Federation of American Hospitals®

Charles N. Kahn III
President and CEO

June 9, 2025

The Honorable Dr. Mehmet Oz, M.D.
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: FY 2026 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update (CMS–1831–P)

Dear Dr. Oz,

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule, Inpatient Psychiatric Facility (IPF) Prospective Payment System—Rate Update ("Proposed Rule") published in the Federal Register on April 11, 2025. The FAH has submitted a separate letter outlining our response to the proposed rule's request for information on deregulation, specifically addressing the questions outlined in the Executive Order issued on January 31, 2025 entitled "Unleashing Prosperity Through Deregulation."

MARKET BASKET UPDATE

For FY 2026, CMS proposes to update the 2021-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2024 forecast with historical data through the 3rd quarter of 2024. Using that forecast, the proposed IPF market basket for FY 2026 is 3.2 percent. Using data from the same period, CMS estimates an offset to the IPF market basket for productivity of 0.8 percentage points. Consequently, CMS proposes an

IPF PPS update of 2.4 percent for FY 2026. For hospitals that do not successfully submit quality data under the IPFQR program, the update is reduced by 2.0 percentage points to 0.4 percent. For the final rule, CMS will use later data on the market basket and productivity.

In our public comments on prior IPF updates, we have expressed concern that inflationary cost pressures hospitals have been experiencing were not captured in the IPF market baskets for FY 2021 through FY 2023. These concerns have been borne out by data released by the CMS' Office of the Actuary (OACT). The below table shows the market basket forecast used for the FY 2021 through FY 2023 IPF PPS update compared to the actual inflationary increase experienced by IPFs based on later data:

IPF Market Basket[1]	FY 2021	FY 2022	FY 2023	FY 2024
Forecast Used in the Update	2.2	2.7	4.1	3.5
Actual Based on Later Utilization	2.8	5.3	4.8	3.8
Difference (Forecast Error)	-0.6	-2.6	-0.7	0.3

As this table reflects, market basket updates to IPFs for FY 2021 through FY 2024 are understating the IPF base rate by a total of 4.2 percentage points. The FAH urges CMS to consider a one-time adjustment for forecast error to ensure that the FY 2026 rate increase is applied to a base rate that more accurately incorporates actual inflation in these years. While the FAH recognizes that CMS has not had a policy to incorporate forecast error into the IPF update, our request is based on the extraordinary understatement of the IPF market basket for 4 consecutive years as a result of the COVID-19 PHE. IPF rates remain permanently too low and below the rate of increase in costs as a result of understatement of the market basket for these years.

The FAH is further concerned that the IPF update for FY 2025 includes a reduction for non-farm productivity of 0.8 percent. The COVID-19 pandemic has had unimaginable impact on US productivity and most estimates of labor productivity highlight uncharacteristic reductions. Even before the pandemic, OACT indicated that hospital productivity will be less than general economy wide productivity that is being used as an offset to the hospital market baskets. In a memorandum dated June 2, 2022, OACT stated: "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." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[2]

While the annual productivity offset is based on a provision of the Affordable Care Act of 2010 and is required by law, the FAH urges CMS to consider the appropriateness of this

[1] OACT, 4th quarter 2023 release of the market basket information with historical data through the 3rd quarter of 2023 (Market Basket Data | CMS) for the actual update based on later utilization.

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

reduction when deciding whether to incorporate a forecast error adjustment to the FY 2026 IPF PPS update based on the understatement of the IPF PPS market basket baskets from FY 2021 to FY 2024 of 4.2 percentage points.

For these reasons, the FAH requests CMS adopt a forecast error adjustment to the FY 2026 IPF PPS update based on the combined 4.2 percentage point difference in the IPF PPS market basket in FY 2021 through FY 2024. If CMS adopted the FAH's recommendation, it would be adopting an IPF update of 3.4 percent plus 4.2 percentage points for forecast error less 0.8 percentage points for productivity. The total update before incorporating later data for the final rule would be 6.5 percent. With this adjustment for forecast error, IPF rates in FY 2026 would appropriately recognize the unprecedented growth in costs not recognized through the statutory update during and following the COVID-19 PHE.

LABOR RELATED SHARE OF THE IPF PPS MARKET BASKET

CMS also proposes to revise the labor-related share of the standard payment conversion factor for FY 2026. CMS proposes a total labor-related share of 78.9 percent for FY 2026 that is 0.1 percentage points higher than the FY 2025 labor share of 78.8 percent. Both of these figures are based on the FY 2021-based IPF market basket. Unlike the inpatient prospective payment system (IPPS), the labor-related share changes annually based on the different rates of price change for these cost categories between the base year (FY 2021) and FY 2026.

The increase in the labor-related share is a result that the FAH expected given our concerns about labor costs increasing at a higher rate than other hospital costs during the pandemic. It follows that the labor-related share of total IPF costs would increase as a result of labor shortages that have increased employed hospital clinical staff wages as well as forcing hospitals to rely on higher cost contract clinical staff. The slight increase in the labor-related share proposed for FY 2026 results from the inflationary changes among the price proxies and the relative importance of each of the categories used in developing the IPF market basket.

The FAH supports the proposed increase in the labor-related share of the IPF market basket for FY 2026. As we indicated in our comments in prior years, 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. 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 public health emergency and labor shortages.

PATIENT LEVEL ADJUSTMENTS

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 FY 2025. Consistent with this statutory provision, CMS developed revised adjustment factors based on a regression analysis of IPF cost and claims data.

The primary sources of this analysis are 2019 through 2021 MedPAR files and FY 2019 through FY 2021 Medicare cost report data (or its most recent cost report going back to FY 2018 if the provider did not have a cost report for any of those years). CMS adopted the revised patient level adjustment factors in the FY 2025 IPF final rule. CMS is not proposing to make any further changes to the patient level adjustment factors.

FACILITY LEVEL ADJUSTMENTS

To mitigate the potential impact of adopting all of the adjustments at the same time, CMS only revised the facility adjustment for hospitals with a qualifying ED in FY 2025. CMS indicated that it would adopt the facility level adjustments for teaching status and rural location in the FY 2026 IPF proposed rule.

Since the inception of the IPF PPS, CMS has provided a 17-percent payment increase for IPFs located in a rural area. Based on the 2020 through 2022 regression analysis, CMS is proposing to increase the rural facility adjustment from 17 to 18 percent beginning in FY 2026. **The FAH supports the proposed increase in the rural facility adjustment.**

CMS is also proposing to revise the teaching adjustment to IPF payments. The teaching adjustment formula is currently:

$$(1 + Interns\ and\ Residents/ADC)\text{^}0.5150$$

Based on the updated regression analysis, CMS is proposing to increase the coefficient value in the above formula from 0.5150 to 0.7981 to recognize the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. **The FAH supports the proposed teaching adjustment.**

As a matter of policy, the FAH agrees that the facility level adjustments that were first derived from 2002 data and have been applied since the initiation of the IPF PPS in FY 2005 should be updated based on more recent data. However, the change to the teaching and rural adjustment factors necessitate a nearly ¾ of 1 percentage point adjustment for budget neutrality. While the rural adjustment increases the adjustment by one percentage point for each rural hospital, the adjustment for teaching can increase dramatically leading to huge swings in payment. To mitigate the impact on hospitals that will not benefit from either of these adjustments, **the FAH requests that CMS transition the impact of the teaching hospital adjustment over two years.**

WAGE INDEX

Consistent with past practice, CMS proposes to use the FY 2026 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2026 IPF wage index. Each wage index assigned to an IPF is 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. On July 21, 2023, OMB issued Bulletin 23–01, which revises the

CBSA delineations based on the latest available data from the 2020 census. CMS adopted the revised CBSA delineations in the FY 2025

The FAH is concerned that the application of the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index is inappropriate in circumstances where the pre-floor, pre-reclassified IPPS hospital wage index is based on data from a hospital that has subsequently closed. In these anomalous situations, the closed hospital data is more likely to be unreliable such that the application of the pre-floor, pre-reclassified IPPS hospital wage index would result in an inappropriately deflated wage index value.

Moreover, the closure of the only IPPS hospital in the CBSA would suggest that the community is currently underserved, making it particularly appropriate to ensure that aberrant wage index data does not serve as an impediment to new IPF services in a community. **To address this situation, the FAH urges CMS to exercise its authority to remedy this data anomaly and appropriately refine the IPF PPS by applying the pre-floor, pre-reclassified IPPS hospital wage index for the CBSA in which the nearest IPPS hospital is located where the pre-floor, pre-classified IPPS hospital wage index for the CBSA in which the IPF is located only includes data from a closed IPPS hospital**.

In our FY 2025, IPF proposed rule comments, the FAH requested that CMS provide a table with the FY 2025 IPF final rule that provides the wage index for each hospital by CCN similar to Table 2 of the IPPS rule. In addition, we requested that CMS show the wage index that applies with the 5 percent cap on wage index reductions. While CMS did not provide the exact table the FAH requested, CMS has provided a new download file not previously available with the IPF proposed rule titled "FY 2026 IPF PPS Proposed Rate Setting Impact File." This file will facilitate analysis of payment impacts of all of CMS' proposals and also includes the FY 2025 and FY 2026 wage index with and without the wage index reduction cap applied by CCN. **The FAH appreciates CMS' responsiveness to our request and for providing this additional information that was very helpful for analyzing CMS' proposals and assisting our members in finding the wage index for their hospital.**

OUTLIERS

The outlier policy is an important component of the IPF PPS that helps ensure that payments for high-cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. For FY 2026, CMS proposes to continue to set the fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS.

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

The proposed increase in the fixed loss threshold for FY 2026 is relatively modest compared to prior years. Nevertheless, the FAH remains concerned that an increase of 3.3 percent in the outlier fixed loss threshold is higher than proposed update to IPF rates of 2.4 percent. For the FY 2022 and FY 2023 IPF PPS, CMS adopted an alternative methodology for determining the fixed loss threshold that involved removing those IPFs with extremely high or low costs per day (3+ standard deviations from the mean). Using this narrower set of more homogeneous IPFs mitigated the proposed increase in the fixed loss threshold in these years.

The FAH requests that CMS again consider removing those IPFs with extremely high or low costs per day (3+ standard deviations from the mean) in the final rule as a means of mitigating the increase in the outlier fixed loss threshold.

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING (IPFQR) PROGRAM

The FAH appreciates CMS' continued efforts to strengthen and modernize the IPFQR Program while seeking opportunities to reduce unnecessary provider burden. We offer the following comments on the proposed changes and requests for information (RFIs) related to the IPFQR Program.

Proposed Measure Removals

CMS proposes to remove four measures from the IPFQR Program beginning with the CY 2024 reporting period and FY 2026 payment determination, including the COVID-19 Vaccination Coverage Among Healthcare Personnel, Facility Commitment to Health Equity, and the Screening for and Screen Positive Rate for Social Drivers of Health (SDOH) measures. **The FAH supports these removals.** While health equity and SDOH are important public health concerns, the rapid development and rollout of these measures, without sufficient infrastructure or validation, resulted in significant confusion and burden for psychiatric facilities—particularly freestanding IPFs that often lack robust electronic health record capabilities.

Patient Experience of Care (PIX) Survey

The FAH remains concerned about the proposed implementation of the patient experience of care (PIX) survey in the IPFQR Program. While we support efforts to assess patient-centered care, we believe in its current form, the PIX introduces a number of unintended consequences. Chief among them is the anonymity requirement, which deprives facilities of actionable feedback tied to specific units, clinicians, or care processes.

Facilities must be able to use patient experience data in real time to improve care delivery. Anonymous results severely limit the ability to identify outliers or high-performing staff, reducing the utility of the data for internal quality improvement. Moreover, IPFs may be forced to conduct parallel patient experience data collection efforts, both to satisfy internal needs and regulatory requirements, imposing a duplicative and unsustainable burden on staff and patients alike.

In light of the lessons learned from the rollout and subsequent rollback of the SDOH measures, **the FAH urges CMS to delay any mandatory implementation of the PIX survey until further testing has been completed and CMS can demonstrate the validity, reliability, and usability of the data for psychiatric care settings.**

Request for Information: IPF Star Ratings

CMS is soliciting input on the potential development of a future star rating system for IPFs. While we support the goal of increasing transparency for consumers, the FAH strongly cautions against launching a public-facing rating system before the IPFQR Program has a core set of stable, validated, and patient-centered measures that reflect the unique nature of psychiatric inpatient care.

Few of the current IPFQR measures meet basic criteria for inclusion in a rating system, including strong psychometric properties, relevance to patient outcomes, representativeness across payer types, and applicability across facilities. Moreover, the assumption that psychiatric patients or their families have meaningful choice in selecting a facility does not reflect the reality of emergency psychiatric admissions in underserved areas.

A star rating system based on unstable or poorly correlated measures could mislead patients and result in reputational and financial harm to facilities. This risk is particularly acute in a setting where stigma is already high, and where inaccurate portrayals of quality may deter patients from seeking necessary care. CMS should instead prioritize enhancing the IPFQR program's core measures, focusing on psychiatric outcomes, patient safety, and validated experience of care tools, before contemplating any public ratings.

Request for Information: Future Measures and Digital Strategy

The FAH appreciates CMS' interest in identifying future measure concepts for the IPFQR Program. We agree that any new measures must be both clinically meaningful and technically feasible. We believe the WHO-5 Well-Being Index could serve as a promising and brief patient-reported outcome measure (PROM) that is applicable across psychiatric conditions and is available in multiple languages. We would welcome CMS' engagement with the field to pilot and validate the use of WHO-5 as part of an expanded PROM strategy.

In addition, the FAH urges CMS to carefully consider the digital infrastructure gaps that persist in psychiatric facilities, especially freestanding IPFs. As CMS pursues a Fast Healthcare Interoperability Resources (FHIR)-based patient assessment reporting system under the requirements of the Consolidated Appropriations Act of 2023, we recommend robust investment in technical assistance, as well as alignment with existing electronic reporting efforts across care settings. Any digital transition should be phased and account for current provider capabilities.

The FAH is committed to working with CMS to advance a robust, equitable, and clinically sound quality measurement program for IPFs. We urge CMS to continue focusing on the foundational stability and relevance of the IPFQR Program before layering on additional public reporting or payment reforms. A strong foundation will ensure that future efforts,

including the addition of star ratings, PROMs, or digital transitions are successful, sustainable, and ultimately beneficial for the patients we serve.

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The FAH appreciates the opportunity to offer comments on the FY 2026 IPF PPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,