs and resources associated with screening patients via manual processes, manually storing such data, training staff, and altering workflows for these measures. In the FY 2024 IPF PPS final rule, we estimated a total annual burden of surveying IPF patients for health-related social needs under the Screening for Social Drivers of Health measures will be 66,414 hours (1,596 facilities × 1,261 patients per facility × 0.033 hr) at a cost of $1,375,434 (66,414 hour × $20.71/hour) across all patients (88 FR 51152). We estimated that the submission of the Screen Positive measure to CMS would have incurred an additional 266 hours across all IPFs, at a cost of $11,933 (88 FR 51152 through 51153). We note that, as stated in section V.B.3. and shown in Tables 8 through 10 of the proposed rule, removal of the Screening for SDOH measure would alleviate an estimated annual burden for patients of 66,414 hours, at a cost of $1,702,191 (90 FR 18525). Also, as stated in section V.B.3. of the proposed rule, removal of both SDOH measures would alleviate an estimated of 532 hours for IPFs to report these measures, at a cost of $29,520, for the FY 2027 payment determination, when these measures would become mandatory (90 FR 18525). Further, we noted that these measures document an administrative process and report aggregate level outcomes, and do not measure the extent to which providers are ultimately connecting patients with resources or services and whether patients are benefiting from these screenings. We stated that the costs of the use of these measures in the IPFQR Program outweigh the benefits to providers and patients. Removal of these measures would alleviate the burden on IPFs to manually screen each patient and submit data each reporting cycle, allowing IPFs to focus resources on measurable clinical outcomes. This would also remove the patient burden associated with repeated SDOH screenings across multiple healthcare facilities. We referred readers to our request for comment ''Request for Information on Future Measures for the IPFQR Program'' in section IV.H.2. of the proposed rule for more information regarding our areas of focus for new measures (90 FR 18520). We acknowledged that some IPFs may have expended resources to implement SDOH screenings, however, IPFs that had already implemented such screenings prior to adoption of the measures would not have expended similar resources in response to the measure. The objectives of the IPFQR Program continue to incentivize the improvement of care quality and health outcomes for all patients through transparency and use of appropriate quality measures.

In the proposed rule, we described scenarios for reporting or non-reporting of these data for the FY 2026 payment determination (90 FR 18517). We wish to clarify that the SDOH measures were adopted as voluntary in the IPFQR Program for the FY 2026 payment determination, and not mandatory until beginning with the FY 2027 payment determination (88 FR 51113 and 88 FR 51119 through 511120). We additionally refer readers to a comment response later in this section V.B.F.

We invited public comment on our proposal to remove these SDOH measures from the IPFQR Program beginning with the CY 2024 reporting period. The following is a summary of the comments we received and our responses.

Comment: Many commenters were supportive of these measure removals, citing high burden for patient screening, data storage, and reporting. Several commenters noted that this burden was highest for IPFs without robust electronic health records (EHRs), which had to track these data manually. Several commenters affirmed the importance of SDOH and screening for social needs in the IPF, but were nevertheless supportive of the removal because of what they perceived to be limitations of these measures beyond the rationale offered by CMS (for example, timing of data collection, appropriateness of screening in this format for the IPF setting).

Response: We thank the commenters for their support.

Comment: Some commenters expressed concerns about frequent changes to measures in the IPFQR Program such as the proposed removal of the SDOH measures shortly after their adoption. They cautioned that there are practical consequences for IPFs and that these changes could damage trust in the IPFQR Program.

Response: We strive to maintain a parsimonious set of measures in the IPFQR Program that are reliable and meaningful to patients and IPFs. Ongoing review and evaluation of measures will result in measures being modified, added, or removed over time. We acknowledge that these changes impact IPFs and strive to provide clear guidance and adequate notice for measure changes to the greatest extent feasible.

Comment: Many commenters were opposed to the removal of the SDOH

measures. Many commenters described how SDOH significantly impacts health outcomes and the types of care and services patients may require in the IPF. These commenters stated that screening for SDOH is fundamental to patient-centered care, including clinical outcomes, treatment adherence, and reducing preventable healthcare utilization (for example, emergency department visits and readmissions). Several commenters stated that there is evidence from research and federal models demonstrating that SDOH screening improves health outcomes, reduces healthcare costs, and decreases avoidable utilization. For example, a commenter cited findings from CMS' Accountable Health Communities Model which found decreased heath care expenditures, inpatient stays, and emergency department visits for model participants. Another commenter stated that they believe there is evidence that unmet social needs can lead to missed follow-up appointments, delayed care, and poor chronic disease management. Some commenters stated that removing these measures would disregard the proven value of SDOH interventions.

Response: We appreciate the commenters' commitment to supporting optimal outcomes for their patients, and we recognize the importance of social factors for individuals as they seek to maintain good health or recover from illness. We reiterate that the goal of the removal of these measures is to reduce administrative burden for IPFs and patients. We recognize that there are many clinical practices employed by facilities that have been shown to produce positive outcomes for patients, and the removal of these measures does not preclude those practices from continuing. As we strive to maintain a parsimonious set of measures in the IPFQR Program, we must balance the need for data collection with the costs that such data collections may have on IPFs and their patients. By streamlining the number of measures required for reporting, we believe IPFs will be able to better focus efforts and resources to address the quality issues that matter most to their patients.

Comment: Some commenters disagreed that the cost of the SDOH measures outweighed the benefit, given cost savings through patients' decreased utilization of avoidable emergency department visits and hospitalizations that commenters stated can result through addressing social factors.

Response: Our proposal to remove these measures from the IPFQR Program was based on our assessment of the burden of data collection and reporting, and our conclusion that, at this time, the benefits of retaining these measures in the IPFQR Program are outweighed by the burden to providers. We acknowledge commenters' concerns and encourage IPFs to continue to close identified gaps in patient care including avoidable ED visits and hospitalizations. We urge IPFs to continue to incorporate industry standards that may address challenges that could impact safe high-quality healthcare delivery. Despite removal of these measures from the IPFQR Program, IPFs will still be able to collect data that is important to their patient care initiatives and reflects the unique needs of their specific patient population.

Comment: A commenter stated that the substantial costs to IPFs have already been incurred as they have set up systems to collect these data, claiming that removing the measures now will have minor impacts on cost.

Response: We acknowledge that some IPFs may have aligned resources to prepare for or to begin implementing SDOH screenings, such as selecting standardized screening questions, updating EHRs, and modifying clinician workflow. However, we believe that removal of these measures at this time will reduce greater levels of burden in the future—specifically, the burden incurred by patients and providers for screening, data storage, and data reporting, annually, going forward.

Comment: Many commenters stated that removing SDOH measures would undermine efforts to reduce health disparities and improve quality of care for all patients. Some commenters expressed concern that removing SDOH measures would shift the focus of quality reporting too narrowly toward clinical outcomes, neglecting the broader context of whole-person care and well-being. Several commenters stated that addressing social needs, such as food insecurity and housing instability, is integral to comprehensive care delivery, and long-term recovery, particularly in psychiatric settings. Several commenters stated these measures are a crucial component in promoting nutrition and well-being, areas that CMS has stated an interest in for future measure concepts.

Response: We acknowledge commenters' concerns that the removal of these measures will compromise the ability of the IPFQR Program to support and improve quality of care for all patients, and that removing these measures creates a risk that quality reporting will become too narrowly focused on clinical outcomes. Although we stated we are re-focusing on clinical outcomes in our proposal to remove these measures, we clarify that whole-person care is a priority for CMS, as well as measures that are meaningful to patients. The objectives of the IPFQR Program continue to be the improvement of care, quality, and health outcomes for all patients through transparency and quality measurement, while balancing burden on essential health providers. We note that we regularly review and evaluate IPFQR Program measures to ensure a parsimonious set of the most meaningful quality measures for the IPFQR Program.

We understand that some commenters believe that addressing social needs may be required for optimal care delivery for some patients. Our proposal to remove these measures from the IPFQR Program was based on our assessment of the burden of data collection and reporting, and our conclusion that, at this time, the benefits of retaining these measures in the IPFQR Program are outweighed by the costs and burden to providers. As discussed earlier, we expect providers to exercise their best judgement around factors to account for in their clinical decision-making.

Some commenters linked these measures to concepts of well-being and nutrition. We note that topical overlap does not resolve the issue of patient and provider burden for manual screening, data storage, and data reporting of these measures.

Comment: Several commenters proposed revising or streamlining the SDOH measures rather than removing them entirely. Suggestions included introducing measures that assess connections to community resources, automating reporting through EHRs, allowing sampling methods, using trainees to conduct screenings, incentivizing IPFs for integrating SDOH into their care, and aligning SDOH measures with existing workflows to reduce burden.

Response: We appreciate commenters' suggestions for various modifications to the measures, and ideas for how to reduce burden associated with screening and data collection. In particular, we appreciate the commenters' suggestion to utilize an EHR data collection framework. We refer readers to section V.H.2. of this final rule for a summary of a request for information on our digital quality measurement strategy and approach to using FHIR® for patient assessment reporting in the IPFQR Program.

The burden of including these measures, in their current state, in the IPFQR Program outweighs the benefits the measure data provides to patients and facilities. Commenters suggested ways to make the screening and

reporting process less burdensome for patients and facilities, and offered ideas for how the data collected by these measures provided more informative or actionable information about patient needs or patient care. However, the changes they suggest to meaningfully reduce burden (that is, automated reporting through EHR integration) would require substantial changes to both the measures (for example, standardization of the screening questions) and to the reporting requirement and technological infrastructure of IPFs. We will consider these comments as we continue to develop policies for future rulemaking.

Comment: Several commenters noted that the proposed rule stated if CMS does not finalize the proposal to remove the SDOH measures, that IPFs that do not report their CY 2024 reporting data for the SDOH measures to CMS would be considered noncompliant with the measures for their FY 2026 payment determination, but pointed out that the SDOH measures are voluntary in the IPFQR Program for the CY 2024 reporting period/FY 2026 payment determination.

Response: The commenters are correct. To clarify, the SDOH measures are voluntary for the IPFQR Program for the FY 2026 payment determination. Even if we were not finalizing our proposal to remove these measures, IPFs could choose not to submit data on these measures for the voluntary CY 2024 reporting period and still be compliant with IPFQR Program requirements for the FY 2026 payment determination.

Comment: Two commenters stated concerns about the timing of the measure removals. A commenter requested that these measures not be removed from the IPFQR Program until the CY 2026 reporting period/FY 2028 payment determination, as IPFs are currently collecting these data (that is, CY 2025 reporting period data for FY 2027 payment determination). Another commenter stated that the proposed measure removals should have been addressed in prior rulemaking, as the current implementation timeline is challenging for health IT vendors to support. They noted that IT vendors are currently engaged in development for an October 1, 2025, implementation of the mandatory reporting period, but note that these proposals may render those investments obsolete. They encouraged CMS to better align measure removal timelines with operational considerations, such as development of health IT.

Response: We acknowledge the impacts of this implementation timeline. The measures are being removed on the proposed timeline to alleviate the burden on patients and providers as soon as possible. Removal on a delayed timeline would mean requiring IPFs to collect and report measures whose benefit has been determined to be outweighed by the cost and burden of implementation and collection.

Final Decision: After consideration of the comments we received, we are finalizing our proposal to remove the Screening for SDOH and Screen Positive measures as proposed.

F. Summary of IPFQR Program Measures

1. IPFQR Program Measures for the FY 2028 Payment Determination

In this final rule, we are modifying the reporting period of one measure (the IPF ED Visit Measure) and removing four measures (the Facility Commitment to Health Equity measure, the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure, the Screening for Social Drivers of Health measure, and the Screen Positive Rate for Social Drivers of Health measure). We did not propose any new measures for the IPFQR Program in the FY 2026 IPF PPS proposed rule. Table 5 sets forth the finalized measures for the IPFQR Program for the FY 2028 payment determination.

TABLE 5—IPFQR PROGRAM MEASURE SET FOR THE FY 2028 PAYMENT DETERMINATION

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.
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 *	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 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.

2. IPFQR Program Measures for the FY 2029 Payment Determination

Table 6 sets forth the finalized measures for the IPFQR Program for the FY 2029 IPFQR payment determination.

TABLE 6—IPFQR PROGRAM MEASURE SET FOR THE FY 2029 PAYMENT DETERMINATION

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.
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	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 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.

G. IPFQR Program Extraordinary Circumstances Exception (ECE) Policy

1. Background

Under the current Extraordinary Circumstances Exception (ECE) policy as set forth in our regulations at 412.433(f), we have granted exceptions with respect to quality data reporting requirements in the event of extraordinary circumstances beyond the control of an IPF. An exception may be granted for extraordinary circumstances including, but not limited to, natural disasters or systemic problems with data collection systems. In the FY 2026 IPF PPS proposed rule, we referred readers to 412.433(f) for our current ECE regulations, as well as the FY 2013 IPPS/LTCH PPS final rule (77 FR 53659 through 53660), FY 2014 IPPS/LTCH PPS final rule (78 FR 50903), FY 2015 IPF PPS final rule (79 FR 45978), and FY 2018 IPPS/LTCH PPS final rule (82 FR 38473 through 38474) for further background and details of the ECE policy (90 FR 18518 through 18519). We also referred readers to the CMS QualityNet website for the specific requirements for submission of an ECE request in the IPFQR Program.[12]

Our ECE policy provides flexibility for IPFQR Program participants to ensure continuity of quality care delivery and measure reporting in the event of an extraordinary circumstance. For instance, we recognized that, in circumstances where a full exception is not applicable, it is beneficial for an IPF to report data later than the reporting deadline. Delayed reporting authorized under our ECE policy allows temporary relief for an IPF experiencing an extraordinary circumstance while preserving the benefits of data reporting, such as transparency and informed decision-making for beneficiaries and providers alike. Accordingly, we proposed to update our regulations to specify that an ECE could take the form of an extension of time for an IPF to comply with a data reporting requirement if CMS determines that this type of relief would be appropriate under the circumstances.

2. Update of the Extraordinary Circumstances Exception (ECE) Policy for the IPFQR Program

As discussed in the FY 2026 IPF PPS proposed rule, we proposed to update the current ECE policy codified at 42 CFR 412.433(f) to include extensions of time as a form of relief and to further clarify the policy (90 FR 18518 through 18519). Specifically, in the introductory text at proposed 42 CFR 412.433(f)(1), we proposed that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—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.

We proposed that the steps required for requesting or granting an ECE would remain the same as the current ECE process, detailed by CMS at the QualityNet website or a successor website.[13] At proposed 42 CFR 412.433(f)(2)(i), we proposed that an IPF may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred. Our current policy allows a request within 90 days; however, the proposed change would align the IPFQR Program policy with CMS systems implementation requirements across all quality reporting programs. Under the proposed codified policy, we clarified that CMS retains the

[12] *https://qualitynet.cms.gov/ipf/ipfqr/participation.*

[13] *https://qualitynet.cms.gov/inpatient/iqr/participation#tab3.*

authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred. At proposed 42 CFR 412.433(f)(2)(ii), we proposed that CMS notify the requestor with a decision in writing, via email. In the event that CMS grants an ECE to the IPF, the written decision will specify whether the IPF is exempted from one or more reporting requirements or whether CMS has granted the IPF an extension of time to comply with one or more reporting requirements.

Additionally, at 42 CFR 412.433(f)(3), we proposed that CMS may grant an ECE to one or more IPFs that have not requested an ECE if CMS determines that: a systemic problem with a CMS data collection system directly impacted the ability of the IPF to comply with a quality data reporting requirement, or that an extraordinary circumstance has affected an entire region or locale. As is the case under our current policy, any ECE granted will specify whether the affected IPFs are exempted from one or more reporting requirements or whether CMS has granted the IPFs an extension of time to comply with one or more reporting requirements.

The proposed ECE policy would provide further reporting flexibility for IPFs and clarify the ECE process.

We invited public comments on our proposals to update the ECE policy for the IPFQR Program.

Comment: Several commenters were supportive of CMS's proposal to modify the ECE policy to explicitly include reporting extensions as a form of exception.

Response: We thank commenters for their support.

Comment: A commenter stated a concern that CMS could effectively replace reporting exceptions with reporting extensions, and that this might not be appropriate for many providers experiencing extraordinary circumstances. The commenter recommended that CMS use extensions sparingly.

Response: We thank the commenters for their recommendations. We will continue to consider ECE applications on a case-by-case basis and offer any exception or extension based on the nature of the extraordinary circumstance and the capacity of the provider, as well as CMS operational feasibility to grant an exception versus an extension. We note our preference to grant an extension when it can be feasibly granted because of the importance of having quality measure data particularly for public reporting purposes, as transparency is a paramount goal of the program.

Comment: A commenter recommended that CMS ensure that the ECE application process is clear, imposes minimal administrative burden, and that CMS provides technical assistance for IPF navigating the ECE process.

Response: To extent applicable, we strive to ensure the ECE application process is aligned across multiple hospital quality reporting programs to minimize administrative burden and promote process clarity, such as by using a single form.

In addition, ECE-related education and outreach materials, as well as copies of the form, are available on QualityNet.[14] We also have the IPFQR Program Help Desk [15] to answer questions from facilities if facilities require assistance.

Comment: A few commenters opposed the update to the timeframe for IPFs to submit an ECE request from 90 days to 30 days. These commenters described 30 days as being inadequate and impractical. A commenter recommended that CMS retain the current policy of 90 days, citing increasing frequency of extreme weather events as well as cyberattacks. A commenter referred to the experience of hospitals in Virginia and North Carolina that experienced severe flooding in 2024, stating that facilities that experience an extraordinary circumstance could reasonably still be restoring operations and focusing on patient care 30 days after the emergency. This commenter expressed concern that moving to a 30-day window could lead to situations where hospitals miss the ECE request deadline because they are still dealing with the emergency. This commenter stated that if CMS believes a shorter timeframe is needed, a 60-day request window would be preferrable to the 30-day window in the proposal. This commenter also recommended that CMS consider late ECE applications on a case-by-case basis.

Response: We appreciate the commenters' responses. We recognize that IPFs may not have the ability to assess the impact on quality data submissions and complete the necessary paperwork within 30 days of the extraordinary circumstance. Due to concerns regarding IPFs' ability to complete the ECE request within 30 days of the extraordinary circumstance, we are modifying the timeframe to allow for 60 days to submit an ECE request. We believe this timeframe will provide sufficient time for IPFs to assess the impact on quality reporting without disrupting operational and care needs. Therefore, we are finalizing a modified policy that states that IPF may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred.

Comment: A commenter recommended that CMS include additional details on how the determination of an exception versus an extension will be made, stating that transparency will help facilities prepare for the outcome of the process (that is, whether they are likely to receive an extension or an exception).

Response: We consider ECE applications on a case-by-case basis and make the decision to offer relief based on the nature of the extraordinary circumstance and the capacity of the provider, as well as CMS operational feasibility to grant an exception or an extension. IPFs applying for an ECE are encouraged to share relevant details that would inform our decision on whether to grant an exception or an extension, which we will take into account when reviewing the application. As noted, we generally will prefer to grant an extension when it can be feasibly granted because of the importance of having quality measure data particularly for public reporting purposes.

Final Decision: After consideration of the comments we received, we are finalizing our proposal to update and codify updates to the ECE policy with modification. After consideration of concerns identified in public comments regarding the proposed 30 calendar day timeframe during which an IPF may request an ECE, and for the reasons described above, we are finalizing a different timeframe in which an ECE can be requested. We will allow up to 60 calendar days for ECE requests after the precipitating event. We are codifying this updated ECE policy at § 412.434(f) with modification to reflect this extended deadline.

H. Requests for Information on Future Changes to the IPFQR Program

We solicited public comment on the three following topics that may have future impacts on the IPFQR Program.

1. Request for Information on Future Star Ratings for IPFs

Section 1886(s)(4)(F) of the Act requires that the Secretary establish procedures for making data submitted under the IPFQR Program available to the public. Such procedures must ensure the IPFs participating in the

[14] *https://qualitynet.cms.gov/ipf/ipfqr/participation#tab3.*

[15] The IPFQR Program Help Desk can be accessed through the Quality Question and Answer Tool at *https://cmsqualitysupport.servicenowservices.com/qnet_qa.*

IPFQR Program have the opportunity to review the data prior to such data being made public. The Secretary must publicly report quality measures that relate to services furnished in IPFs on the CMS website. Currently, we publicly report data on measures under the IPFQR Program on the Compare tool on *Medicare.gov*.[16]

Star ratings summarize facility or provider performance using symbols to help patients and caregivers quickly and easily understand quality of care information. Star ratings serve an important function for patients, caregivers, and families, helping them to more quickly comprehend complex information about a healthcare providers' care quality and to easily assess differences among providers. Star ratings also spotlight differences in healthcare quality and identify areas for improvement and may motivate providers to perform well on measures in CMS quality reporting programs. This transparency serves an important educational function for consumers, while also helping to promote competition in health care markets. Informed patients and consumers are more empowered to select among healthcare providers, fostering continued quality improvement.

The Compare tool currently displays star ratings for many provider types, including doctors and clinicians, some types of hospitals not including inpatient psychiatric hospitals, nursing homes, home health, hospice, and dialysis facilities. The method to calculate star ratings differs by provider type. Differences include data sources, which measures are included, and how the components of the star ratings are combined. Some providers receive ''patient survey'' star ratings, a composite score derived from patient experience of care surveys, in addition to ''overall star ratings,'' which are a composite score calculated using different data sources, such as quality measures or survey results.

Although we publicly report data on measures under the IPFQR Program on the Compare tool, there are currently no star ratings displayed for IPFs, and IPFs are not included in hospital star ratings. We sought feedback on the development of a five-star methodology for IPFs that can meaningfully describe the quality of care offered by IPFs. Star ratings for IPFs would be designed to help consumers quickly identify differences in quality when selecting an IPF. We are committed to developing a well-tested, data-driven methodology that encourages continuous quality improvement. We plan to engage with the IPF community and provide multiple opportunities for IPFs and other interested parties to give input on the development of a star rating system for IPFs. We noted that IPFs would have the ability to preview their own facility's quality data before public posting of the IPF's star rating on the Compare tool in accordance with section 1886(s)(4)(F) of the Act.[17]

Specifically, in the FY 2026 IPF PPS proposed rule, we invited public comments on the following topics (90 FR 18519 through 18520).

Criteria for Measure Selection

1. Are there specific criteria CMS should use to select measures for an IPF star rating system, such as a measure's generalizability (degree to which a measure is applicable to a broad segment of patients)?

2. Should an IPF star rating system be limited to or more heavily weight certain types of measures (for example, outcome measures, process measures, structural measures; measures that address certain topics, such as safety, psychiatric treatment, substance use treatment, whole-person care, or patient experience)?

Suitability of Measures Currently in the IPFQR Program

3. From the perspective of patients and families or other caregivers, which measures currently adopted for the IPFQR Program are most important when attempting to summarize quality of care in IPFs? Which are least important? Are there any measures in the program that should be specifically excluded or included in IPF Star Ratings? For the list of IPFQR Program measures, we referred the reader to Table 6 in section IV.F. in the proposed rule.

4. From the perspective of referring providers, payers, or other interested parties, which measures currently adopted for the IPFQR Program are most important when attempting to summarize quality of care in IPFs? Which are least important? Are there any measures in the program that should be specifically excluded or included in an IPF star ratings system?

5. Two measures currently in the IPFQR Program—Hours of Physical Restraint Use (HBIPS–2) and Hours of Seclusion Use (HBIPS–3)are calculated and publicly reported as a rate per 1000 hours of patient care. Does the way these measures are currently specified and displayed create challenges for including these measures in a star rating calculation? If these measures were selected to be included in a star rating calculation, are there recommendations about how these measures should be included in a larger star rating methodology? For example, should the rate be made into a categorical variable (for example, quartiles)?

Future Use of Additional Data for an IPF Star Rating System

6. In the FY 2024 IPF PPS final rule (88 FR 51128), we finalized the Psychiatric Inpatient Experience (PIX) survey as a measure of patient experience in IPFs. The PIX survey will become mandatory for the FY 2028 payment determination—that is, data collection occurring in CY 2026. Although PIX data may not be available for an initial version of an IPF star rating system, what considerations should CMS give these data, when they become available? For example, should they be included as part of an overall star rating, or used to derive a stand-alone patient experience star rating? See for example the Hospital patient experience star rating,[18] which is derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS©) survey and displayed as ''Patient survey rating'' on the Compare tool.

7. Are there other measurement topics that are currently not addressed by an IPFQR Program measure, but would be valuable in an IPF star rating?

We intend to use this input to inform our future star rating development efforts. We intend to consider how a rating system would determine an IPF's star rating, the methods used for such calculations, and an anticipated timeline for implementation. We will consider comments in response to this RFI for future rulemaking.

The following is a summary of the comments we received and our responses.

Comment: Many commenters acknowledged the potential value of a star rating system for IPFs, but some expressed concerns about the uses and usability of star ratings for patients and providers, as well as the readiness of the IPFQR Program to supply sufficient and appropriate data to support star rating development at this time.

A few commenters agreed with CMS that star ratings can help consumers make sense of the complex quality measure information available on Care Compare, and could support consumer

[16] *https://www.medicare.gov/care-compare.*

[17] Currently IPFs preview their data via the ''IPF-specific report (ISR)'' distributed to providers through CMS' Hospital Quality Reporting system.

[18] *https://hcahpsonline.org/en/hcahps-star-ratings/.*

choice in addition to accountability and quality improvement. However, several commenters stated that the existing CMS star rating systems are not widely known or understood by consumers, limiting their effectiveness in helping patients make informed decisions. In addition, some comments noted that patients seeking psychiatric care often do so in crisis situations, where facility choice is constrained by bed availability, geographic limitations, or insurance coverage. They stated concerns that these constraints may limit the usefulness of star ratings to patients and caregivers. Some commenters cautioned that star ratings can affect IPFs referral and payment patterns, and urged CMS to be cautious in ensuring that ratings did not disadvantage certain providers based on patient case-mix (for example, patients who are involuntarily admitted, patients with high levels of social needs), available of resources in the geographic area, or state-level policies.

Many commenters recommended that CMS prioritize certain domain areas for measures included in a star rating system, chiefly aspects of care that they stated are important to most psychiatric patients. These domains included patient safety (including physical assaults, sexual assaults, suicides, unexpected deaths, injuries, and elopements; facility inspection reports, complaints, and regulatory violations), patient experience (including patient dignity and rights, and patient-reported experience of care), and topics and outcomes specific to psychiatric care.

In addition, many commenters recommended evaluation criteria for CMS to use when selecting measures. Criteria included usefulness, scientific quality of the measure (for example, well-defined, accurate, reliable), extent to which the measure included a broad segment of the patient population, reportability (that is, that most IPFs would have sufficient data to report on the measure), and measures that are linked to IPFs' care processes or patient outcomes. Some commenters also recommended that new measures or measures that have changed specifications be excluded from consideration. Many commenters, after applying their suggested criteria, stated that only two measures currently in the IPFQR Program—HBIPS–2 and HBIPS–3—are appropriate to include in a rating system.

Many commenters emphasized the need for methodological rigor as well as collaboration with experts and interested parties—including people affected by serious mental illness and their families—to ensure that any future star rating system is developed in a way that it is meaningful to patients, reflective of quality of care, and fair to the wide range of IPF providers.

Response: We thank commenters for their responses to this comment solicitation. We will consider these comments as we continue to develop policies for future rulemaking.

2. Request for Information on Future Measures for the IPFQR Program

In the FY 2026 IPF PPS proposed rule, we sought input on the importance, relevance, appropriateness, and applicability of two concepts under consideration for future years in the IPFQR Program (90 FR 18520).

We sought input on a quality measure concept of well-being for future quality measures. Well-being is a comprehensive approach to disease prevention and health promotion, as it integrates mental, social, and physical health [19] [20] while emphasizing preventive care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting well-being of patients and their family members. We requested input and comment on tools and measures that assess for overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, fulfillment, and self-care work. We requested input on the relevant aspects of well-being for the IPF setting.

We sought input on a quality measure concept of nutrition for future quality measures. Assessment of an individual's nutritional status may include various strategies, guidelines, and practices designed to promote healthy eating habits and ensure individuals receive the necessary nutrients for maintaining health, growth, and overall well-being. This also includes aspects of health that support or mediate nutritional status, such as physical activity and sleep. In this context, preventable care plays a vital role by proactively addressing factors that may lead to poor nutritional status or related health issues. These efforts not only support optimal nutrition but also work to prevent conditions that could otherwise hinder an individual's health and nutritional needs. We requested input and comment on tools and frameworks that promote healthy eating habits; exercise, nutrition, or physical activity for optimal health; well-being; and best care for all. Please provide input on the relevant aspects of nutrition for the IPF setting.

We noted that we plan to use this input to inform our future measure development efforts.

The following is a summary of the comments we received and our responses.

Comment: Many commenters expressed concerns about the applicability of well-being and nutrition measures in the IPF setting, where care is focused on stabilizing patients experiencing acute mental health crises. They stated that these measures do not align with the primary focus of IPFs, which is safety and stabilization of severe psychiatric conditions. Several commenters were critical of the relationship between nutrition or well-being measures and the quality of care of an IPF, stating that measures on these topics were not likely to reflect patient care and rather only describe the patients' experience in the time before they entered the IPF.

Several commenters stated that many aspects of well-being and nutrition are already addressed by IPFs in current workflows, in a way that is appropriate for IPFs and tailored to individual patients' needs. Some commenters stated concerns that measures on these topics would add administrative burden without providing meaningful benefits. Some commenters stated concerns about the operational challenges of implementing new measures, including costs, technology upgrades, and methodological issues. Some commenters encouraged engagement with experts and IPF interested parties in the development of measures to address these topics.

With regard to well-being, a few commenters questioned the ability of IPF patients to comprehend and accurately respond to well-being measures at the time of an IPF stay. A commenter noted that well-being measures, such as happiness and life satisfaction, are better suited to less-intensive care settings. A few commenters recommended that CMS consider scales from the Patient-Reported Outcomes Measurement Information System (PROMIS), which includes patient-centered measures covering domains like global health and social participation. A few commenters recommended that CMS consider the World Health Organization Well-Being Index (WHO–5), which is brief, validated, and applicable across psychiatric conditions.

[19] Overall well-being. See more information at *https://odphp.health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measures/overall-well-being-ohm-01.*

[20] Well-Being Measurement. See more information at *https://www.va.gov/WHOLEHEALTH/professional-resources/well-being-measurement.asp.*

With regard to nutrition, some commenters were concerned that full nutritional assessment for each patient would not be appropriate nor an efficient use of resources; they stated that IPFs already screen for nutritional issues and conduct further assessment or develop treatment plans as appropriate for individual cases. Commenters were mixed on their support for specific measures of nutrition. A few commenters supported the Global Malnutrition Assessment Measures, largely because it is already in use in other programs and hospital types, while a few commenters recommended that CMS select an alternative to these measures due to its administrative burden and concerns about scoring. A few commenters recommended measuring nutrition via food-related SDOH constructs, such as residing in a food desert or food insecurity.

Many commenters highlighted the connection between well-being, nutrition, and social factors, such as those assessed by the SDOH screening measure that CMS is removing from the IPFQR Program. Several commenters opposed the removal of those measures and suggested that CMS develop new measures for well-being and nutrition that align with or expand on the existing SDOH assessments.

Response: We thank commenters for their responses to this comment solicitation. We will consider these comments as we continue to develop policies for future rulemaking.

3. Request for Information on Digital Quality Measurement Strategy: Approach to FHIR® Patient Assessment Reporting in the IPFQR Program

Section 4125(b) of the Consolidated Appropriations Act of 2023 (CAA, 2023) (Pub. L. 117–328, Dec. 29, 2022) [21] amended section 1886(s)(4) of the Act by adding a new subparagraph (E), which requires an IPF participating in the IPFQR Program to collect and submit specified standardized patient assessment data using a new standardized patient assessment instrument, for rate year 2028 and each subsequent year.

As noted in the RFI [22] in the FY 2025 IPF PPS proposed rule (''Patient Assessment Instrument Under IPFQR Program (IPF PAI) to Improve the Accuracy of PPS''), achieving interoperability is important and it is our goal to facilitate safe and secure data sharing, access, and utilization of electronic health information to enhance decision-making and create a more efficient healthcare system (89 FR 23201 through 23204). We also stated that we are considering ways to ensure that the Inpatient Psychiatric Facility Patient Assessment Instrument (IPF–PAI) can be represented using Fast Healthcare Interoperability Resources® (FHIR®) standards (89 FR 23201). As part of that RFI, we requested and received input on topics including whether Standardized Patient Assessment Data Elements already in use in the CMS Data Element Library (DEL) [23] are appropriate and clinically relevant for the IPF setting, use of CMS reporting systems, and other interoperability-related considerations (89 FR 23201). In the FY 2025 IPF PPS final rule, we acknowledged a recommendation to align the IPF–PAI with United States Core Data for Interoperability (USCDI) [24] and several commenters noted IPFs did not receive funding to adopt CEHRT, suggesting we consider how the implementation of the IPF–PAI would affect providers without EHRs (89 FR 64646).

We are considering opportunities to advance FHIR-based reporting of patient assessment data for the IPF–PAI mandated by the CAA, 2023. The FY 2026 IPF PPS proposed rule included questions in this section and sought to gain an understanding of the current adoption and use of EHRs, other health IT, and data standards supporting interoperability (such as FHIR and USCDI) within IPFs (90 FR 18520 through 90 FR 18523). We also aimed to identify the extent of technology adoption beyond certified health IT and EHRs and seek a better understanding of how FHIR-standardized data can be generated, used, and shared through other technologies, without use of EHRs. Our objective was to explore how IPFs typically integrate technologies with varying complexity into existing systems and how this affects IPF workflows. We sought to identify the challenges or opportunities that may arise during this integration, and determine the support needed to complete and submit the IPF–PAIs in ways that protect and enhance care delivery. This insight will help inform the technologies we may consider for use with the IPF–PAI and quality data reporting. This same RFI also appeared in the FY 2026 IPPS proposed rule, as a majority of IPFs are hospital-based,[25] to increase the number of interested parties who learn about this opportunity to provide feedback (90 FR 18326 through 18327).

We sought feedback on the current state of health IT use, including EHRs, in IPFs:

- To what extent does your facility use health IT systems to maintain and exchange patient records?
- If your facility has transitioned to using electronic records in whole or in part, what types of health IT does your IPF use to maintain patient records? Are these health IT systems certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification program? [26] Does your facility use EHRs or other health IT products or systems that are not certified under the ONC Health IT Certification Program? If so, do these systems exchange data using standards and implementation specifications adopted by HHS? [27] Please specify.
- Does your IPF submit patient data to CMS directly from your health IT system, without the assistance of a third-party intermediary? If a third-party intermediary is used to report data, what type of intermediary service is used? How does your facility currently exchange health information with other healthcare providers or systems, specifically between IPFs and other provider types, or with public health agencies? What challenges do you face with the electronic exchange of health information?
- Are there any challenges with your current electronic devices (for example, tablets, smartphones, computers) that hinder your ability to easily exchange information across health IT systems? Please describe any specific issues you encounter.
- Does limited internet or lack of internet connectivity impact your ability to exchange data with other healthcare providers, including community-based care services, or your ability to submit patient data to CMS?
- What steps does your IPF take to ensure compliance in using health IT with security and patient privacy requirements such as the requirements of the regulations promulgated under

[21] *https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.*

[22] ''Patient Assessment Instrument Under IPFQR Program (IPF PAI) to Improve the Accuracy of PPS'' (89 FR 23200 through 23204).

[23] *https://del.cms.gov/DELWeb/pubHome.*

[24] *https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.*

[25] We refer readers to the FY 2025 IPF PPS-Rate Update final rule, Table 24 (89 FR 64670). Based on this data, 59.3 percent of IPFs were hospital-based units, a figure derived by dividing the sum of urban and rural units by the total number of facilities.

[26] *https://www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program.*

[27] For instance, see standards adopted by ASTP/ONC on behalf of HHS in 45 CFR part 170, subpart B.

the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104–191, 110 Stat. 1936 (August 21, 1996) and related regulations?

- Does your IPF refer to the SAFER Guides (see newly revised versions published in January 2025 at *https://www.healthit.gov/topic/safety/safer-guides*) to self-assess EHR safety practices? [28]

- What challenges or barriers does your IPF encounter when submitting quality measure data to CMS as part of the IPFQR Program? Please identify any factors that hinder successful data submission. What opportunities or factors could improve your facility's successful data submission to CMS?

- What types of technical assistance, guidance, workforce training resources, and other resources would help IPFs to successfully implement FHIR-based technologies for submitting the IPF–PAI to CMS? What strategies can CMS, HHS or other Federal partners take to ensure that technical assistance is both comprehensive and user-friendly? How could Quality Improvement Organizations or other entities enhance this support?

- Is your facility using technology that utilizes APIs based on the FHIR standard to enable electronic data sharing? If so, with whom are you sharing data using the FHIR standard and for what purpose(s)? For example, have you used FHIR APIs to share data with public health agencies? Does your facility use any Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR [29] applications? If so, are the SMART on FHIR applications integrated with your EHR or other health IT?

- What benefits or challenges have you experienced with implementing technology that uses FHIR-based APIs? How can adopting technology that uses FHIR-based APIs to facilitate the reporting of patient assessment data impact provider workflows? What impact, if any, does adopting this technology have on quality of care?

- Does your facility have any experience using technology that shares electronic health information using one or more versions of the USCDI standard? [30]

- Would your IPF and/or vendors be interested in participating in testing to explore options for transmission of assessments, for example, testing methods to transmit assessments that incorporate FHIR-enabled data to CMS?

- What other information should we consider, to facilitate successful adoption and integration of FHIR-based technologies and standardized data for patient assessment instruments like the IPF–PAI? We invited any feedback, suggestions, best practices, or success stories related to the implementation of these technologies.

The following is a summary of the comments we received to this RFI from both the FY 2026 IPF PPS proposed rule (90 FR 18520 through 90 FR 18523) and the FY 2026 IPPS proposed rule (90 FR 18326 through 18327), where this RFI also appeared.

Comment: Many commenters expressed support for CMS' intent to transition to the FHIR-based standard in IPFQR, particularly for the IPF–PAI. A few commenters noted the opportunity for a FHIR-based standard to improve care coordination, enable actionable insights, and integrate structured data into EHRs. A few commenters highlighted the potential for FHIR to modernize behavioral health data reporting, enhance discharge planning, and enable meaningful performance measurement.

Many commenters identified challenges that may hinder interoperability efforts in IPFs. Challenges shared included: inconsistent state laws governing data-sharing and outdated provider directories, expense and complexity caused by non-standard reporting requirements, internet connectivity issues (particularly in rural areas), lack of ability for some IPFs to accept direct messaging, and outdated systems, particularly in stand-alone IPFs. A few commenters noted the high cost and burden of implementing FHIR-based technologies for facilities without certified EHRs.

A few commenters described variability in EHR adoption and infrastructure readiness across IPF facilities. A few commenters reported adopting EHRs capable of utilizing USCDI, with a commenter indicating that most of their members have or are currently implementing EHRs that support both USCDI and FHIR. Several commenters noted that while adoption continues to improve, they remain concerned about the low adoption rate of certified EHRs in IPFs compared to other healthcare settings. A few commenters urged CMS to provide financial incentives and technical assistance to support rural and resource-constrained IPF facilities in transitioning to FHIR-based systems. A few commenters specifically highlighted IPFs' exclusion from the HITECH Act as a cause for many IPFs having outdated systems that are incapable of interoperable data exchange and urged CMS to provide equitable support for IPFs. Lastly, a few commenters noted that many freestanding IPFs rely on non-EHR vendors for data submission, which further complicates their ability to transition to FHIR-based reporting.

A few commenters provided recommendations to support the dQM transition in IPFs. Recommendations to CMS included: updating USCDI standards to incorporate specific FHIR-based data elements, providing consistent reporting processes to reduce provider burden, encouraging collaboration with health IT vendors, testing FHIR-enabled data submission methods, ensuring solutions reflect the unique needs of IPFs, and allowing 18 to 24 months for FHIR API development and testing.

Response: We appreciate all the comments received on this topic as we continue transitioning to dQM in CMS quality programs, and in our efforts toward a patient-centric digital health ecosystem.

VI. Collection of Information Requirements

This final rule updates the prospective payment rates, outlier threshold, and wage index for Medicare inpatient hospital services provided by IPFs. In addition, we are finalizing the removal of one measure in the IPFQR Program that will affect the information collection burden under OMB control number 0938–0050.

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), 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. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

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:

[28] The SAFER Guides are an evidence-based set of recommendations in the form of nine stand-alone, subject-oriented chapters that present the health IT community, including eligible hospitals and CAHs that use health IT, with best practice recommendations to improve the safety and safe use of EHRs. See *https://www.healthit.gov/topic/safety/safer-guides.*

[29] *https://smarthealthit.org/.*

[30] For more information about USCDI see *https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.*

• 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 solicited public comment (see section V.E. of the proposed rule) on each of these issues for the following sections of this document that contain information collection requirements.

The following changes will be submitted to OMB for review under control number 0938–1171 (CMS–10432). We did not propose any changes that would change any of the data collection instruments that are currently approved under that control number.

In section VI.B. of this final rule, we restated our currently approved burden estimates. In section VI.C. of this final rule, we estimate the changes in burden associated with the update to more recent wage rates. Then in section VI.D. of this final rule, we discuss the policies finalized in this final rule.

A. Wage Estimates

In the FY 2025 IPF PPS final rule, we utilized the median hourly wage rate for Medical Records Specialists, in accordance with BLS, to calculate our burden estimates for the IPFQR Program (89 FR 64664). While the most recent data from the BLS reflects a mean hourly wage of $25.81 per hour for all medical records specialists, $27.69 is the mean hourly wage for ''general medical and surgical hospitals,'' which is an industry within medical records specialists.[31] We believe the industry of ''general medical and surgical hospitals''' is more specific to the IPF setting for use in our calculations than other industries that fall under medical records specialists, such as ''office of physicians'' or ''nursing care facilities (skilled nursing facilities).'' We calculated the cost of indirect costs, 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 other indirect 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 ($27.69 × 2 = $55.38) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we would calculate cost burden to IPFs using a wage plus benefits estimate of $55.38 per hour throughout the discussion in this section of this rule for the IPFQR Program.

Some of the activities previously finalized for the IPFQR Program require beneficiaries to undertake tasks such as responding to survey questions on their own time. In the FY 2025 IPF PPS final rule, we estimated the hourly wage rate for these activities to be $24.04/hr (89 FR 64664). We are updating that estimate to a post-tax wage of $25.63/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 undertake activities on their own time.[32] For FY 2026 we propose to derive the costs for beneficiaries using the usual weekly earnings of wage and salary workers of $1,192, divided by 40 hours to calculate an hourly pre-tax wage rate of $29.80/hr.[33] 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,[34] resulting in the post-tax hourly wage rate of $25.63/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. Information Collection Requirements for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

1. Previously Finalized IPFQR 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 2028 payment determination occurs during CY 2027 and generally reflects care provided during CY 2026. Our currently approved burden for CY 2026 is set forth in Table 7.

TABLE 7—PREVIOUSLY FINALIZED IPFQR PROGRAM INFORMATION COLLECTION BURDEN FOR CY 2026

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	52.12	16,431	26,223,605
Hours of Seclusion Use	1,596	1,261	2,012,556	0.25	315	503,139	52.12	16,431	26,223,605
Follow-Up After Psychiatric Hospitalization	1,596	0	0	0	0	0	52.12	0	0
Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention	1,596	609	971,964	0.25	152	242,991	52.12	7,935	12,664,691
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB–3a Alcohol and Other Drug Use Disorder Treatment at Discharge	1,596	609	971,964	0.25	152	242,991	52.12	7,935	12,664,691
Tobacco Use Treatment Provided or Offered at Discharge and TOB–3a Tobacco Use Treatment at Discharge	1,596	609	971,964	0.25	152	242,991	52.12	7,935	12,664,691
Influenza Immunization	1,596	609	971,964	0.25	152	242,991	52.12	7,935	12,664,691

[31] *https://www.bls.gov/oes/current/oes292072.htm.*

[32] *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

[33] *https://www.bls.gov/news.release/pdf/wkyeng.pdf.* Accessed January 24, 2025.

[34] *https://www.census.gov/library/publications/2024/demo/p60-282.html.* Accessed January 24, 2025.

TABLE 7—PREVIOUSLY FINALIZED IPFQR PROGRAM INFORMATION COLLECTION BURDEN FOR CY 2026—Continued

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 ($)
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	52.12	7,935	12,664,691
Screening for Metabolic Disorders	1,596	609	971,964	0.25	152	242,991	52.12	7,935	12,664,691
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	1,596	0	0	0	0	0	52.12	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	52.12	0	0
Medication Continuation Following Inpatient Psychiatric Discharge	1,596	0	0	0	0	0	52.12	0	0
Modified COVID–19 Healthcare Personnel (HCP) Vaccination Measure*	1,596	0	0	0	0	0	52.12	0	0
Facility Commitment to Health Equity*	1,596	1	1,596	0.167	0	267	52.12	9	13,892
Screening for Social Drivers of Health (Data Submission)*	798	1	798	0.167	0	133	52.12	9	6,946
Screen Positive Rate for Social Drivers of Health*	798	1	798	0.167	0	133	52.12	9	6,946
Non Measure Data Collection	1,596	4	6,384	0.5	2	3,192	52.12	104	166,367
Subtotal for Medical Records Specialists	*1,596*	*6,183*	*9,866,472*	*Varies*	*1,547*	*2,467,949*	*52.12*	*80,604*	*128,629,505*
Screening for Social Drivers of Health (Patient Screening)*	1,596	1,261	2,012,556	0.033	42	66,414	24.04	1,000	1,596,601
Psychiatric Inpatient Experience Survey	798	300	239,400	0.121	36	28,967	24.04	873	696,376
Subtotal for Individuals	*1,596*	*1,561*	*2,251,956*	*Varies*	*78*	*95,382*	*24.04*	*1,873*	*2,292,977*
Totals	1,596	7,744	12,118,428	Varies	1,624	2,563,331	N/A	82,477	130,922,482

*We note that we are removing these measures in this final rule.

2. Updates Due to More Recent Information

In section VI.A. of this final rule, we describe our updated wage rates which increase from $52.12/hr to $55.38/hr (an increase of $3.26/hr) for activities performed by Medical Records Specialists and from $24.04/hr to $25.63/hr (an increase of $1.59/hr) for activities performed by individuals. The effects of these updates are set forth in Table 8.

TABLE 8—EFFECTS OF WAGE RATE UPDATES

Measure/response description	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.	9,866,472	Varies	1,547	2,467,949	3.26	5,042	8,045,514
Subtotal for Individuals	2,251,956	Varies	78	95,382	1.59	124	151,657
Totals	12,118,428	Varies	1,624	2,563,331	Varies	5,165	8,197,171

3. Updates Due to Policies in This Final Rule

In section V.B. of this final rule, we are finalizing changes to begin use of the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge measure (IPF ED Visit measure) in the IPFQR Program with the FY 2029 payment determination instead of the FY 2027 payment determination, and to modify the reporting period for the IPF ED Visit measure to a 2-year reporting period that runs from July 1st 4 years prior to the applicable fiscal year payment determination to June 30th 2 years prior to the applicable fiscal year payment determination. As discussed in the FY 2025 IPF PPS final rule, the IPF ED Visit measure is a claims-based measure and there is no additional burden outside of submitting a claim, the submission of which is approved under OMB control number 0938–0050 (89 FR 64667). This rule does not warrant any changes under that control number.

In section V.C. of this final rule, we are removing the Facility Commitment to Health Equity measure from the IPFQR Program beginning with the FY 2026 payment determination. This measure and the associated information collection burden was previously finalized in the FY 2024 IPF PPS final rule and is approved under OMB control number 0938–1171 (88 FR

51151). We estimate that this removal would result in a total annual burden decrease of 267 hours (0.167 hours × 1,596 IPFs) at a savings of $14,761 (267 hours × $55.38/hour). This estimate is summarized in Table 9.

In section V.D. of this final rule, we are removing the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the IPFQR Program beginning with the FY 2026 payment determination. This measure and the associated information collection burden was previously finalized in the FY 2022 IPF PPS final rule and is approved under OMB control number 0920–1317 (86 FR 42668 and 42669). IPFs have the option to manually enter data directly into the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) web-based application or by uploading a CSV file. CDC estimates that each IPF requires between 40 minutes (0.67 hours) to upload a CSV file and 45 minutes (0.75 hours) monthly to enter the data manually. Therefore, we estimate that this removal will result in a decrease in burden of between 12,768 hours (0.67 hours × 12 months × 1,596 IPFs) and 14,364 hours (0.75 hours × 12 months × 1,596 IPFs) annually across all 1,596 IPFs. While there is no information collection burden associated with this measure under OMB control number 0938–0050, we have included the removal of this measure in Table 9 to be consistent with the measure's inclusion in Table 8.

In section V.E. of this final rule, we are removing the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures from the IPFQR Program beginning with the FY 2026 payment determination. These measures and the associated information collection burden were previously finalized in the FY 2023 IPF PPS final rule and are approved under OMB control number 0938–1171 (88 FR 51150 through 51153). With regard to the Screening for Social Drivers of Health measure, there are two components: patient screening for five health-related social needs domains and IPF submission of aggregated IPF-level measure data. For the Screen Positive Rate for Social Drivers of Health measure, IPFs are required to report on an annual basis the number of patients who screen positive for one or more of the five Social Drivers of Health domains divided by the total number of patients screened (reported as five separate rates). With regard to patient screening, the currently approved burden estimate under OMB control number 0938–1171 for the FY 2026 payment determination and subsequent years is 66,414 hours annually for 2,012,556 patients (0.033 hours × 2,012,556 patients). With regard to measure reporting, due to data submission being voluntary for the FY 2026 payment determination, the currently approved burden estimate is 133 hours annually across 798 IPFs (0.167 hours × 798 IPFs) per measure. For mandatory data submission in the FY 2027 payment determination and subsequent years, the currently approved burden estimate is 267 hours annually across 1,596 IPFs (0.167 hours × 1,596 IPFs) per measure. Therefore, we estimate that this policy would result in a decrease in burden of 66,680 hours (66,414 + 133 + 133) annually across all 1,596 IPFs for the FY 2026 payment determination and 66,948 hours (66,414 + 267 + 267) annually across all 1,596 IPFs for the FY 2027 payment determination and subsequent years. These estimates are summarized in Tables 9 through 11.

In section V.F. of this final rule, we are finalizing changes to our codified ECE policy. Because the process for requesting or granting an ECE would remain the same as the current ECE process, these updates would not affect burden associated with the submission of the ECE form, which is accounted for under OMB control number 0938–1022 (expiration date April 30, 2027).

In total, for CY 2026 we estimate a decrease in burden of 66,947 hours (267 + 66,414 + 133 + 133) at a savings of $1,731,712 ($14,761 + $1,702,191 + $7,380 + $7,380). We estimate that beginning with CY 2027 the savings will increase to a total reduction in burden of 67,215 (267 + 66,414 + 267 + 267) hours at a savings of $1,746,474 ($14,761 + $1,702,191 + $14,761 + $14,761) associated with these policies.

TABLE 9—TOTAL CY 2026 FACILITY INFORMATION COLLECTION BURDEN CHANGES

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 ($)
Facility Commitment to Health Equity	1,596	1	(1,596)	0.167	(0.167)	(267)	(14,761)
Modified COVID–19 Healthcare Personnel (HCP) Vaccination Measure	1,596	0	0	0	0	0	0
Screening for Social Drivers of Health (Data Submission)	798	1	(798)	0.167	(0.167)	(133)	(7,380)
Screen Positive Rate for Social Drivers of Health	798	1	(798)	0.167	(0.167)	(133)	(7,380)
Total	1,596	1	(3,192)	0.167	(0.5)	(533)	(29,521)

TABLE 10—TOTAL CY 2026 PATIENT SURVEY INFORMATION COLLECTION BURDEN CHANGES

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 ($)
Screening for Social Drivers of Health (Patient Screening)	1,596	1,261	(2,012,556)	0.033	(41.6)	(66,414)	(1,702,191)
Total	1,596	1,261	(2,012,556)	0.033	(41.6)	(66,414)	(1,702,191)

TABLE 11—TOTAL CY 2027 FACILITY INFORMATION COLLECTION BURDEN CHANGES

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 ($)
Screening for Social Drivers of Health (Data Submission)	798	1	(798)	0.167	(0.167)	(133)	(7,380)
Screen Positive Rate for Social Drivers of Health	798	1	(798)	0.167	(0.167)	(133)	(7,380)
Total	798	1	(1,596)	0.167	(0.33)	(267)	(14,761)

We invited public comments on the proposed removal of the SDOH information collection requirements and whether our estimated burden reduction of 0.033 hours per patient and an annual decrease of 0.167 hours in burden per IPF for each measure is an accurate estimate.

Comments: We received no comments.

C. Submission of PRA-Related Comments

We have submitted a copy of the information collection requirements related to this rule to OMB for their review. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed previously, please visit the CMS website at *https://www.cms.gov/regulationsand-guidance/legislation/paperworkreduction actof1995/pralisting,* or call the Reports Clearance Office at 410–786–1326.

VII. Regulatory Impact Analysis

A. Statement of Need

This rule finalizes updates to the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2026 (October 1, 2025, through September 30, 2026). We are finalizing our proposal to apply the 2021-based IPF market basket increase for FY 2026 of 3.2 percent, reduced by the productivity adjustment of 0.7 percentage point as required by section 1886(s)(2)(A)(i) of the Act for a total FY 2026 payment rate update of 2.5 percent. In this final rule, we are finalizing our proposal 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 2026 hospital inpatient wage index. Section 1886(s)(4) of the Act requires IPFs to report data in accordance with the requirements of the IPFQR 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 2026 payments compared to FY 2025 payments will be an increase of approximately $70 million. This reflects a $70 million increase from the update to the payment rates (+$90 million from the 2021-based IPF market basket increase of 3.2 percent, and −$20 million for the productivity adjustment of 0.7 percentage point). Outlier payments are estimated to change from 2.1 percent in FY 2025 to 2.0 percent of total estimated IPF payments in FY 2026. While it does not affect the overall impact, we estimate this change in outlier payments will reduce total IPF PPS payments by approximately $3 million.

Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is ''significant,'' though not significant under section 3(f)(1) of Executive Order 12866. 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 discussed 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 IV.D.4.c. of this final rule, we are updating 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. In addition, as discussed in section IV.D.9. of this final rule, we are applying a refinement standardization factor to the Federal per diem base rate and ECT payment per treatment to account for the revisions to the adjustment factors for teaching status and for IPFs located in rural areas (as previously discussed in sections IV.D.5 and IV.D.6 of this final rule, and summarized in Addendum A), which must be made budget-neutrally. Therefore, the budgetary impact to the Medicare program of this final rule will be due to the final market basket increase for FY 2026 of 3.2 percent (see section IV.A.2 of this final rule) reduced by the productivity adjustment of 0.7 percentage point required by section 1886(s)(2)(A)(i) of the Act and the update to the outlier fixed dollar loss threshold amount.

We estimate that the impact of the FY 2026 IPF PPS final rule will be a net increase of $70 million in payments to IPF providers. This reflects an estimated $70 million increase from the update to the payment rates and the $3 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 IV.B.3. of this final rule).

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this final rule, we compared estimated payments under the IPF PPS rates and factors for FY 2026 versus those under FY 2025. We determined the percent change in the estimated FY 2026 IPF PPS payments compared to the estimated FY 2025 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 revisions to the facility-level adjustment factors; the updated wage index data and labor-related share; and the market basket increase for FY 2026, as reduced by the productivity adjustment according to section 1886(s)(2)(A)(i) of the Act.

To illustrate the impacts of the changes to the IPF PPS discussed in this final rule, our analysis begins with FY 2024 IPF PPS claims (based on the 2024 MedPAR claims, March 2025 update). We estimated FY 2025 IPF PPS payments using these 2024 claims, the finalized FY 2025 IPF PPS Federal per diem base rate and ECT per treatment amount, and the finalized FY 2025 IPF PPS patient- and facility-level adjustment factors (as published in the FY 2025 IPF PPS final rule (89 FR 64582)). We then estimated the FY 2025 outlier payments based on these simulated FY 2025 IPF PPS payments using the same methodology as finalized in the FY 2025 IPF PPS final rule (89 FR 64636 and 64637) where total outlier payments are maintained at 2 percent of total estimated FY 2025 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 update to the outlier fixed dollar loss threshold amount.
- The revisions to facility-level adjustment factors for teaching status and for IPFs located in rural areas.
- The FY 2026 IPF wage index and the FY 2026 labor-related share.
- The IPF market basket increase for FY 2026 of 3.2 percent reduced by the productivity adjustment of 0.7 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act for a FY 2026 payment rate update of 2.5 percent.

Our column comparison in Table 12 illustrates the percent change in payments from FY 2025 (that is, October 1, 2024, to September 30, 2025) to FY 2026 (that is, October 1, 2025, to September 30, 2026) including all the final payment policy changes.

TABLE 12—FY 2026 IPF PPS PAYMENT IMPACTS

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]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,387	−0.1	0.0	0.0	2.4
Total Urban	1,147	−0.1	0.0	0.1	2.5
Urban unit	628	−0.1	0.4	0.1	2.9
Urban hospital	519	0.0	−0.5	0.0	1.9
Total Rural	240	0.0	0.2	−0.4	2.3
Rural unit	178	0.0	0.2	−0.4	2.2
Rural hospital	62	0.0	0.2	−0.3	2.3
By Type of Ownership:					
Freestanding IPFs:					
Urban Psychiatric Hospitals:					
Government	112	−0.1	0.7	0.4	3.5
Non-Profit	97	0.0	−0.3	−0.1	2.1
For-Profit	310	0.0	−0.7	−0.1	1.6
Rural Psychiatric Hospitals:					
Government	28	0.0	0.2	0.3	2.9
Non-Profit	13	−0.1	0.3	−0.6	2.0
For-Profit	21	0.0	0.1	−0.5	2.1
IPF Units:					
Urban:					
Government	91	−0.2	1.4	−0.1	3.7
Non-Profit	419	−0.1	0.3	0.3	3.0
For-Profit	118	0.0	−0.4	−0.1	2.0
Rural:					
Government	41	0.0	0.2	−0.5	2.1
Non-Profit	99	0.0	0.2	−0.1	2.6
For-Profit	38	0.0	0.1	−0.9	1.7

TABLE 12—FY 2026 IPF PPS PAYMENT IMPACTS—Continued

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]
(1)	(2)	(3)	(4)	(5)	(6)
By Teaching Status:					
Non-teaching	1,178	0.0	−0.6	0.0	1.9
Less than 10% interns and residents to beds	103	−0.1	0.5	−0.1	2.9
10% to 30% interns and residents to beds	79	−0.1	3.0	0.2	5.7
More than 30% interns and residents to beds	27	−0.2	10.4	−0.6	12.3
By Region:					
New England	94	−0.1	0.1	1.2	3.8
Mid-Atlantic	195	−0.1	0.3	−0.2	2.5
South Atlantic	222	0.0	0.4	0.1	2.9
East North Central	218	0.0	−0.2	0.4	2.6
East South Central	136	0.0	−0.2	0.2	2.4
West North Central	88	−0.1	0.0	1.0	3.4
West South Central	214	0.0	−0.2	−0.8	1.5
Mountain	95	0.0	−0.3	0.3	2.4
Pacific	125	−0.1	−0.2	−0.9	1.3
By Bed Size:					
Psychiatric Hospitals:					
Beds: 0–24	91	0.0	−0.4	−0.2	1.9
Beds: 25–49	88	0.0	−0.7	0.3	2.1
Beds: 50–75	94	0.0	−0.4	0.0	2.1
Beds: 76 +	308	0.0	−0.4	−0.2	1.9
Psychiatric Units:					
Beds: 0–24	402	0.0	−0.1	0.0	2.3
Beds: 25–49	231	−0.1	0.6	0.1	3.2
Beds: 50–75	100	−0.1	0.6	0.2	3.2
Beds: 76 +	73	−0.1	0.7	0.0	3.1

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the final IPF market basket update factor for FY 2026 (3.2 percent), reduced by 0.7 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.

3. Impact Results

Table 12 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 the table shows the overall impact on the 1,387 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 2024.

In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.1 percent in FY 2025. Therefore, we adjusted the outlier threshold amount to maintain total estimated outlier payments equal to 2.0 percent of total payments in FY 2026. The estimated change in total IPF payments for FY 2026, therefore, includes an approximate 0.1 percent decrease in payments because we would expect the outlier portion of total payments to decrease from approximately 2.1 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 12), across all hospital groups, is a 0.1 percent decrease. The largest decrease in payments due to this change is estimated to be 0.2 percent for urban government-owned IPF units.

In column 4, we present the effects of the final revisions to the facility-level adjustment factors and the application of the refinement standardization factor that is discussed in section IV.D.9 of this final rule. We estimate the largest payment increase of 10.4 percent will be for teaching IPFs with more than 30 percent interns and residents to beds. Conversely, we estimate that urban for-profit hospitals will experience the largest payment decrease of 0.7 percent. Payments to IPF units in urban areas will increase by 0.4 percent, and payments to IPF units in rural areas will increase by 0.2 percent.

In column 5, we present the effects of the budget-neutral update to the IPF wage index and the 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 IV.D.4.c. of this final rule. That is, the impact represented in this column reflects the final update from the FY 2025 IPF wage index to the final FY 2026 IPF wage index, which includes basing the FY 2026 IPF wage index on the FY 2026 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 78.8 percent in FY 2025 to 79.0 percent in FY 2026. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 5; however, there will be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 1.2 percent for IPFs in New England, and the largest decrease in payments to be 0.9 percent for IPFs in the Pacific region and rural for-profit IPF units.

Overall, IPFs are estimated to experience a net increase in payments of 2.4 percent as a result of the updates in this final rule. IPF payments are therefore estimated to increase by 2.5 percent in urban areas and 2.3 percent in rural areas. The largest payment increase is estimated at 12.3 percent for IPFs with more than 30 percent interns and residents to beds.

4. Effect on Beneficiaries

Under the FY 2026 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 2026 IPF PPS will enhance the efficiency of the Medicare program.

5. Effects of the Updates to the IPFQR Program

In section V.B. of this final rule, we finalize changes to begin use of the IPF ED Visit measure in the IPFQR Program with the FY 2029 payment determination instead of the FY 2027 payment determination, and to modify the reporting period for the IPF ED Visit measure to a 2-year reporting period that runs from July 1st 4 years prior to the applicable fiscal year payment determination to June 30th 2 years prior to the applicable fiscal year payment determination. While the modification may allow providers additional time to incorporate changes to IPF workflows and clinical processes to improve care coordination and discharge planning, we do not expect any additional effects beyond those discussed in the FY 2025 IPF PPS final rule (89 FR 64672).

In section V.C. of this final rule, we finalize the removal of the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination. Because this measure requires IPFs to attest yes or no if they have in place certain structures or processes of care, we do not expect the removal of this measure to impact providers beyond reduction in information collection costs.

In section V.D. of this final rule, we finalize the removal of the COVID–19 Vaccination Coverage Among HCP measure beginning with the FY 2026 payment determination. Because this measure requires IPFs to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers, and other contract personnel and report the data monthly to NHSN, we expect the removal of this measure to reduce information collection burden on providers.

In section V.E. of this final rule, we finalize the removal of the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures from the IPFQR Program beginning with the FY 2026 payment determination. Because these measures require IPFs to screen patients for five health-related social needs domains and submit aggregated IPF-level measure data, we expect the removal of these measures to reduce information collection burden on providers and patients.

In section V.G. of this final rule, we finalize updates to our ECE policy. Because the process for requesting or granting an ECE will remain the same as the current ECE process, we do not expect these updates to impact providers.

In accordance with section 1886(s)(4)(A) of the Act, we will apply a 2-percentage point reduction to the FY 2026 market basket update for IPFs that have failed to comply with the IPFQR Program requirements for the FY 2026 payment determination, including reporting on the mandatory measures. For the FY 2025 payment determination, of the 1,514 IPFs eligible for the IPFQR Program, 126 IPFs did not receive the full IPF market basket update because of the IPFQR Program; 40 of these IPFs chose not to participate and 86 did not meet the requirements of the program. We intend to closely monitor the effects of the IPFQR 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 the 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 the 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 final rule. For this FY 2026 IPF PPS final 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 welcomed any public comments on the approach in estimating the number of entities that would review the proposed rule. We did not receive any public comments specific to our solicitation.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule, and therefore for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule. We sought public comments on this assumption. We did not receive any public comments specific to our solicitation.

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 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 1.67 hours for the staff to review half of this final rule which contains a total of approximately 50,000 words. For each entity that reviews the rule, the estimated cost is $221.17 (1.67 hours × $132.44). Therefore, we estimate that the total cost of reviewing this regulation is $12,164.35 ($221.17 × 55).

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 proposed and are finalizing updates to the IPF PPS using the methodology published in the RY 2005 IPF PPS final rule (our ''standard methodology''), 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. In addition, we are finalizing our proposal to revise the facility-level adjustment factors for teaching status and for IPFs located in

rural areas. We also considered, but did not propose, maintaining the existing adjustment factors for teaching status and for IPFs located in rural areas. However, for the reasons discussed earlier in this final rule, we believe it would be more appropriate to update these adjustment factors based on the results of our latest available analysis.

Lastly, as discussed in section IV.D.7. of this final rule, we are finalizing our proposal to maintain the existing COLA factors for IPFs 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. However, as discussed earlier in this final rule, in order to maintain consistency in payments for IPFs and other hospitals located in Alaska and Hawaii, for FY 2026 we are maintaining the existing COLA factors that are applicable for FY 2025.

E. Accounting Statement

Consistent with OMB Circular A–4 (available at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 13, 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 final rule. Table 13 provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this final rule and is based on 1,387 IPFs that had data available in the PSF and claims in our FY 2024 MedPAR claims dataset. Lastly, Table 13 also includes our best estimate of the costs of reviewing and understanding this final rule.

TABLE 13—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTMATED COSTS, SAVINGS, AND TRANSFERS

Category	Primary estimate ($million/year)	Year dollars	Period covered
Regulatory Review Costs	0.012164	2025	FY 2026
Annualized Monetized Transfers from Federal Government to IPF Medicare Providers	70	2025	FY 2026

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. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of less than $47 million in any 1 year as of 2023 [35]).

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.

As discussed earlier in this final rule, the only costs imposed by this final rule are the regulatory review costs, which we estimate at $221.17 per IPF. However, as discussed in section VI.B.3. of this final rule, the removal of the Facility Commitment to Health Equity, Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health measures from the IPFQR Program result in an estimated decrease in cost of $1,094 per IPF. As a result, there are negative costs (that is, savings) of $872.83 per IPF imposed as a result of this final rule.

TABLE 14—NAICS 622210 PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS SIZE STANDARDS

NAICS (6-digit)	Industry subsector description	SBA size standard/small entity threshold	Total small businesses
622210	Psychiatric and Substance Abuse Hospitals	$47 Million	200

Source: US Census 2022 SUSB.

TABLE 15—CONCENTRATION RATIOS (NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS

Firm size (by receipts)	Firm count	% of small firms	Average revenue
Small Hospitals:	200	100.0	$ 20,771,755.00
<100,000	4	2.0	20,000
100,000–499,999	6	3.0	225,667
1,000,000–2,499,999	5	2.5	1,890,000
2,500,000–4,999,999	10	5.0	3,622,800
5,000,000–7,499,999	6	3.0	5,485,333
7,500,000–9,999,999	20	10.0	8,288,050
10,000,000–14,999,999	12	6.0	11,324,833
15,000,000–19,999,999	24	12.0	15,943,667
20,000,000–24,999,999	22	11.0	20,138,000
25,000,000–29,999,999	18	9.0	23,777,278
30,000,000–34,999,999	19	9.5	28,946,895
35,000,000–39,999,999	21	10.5	30,214,762
40,000,000–49,999,999	33	16.5	40,439,152

[35] *https://www.naics.com/wp-content/uploads/2017/10/SBA_Size_Standards_Table.pdf.*

TABLE 15—CONCENTRATION RATIOS (NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS—Continued

Firm size (by receipts)	Firm count	% of small firms	Average revenue
Large Hospitals: Receipts > 49 million	218	NA	296,853,795.10

Source: US Census 2022 SUSB.

TABLE 16—(NAICS 622210) PSYCHIATRIC AND SUBSTANCE ABUSE HOSPITALS IMPACTS ON SMALL ENTITES

Firm size (by receipts)	Avg. annual revenue	Annualized cost per firm	% of small firms	Revenue test (%)
All Hospitals	$317,625,550.10	$ (873)	N/A	0.00
Small Hospitals	20,771,755.00	(873)	100	0.00
<100,000	20,000	(873)	2.0	4.37
100,000–499,999	225,667	(873)	3.0	0.39
1,000,000–2,499,999	1,890,000	(873)	2.5	0.05
2,500,000–4,999,999	3,622,800	(873)	5.0	0.02
5,000,000–7,499,999	5,485,333	(873)	3.0	0.02
7,500,000–9,999,999	8,288,050	(873)	10.0	0.01
10,000,000–14,999,999	11,324,833	(873)	6.0	0.01
15,000,000–19,999,999	15,943,667	(873)	12.0	0.01
20,000,000–24,999,999	20,138,000	(873)	11.0	0.00
25,000,000–29,999,999	23,777,278	(873)	9.0	0.00
30,000,000–34,999,999	28,946,895	(873)	9.5	0.00
35,000,000–39,999,999	30,214,762	(873)	10.5	0.00
40,000,000–49,999,999	40,439,152	(873)	16.5	0.00

Source: US Census 2022 SUSB.

According to Table 15, 200 psychiatric and substance abuse hospitals can be considered small according to the SBA. As we stated earlier, the SBA defines small Psychiatric and Substance Abuse hospitals as businesses having less than $47 million in total annual revenue. We note that Tables 15 and 16 show revenue up to $49.9 million since the data does not provide the exact estimate for $47 million. Table 15 shows that there are 218 Psychiatric and Substance Abuse hospitals that earn revenue in excess of $49 million.

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. For the purposes of the RFA, as can be seen in Table 15, we estimate that average revenue for the small Psychiatric and Substance Abuse hospitals is only 0.065 percent ($20,771,755.00/$317,625,550.10) of the average revenue earned in the industry. Furthermore, according to the IPF database with 1,387 small Psychiatric and Substance Abuse hospitals, and for the purposes of the RFA, we estimate that approximately 0.14 percent (200/1,387) of small Psychiatric and Substance Abuse hospitals are small entities as that term is used in the RFA. As shown in Table 16, 100 percent of these small Psychiatric and Substance Abuse hospitals will reduce costs as opposed to incurring any costs that will have an impact on their revenue. That is, there will be no revenue impact on this industry.

According to Table 16, this final rule will have a 0.00 percent impact on small Psychiatric and Substance Abuse hospitals. As such, 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 final rule. Therefore, the Secretary has certified that this final rule will *not have a significant* economic impact on the 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 604 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 final rule, the rates and policies set forth in this final rule will not have an adverse impact on the rural hospitals based on the data of the 178 rural excluded psychiatric units and 62 rural psychiatric hospitals in our database of 1,387 IPFs for which data were available. Therefore, the Secretary has determined that this final 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 2025, that threshold is approximately $187 million. This final rule does not mandate any requirements for State, local, or tribal governments, or for the private sector. This final 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 $187 million in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final 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 final rule is considered an E.O. 14192 deregulatory action. We estimate that this rule will generate $24 million in annualized cost savings at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon.

This final 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 July, 21, 2025.

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 amends 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 412.433 is amended by revising paragraph (f) to read as follows:

§ 412.433 Procedural requirements under the IPFQR Program.

* * * * *

(f) *Extraordinary Circumstance Exception (ECE)*—(1) *General rule.* CMS may grant an extraordinary circumstance exception (ECE) with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the IPF. For purposes of this paragraph (f), an extraordinary circumstance is 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 IPF to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) An IPF may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at *QualityNet* or a successor website.

(ii) CMS notifies the IPF of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the IPF, the written decision will specify whether the IPF is exempted from one or more reporting requirements or whether CMS has granted the IPF an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* CMS may grant an ECE to one or more IPFs that have not requested an ECE if CMS determines that—

(i) A systemic problem with a CMS data collection system directly impacted the ability of the IPF to comply with a quality data reporting requirement, or

(ii) An extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (f)(3) will specify whether the affected IPFs are exempted from one or more reporting requirements or whether CMS has granted the IPF an extension of time to comply with one or more reporting requirements.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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