Federation of American Hospitals

Charlene K. MacDonald
President and CEO

June 1, 2026

Via electronic submission at *http://www.regulations.gov*

The Honorable 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 2027 Inpatient Psychiatric Facilities Prospective Payment System Rate Update (CMS–1847–P)

Dear Dr. Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, Inpatient Psychiatric Facility (IPF) Prospective Payment System Rate Update (Proposed Rule), published in the Federal Register on April 7, 2026. As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, including teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals, FAH members provide inpatient psychiatric services in both freestanding facilities and psychiatric units of acute care hospitals across the country.

Inpatient psychiatric facilities occupy a critical place in the nation's behavioral health system. They provide the acute, stabilizing care that patients in psychiatric crisis—including those presenting with suicide risk, severe depression, acute psychosis, and co-occurring substance use disorders—depend on when no other setting can safely meet their needs. The Administration has made strengthening the behavioral health system, confronting the addiction and overdose crisis, and better connecting physical and behavioral health national priorities, and IPFs are an indispensable part of delivering on those goals. The Administration has likewise emphasized that quality measurement should be meaningful and measurable and that payment policy should rest on sound data and analysis. FAH shares these commitments. The recommendations below are offered in that spirit: to ensure that IPF payment policy reflects the actual cost of caring for the most acutely ill psychiatric patients, and that new quality and reporting requirements produce data that is clinically meaningful, reliable, and worthy of the patients and facilities it is meant to serve.

EXECUTIVE SUMMARY

The Proposed Rule includes a number of substantive policy changes for FY 2027, several of which warrant additional analysis or revision before finalization. FAH's principal recommendations are as follows.

FAH urges CMS not to finalize the proposed IPF Patient Assessment Instrument (IPF-PAI) and instead to work with IPF clinical experts and the broader behavioral health stakeholder community and with Congress to revise the statutory assessment domains and develop a clinically meaningful instrument that reflects the care IPFs actually provide. The Consolidated Appropriations Act, 2023 directed CMS to create a standardized assessment tool for IPFs and specified the broad categories of data the tool must capture. Those categories were drawn from instruments built for nursing homes and rehabilitation facilities, and they emphasize physical function—mobility, hearing, speech, and vision—rather than the psychiatric illness, acuity, and treatment response that define an IPF stay. As a result, the instrument CMS has proposed would generate pages of data that say little about whether a patient admitted in psychiatric crisis actually improved. FAH believes the better course is to get the instrument right before implementation. We urge CMS to convene the clinicians who actually deliver this care and, because the statute itself fixed the data categories, work with Congress to update those categories so the instrument measures what matters in

inpatient psychiatric care. In the meantime, CMS can meet the statutory deadline without penalizing facilities and we outline our recommendations in the detailed comments below.

FAH urges CMS to hold the outlier fixed dollar loss threshold at the FY 2026 level of $39,360 while it completes the analysis its own Request for Information seeks, and not to implement the proposed 20 percent cap. An analysis FAH commissioned with the National Association for Behavioral Healthcare and the American Hospital Association indicates that the facilities the cap would affect tend to differ from other IPFs—more often urban teaching facilities serving younger patients with higher comorbidity rates, schizoaffective disorder, and other complex psychiatric illness, and using electroconvulsive therapy (ECT) more frequently. If that pattern holds, these are the kinds of patients an outlier policy is meant to protect. Just as important, the analysis shows that even a full statistical model explains less than 10 percent of the variation in outlier payment share across IPFs—meaning what drives outlier concentration is not yet well understood. Combined with the fact that the set of affected facilities churns from year to year and the 20 percent threshold was selected without stated analytic support, this points to a cap that is premature and insufficiently refined. CMS should not adopt a new payment limitation before completing the analysis its own Request for Information seeks.

FAH urges CMS to adopt a one-time forecast error adjustment to the FY 2027 market basket update and to reexamine whether the productivity adjustment is consistent with the agency's own findings on hospital sector productivity. CMS proposes a net update of 2.3 percent (a 3.1 percent market basket increase less a 0.8 percentage point productivity adjustment), which does not keep pace with the cost pressures IPFs face. CMS Office of the Actuary data show that the market basket forecasts used for FY 2021 through FY 2024 understated actual IPF inflation by a cumulative 4.2 percentage points—understatements now permanently embedded in the IPF base rate—and consumer prices rose 3.8 percent over the 12 months ending April 2026, well above the proposed update.

Our specific comments are detailed in Appendix A.

CONCLUSION

FAH appreciates the opportunity to comment on the FY 2027 IPF PPS Proposed Rule. The IPF setting and the Medicare beneficiaries it serves are essential parts of the nation's behavioral health infrastructure, and the financial and operational sustainability of IPFs depends on payment policies that recognize the actual cost of care and on quality and reporting frameworks that are clinically meaningful and operationally feasible. We urge CMS to consider our comments above as it develops the final rule. If you have any questions or would like to discuss further, please do not hesitate to contact Alyssa Keefe, SVP Head of Policy at (202) 624-1500 or akeefe@fah.org.

Sincerely,

/s/
Charlene MacDonald
President and CEO

Appendix A
FAH Detailed Comments FY 2027 IPF PPS Proposed Rule Comments

III. PROPOSED PAYMENT POLICIES UNDER THE IPF PPS (Part III)

A. Proposed FY 2027 Market Basket Update and Productivity Adjustment (Part III.A)

For FY 2027, CMS proposes to update the 2021-based IPF market basket using IHS Global Inc.'s (IGI) fourth-quarter 2025 forecast with historical data through the third quarter of 2025. Using that forecast, the proposed IPF market basket update for FY 2027 is 3.1 percent. Using data from the same period, CMS estimates an offset for productivity of 0.8 percentage points, resulting in a proposed IPF PPS update of 2.3 percent for FY 2027 for IPFs that submit quality data.

The current proposed update does not fully reflect the cost pressures IPFs continue to face and we urge CMS to reconsider. The inadequacy of the proposed 2.3 percent update is underscored by current inflation data. According to the Bureau of Labor Statistics, the all-items Consumer Price Index (CPI) rose 3.8 percent over the 12 months ending April 2026, leaving the proposed update 1.5 percentage points below overall inflation. The CPI measures a different set of goods and services than the IPF market basket, but the rapid changes in the CPI in recent months indicate that we are entering into a period of rapid inflation that would be expected to also impact the IPF market basket in FY 2027 in ways that could not be reflected in IGI's forecast due to reliance on 2025 data.

Preexisting workforce shortages that worsened during the COVID-19 public health emergency (PHE) have not abated and are particularly acute in the behavioral health workforce on which IPFs depend. The specialized clinical workforce that delivers inpatient psychiatric care, including psychiatrists, psychiatric advanced practice providers, psychiatric registered nurses, mental health technicians, psychiatric social workers and other behavioral health professionals, commands compensation that has risen faster than the broader economic indicators on which market basket forecasts depend. The acute psychiatric population served in IPFs, including patients presenting with suicide attempt or self-harm, acute mania, acute depression and acute psychosis, requires intensive clinical staffing models that magnify the impact of behavioral health workforce shortages on IPF cost. Further, total hospital expenses grew 7.5 percent in 2025, more than twice the rate of growth in hospital prices, driven by a 13.6 percent increase in drug expenses and a 9.9 percent increase in supply expenses, underscoring the structural gap between rising input costs and the proposed payment update. FAH urges CMS to carefully review inflation trends in light of recent growth and projected volatility so as to avoid a significant understatement of market-basket changes in FY 2027.

This concern is not theoretical. CMS Office of the Actuary (OACT) data confirms that market basket forecasts used in the final rules for FY 2021 through FY 2024 understated the actual inflationary increase experienced by IPFs by a cumulative 4.2 percentage points. These understatements are now permanently embedded in the IPF base rate and continue to compound year over year. With early economic indicators suggesting a period of significant inflation and continued behavioral health workforce shortages, FAH strongly urges CMS to carefully consider whether IGI's forecast adequately captures volatile market indicators when projecting the FY 2027 IPF market basket, and to adopt a one-time forecast error adjustment so that the FY 2027 rate increase is applied to a base rate that more accurately reflects the actual inflation IPFs experienced during the PHE and the years that followed.

FAH is further concerned that the productivity adjustment continues to rely on an economy-wide total factor productivity measure that overstates the productivity gains achievable in the hospital sector. In a June 2, 2022 memorandum, OACT concluded that, over the period 1990 through 2019, the average growth rate of hospital productivity ranged from 0.2 percent to 0.5 percent, compared with average growth in private nonfarm business productivity of 0.8 percent. OACT further indicated that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable, compared with an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent. CMS proposes a 0.8 percentage point productivity offset for FY 2027, which is roughly double the rate OACT has identified as reasonable for the hospital sector. Every year the productivity adjustment is set at a level the hospital sector cannot achieve, the IPF PPS base rate moves further away from the cost reality IPFs face.

FAH recognizes that the productivity adjustment is required by section 1886(s)(2)(A)(i) of the Social Security Act, and that the statute does not provide CMS unilateral authority to set the adjustment at zero. The statute does not, however, require CMS to disregard the documented mismatch between the offset and OACT's own analysis of hospital sector productivity. **FAH urges CMS to work with Congress to modify the statute to focus on adjustments based on productivity changes in hospitals rather than private nonfarm businesses. We also urge CMS to engage OACT and the relevant offices within the Department of Health and Human Services in reexamining whether the methodology currently used to compute the productivity adjustment is consistent with the agency's own analytical findings about hospital sector productivity.**

Taken together, the proposed 3.1 percent gross market basket update and the 0.8 percentage point productivity offset do not keep pace with the inflationary cost pressures IPFs continue to confront. FAH urges CMS to use the tools available within its statutory authority to ensure that the FY 2027 IPF PPS update more accurately reflects the cost environment in which IPFs are operating and the cost pressures that have not abated since the PHE.

B. Proposed Labor-Related Share (Part III.A.3)

CMS proposes to update the labor-related share of the IPF PPS national base rate and the ECT payment per treatment from 79.0 percent in FY 2026 to 79.1 percent in FY 2027 based on the 2021-based IPF market basket. FAH supports the proposed increase in the labor-related share. This adjustment is consistent with the labor cost pressures IPFs continue to experience, including persistent wage growth and continued reliance on higher-cost contract clinical labor. As we noted in our FY 2026 comments, CMS should also consider a shorter rebasing cycle for the IPF market basket so that the labor-related share more rapidly reflects post-pandemic labor cost dynamics.

D. Wage Index (Part III.D.1)

Consistent with past practice, CMS proposes to use the FY 2027 pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index, applied to the proposed labor-related share of 79.1 percent, with a wage index budget neutrality factor of 0.9991. CMS proposes to continue applying the permanent 5 percent cap on year-over-year wage index decreases finalized in the FY 2023 IPF PPS final rule. The Proposed Rule also includes a request for comment on whether to develop an IPF-specific wage index using alternative data sources such as Bureau of Labor Statistics (BLS) occupation-level wage data or IPF cost report data, similar to the approach finalized in the CY 2025 ESRD PPS final rule.

Continued Use of the Pre-Floor, Pre-Reclassified IPPS Wage Index.

FAH supports continued use of the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index and supports continued application of the 5 percent cap on year-over-year wage index decreases. The IPPS-based wage index reflects the labor markets in which IPFs actually compete for clinical staff, including registered nurses, psychiatric technicians, behavioral health professionals and support personnel. Because most IPFs draw from the same local labor pool as IPPS hospitals (including the psychiatric units of acute care hospitals against which freestanding IPFs frequently compete for nursing staff), the IPPS wage index is the most appropriate available measure of IPF labor cost variation across geographic areas.

Response to Request for Information on Alternative Wage Index Data Sources. (Part III.D.1)

CMS solicits comment on whether to develop an IPF-specific wage index using alternative data sources, including BLS occupation-level wage data or IPF cost report data, similar to the approach finalized in the CY 2025 ESRD PPS final rule. **FAH does not support either alternative and recommends that CMS retain the current methodology based on the concurrent pre-floor, pre-reclassified IPPS hospital wage index, refined as described above to address the closed-IPPS-hospital anomaly. The reasons for our position are set out below.**

FAH opposes replacing the current IPPS hospital wage index with BLS occupational wage data as the basis for the IPF wage index. IPFs, whether freestanding or operated as units of acute care hospitals, compete directly with general acute care hospitals for the behavioral health clinical workforce, including psychiatrists, psychiatric advanced practice providers, psychiatric registered nurses, mental health technicians, psychiatric social workers and other specialized clinical staff, because IPFs and acute care hospitals (including the psychiatric units within acute care hospitals) draw from the same hospital-grade labor pool. The IPPS hospital wage index, which is constructed from actual hospital wages and benefits reported on Medicare cost reports, reflects the labor costs that IPFs face in their local markets. The BLS Occupational Employment and Wage Statistics (OEWS) data, by contrast, are not constructed for the purpose of measuring hospital-sector wages and have several characteristics that make them less suitable as a basis for the IPF wage index.

BLS data are not setting-specific. OEWS reports occupational wages across all employers within an industry, not within hospital settings specifically. The same nurse occupation code captures wages paid by hospitals, outpatient mental health clinics, residential treatment facilities, nursing facilities and other settings, blending wage levels that do not reflect the hospital-grade compensation IPFs must offer to recruit and retain clinical staff to care for patients in acute psychiatric crisis. BLS data also exclude benefits. OEWS captures wages only and does not include the benefits costs that constitute a substantial share of hospital labor compensation; the IPPS hospital wage index, in contrast, is built from total wage and benefit costs reported on the Medicare cost report. BLS data are subject to survey-based volatility from sampling variation, reporting lags and revisions that reduce payment stability and predictability, and they are not subject

to provider-level Medicare audit and verification standards in the way Medicare cost report data are. Finally, the geographic granularity of BLS aggregations, whether at the MSA, county or state level, does not necessarily match the labor markets IPFs actually draw from, which mirror the markets faced by IPPS hospitals competing for the same staff and are well captured by the CBSA-level wage data already underlying the IPPS wage index.

The ESRD precedent is not directly applicable. The ESRD setting has a different labor profile from the IPF setting, with a smaller share of acute hospital-grade clinical staff and a wage structure that lends itself more readily to occupational survey data. The rationale CMS articulated for transitioning the ESRD wage index to BLS occupational data does not transfer to a setting (the IPF setting) that draws from the same labor pool as the IPPS hospitals whose wage data already underpin the existing IPF wage index. FAH also notes that an IPF-specific application of BLS data would face additional structural problems: the IPF cost report sample is substantially smaller than the IPPS sample, which raises concerns about CBSA-level statistical reliability, and many CBSAs would have only one or two reporting IPFs, creating volatility and confidentiality issues. Many of those IPFs are units of acute care hospitals for which the host hospital's IPPS wage index is the most appropriate measure of local labor costs.

For these reasons, FAH urges CMS to retain the IPPS hospital wage index as the basis for the IPF wage index. To the extent CMS is interested in refining the existing wage index, FAH believes that effort is better directed toward the targeted refinement raised elsewhere in this letter, specifically the closed-IPPS-hospital anomaly described above.

Continued Publication of the IPF PPS Proposed Rate Setting Impact File.

FAH continues to appreciate CMS's publication of the FY 2027 IPF PPS Proposed Rate Setting Impact File, which provides facility-level wage index, outlier and payment data and substantially supports member analysis. We encourage CMS to continue publishing this file with future proposed and final rules and to expand it where additional facility-level data would aid public comment.

E. Outlier Payment Policy (Part III.E.1)

CMS proposes two changes to the IPF PPS outlier payment policy for FY 2027. First, CMS proposes to maintain total outlier payments at 2.0 percent of total estimated aggregate IPF PPS payments and to update the outlier fixed dollar loss threshold from $39,360 in FY 2026 to $37,820 in FY 2027. Second, CMS proposes a new facility-level cap that would limit total outlier payments at any individual IPF to 20 percent of that facility's total IPF PPS payments. CMS also requests comment on (i) the appropriate cap level, citing alternatives of 10, 15, 25 and 30 percent; (ii) the proposed implementation approach for interim payments and at cost report settlement; (iii) whether to apply the cap only to facilities with more than a minimum number of stays per year, with CMS using 25 stays in its illustrative simulation; and (iv) the factors that drive higher costs at facilities receiving an unusually high share of outlier payments.

1. **Outlier Threshold and Methodology.**

The outlier policy is an important component of the IPF PPS that helps ensure payments for high-cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. FAH supports CMS's continued use of a 2.0 percent outlier target. We recognize that the fixed dollar loss threshold has risen meaningfully in recent years and that, absent corrective action, it has the potential to make outlier protection less accessible to the broad population of IPFs treating high-cost patients.

At the same time, FAH is concerned that CMS has proposed a 20 percent cap on outlier payments before completing the underlying analysis necessary to support it. The six questions CMS poses in its outlier policy RFI are exactly the questions that need to be answered ***before*** CMS can determine whether a facility-level cap is warranted, at what level, and with what design. CMS instead appears to have assumed that the high outlier concentration at a small number of IPFs reflects payment system gaming or unjustified cost growth, without first examining whether it instead reflects patient acuity, case complexity, specialized services or other structural factors the IPF PPS does not currently recognize. The directional findings summarized below indicate that these alternative explanations are plausible and merit examination before CMS acts. They also indicate that what drives outlier concentration is not yet well understood, which is itself a reason for CMS to complete further analysis before adopting a cap.

In light of this evidence, FAH urges CMS not to adopt the proposed 20 percent cap and instead to hold the outlier fixed dollar loss threshold at the FY 2026 level of $39,360 while it completes the analysis its own Request for Information seeks, advancing any further policy change only once that analysis is done. The Proposed Rule would instead set the threshold at $37,820, a lower figure that results from the proposed cap. CMS has

precedent for holding the threshold steady within this same rulemaking cycle: in the FY 2027 LTCH PPS proposed rule, CMS proposed to maintain the long-term care hospital outlier threshold at its FY 2026 level of $78,936 rather than allow it to rise.

2. Proposed 20 Percent Facility-Level Outlier Cap.

CMS is currently proposing a 20 percent facility-level outlier cap. The proposed cap is a blunt instrument that could limit access for patients with acute psychiatric needs. The available evidence indicates that the facilities that would be capped are systematically different from other IPFs in ways that suggest the cap could compromise beneficiary access to care for patients with the highest clinical needs.

Independent Analysis of Capped IPF Characteristics. To inform our response, FAH (together with the National Association for Behavioral Healthcare and the American Hospital Association) commissioned a preliminary analysis examining FY 2023 through FY 2025 Medicare fee-for-service IPF claims, applying CMS's proposed cap methodology to historical data to identify which facilities would have been capped and how they compare to other IPFs. This work is ongoing, but the directional findings to date raise concerns that the proposed cap may not be well targeted and that the facilities it would affect appear to care for patients with substantial clinical complexity. We summarize the key directional findings here and would welcome the opportunity to share the underlying analysis with CMS as it is finalized.

The analysis identifies five findings of particular relevance to the proposed cap policy:

- **Year-over-year churn in capped facilities.** Across the three-year period, only 11 IPFs would have been capped in all three years; 20 in two years; and 56 in only one year. The proposed cap therefore would not consistently identify the same set of facilities each year, indicating that the facilities affected by the cap are not a stable group of structurally high-outlier facilities but rather a rotating group whose outlier exposure varies materially from year to year.
- **Capped IPFs are predominantly urban teaching facilities.** Across the three years, 84 to 92 percent of capped IPFs were urban (compared with about 82 percent of non-capped IPFs), and 32 to 45 percent were teaching facilities (compared with about 13 percent of non-capped IPFs). These differences are statistically significant in all three years. These are the facilities that typically serve complex patient populations and provide specialized services not available in many community settings.
- **Capped IPFs treat clinically complex psychiatric patients.** Capped IPFs treat a higher share of patients in DRG 885 (Psychoses), with a particularly higher share of patients with schizoaffective disorder (27 to 33 percent versus 23 percent at non-capped IPFs), a higher rate of comorbidities, and a younger average patient age. The higher proportion of ECT treatments at capped IPFs (3 to 4 percent versus less than 2 percent at non-capped IPFs) is consistent with the role these facilities play in providing one of the most resource-intensive psychiatric treatments. While these data cannot by themselves establish what drives the cost differences, the pattern is consistent with capped facilities treating a more clinically complex psychiatric population, and it underscores why CMS should examine these alternative explanations before concluding that high outlier shares reflect billing behavior or length-of-stay incentives.
- **Even a full statistical model leaves most of the variation in outlier payment share unexplained.** The analysis constructed a multivariate regression of outlier payments as a share of total IPF PPS payments controlling for patient characteristics (age, comorbidities, DRG 885 and its subcategories including schizophrenia and schizoaffective disorder), geography, ownership, teaching and freestanding status, stay volume, bed size, wage index and ECT use. That model explained less than 10% percent of the variation in outlier payment share across IPFs, meaning that more than 90 percent of the variation in which facilities draw a high share of outlier payments is not explained. Among the patient characteristics, schizoaffective disorder was the single largest contributor to the variation, consistent with the descriptive finding that capped facilities treat a more clinically complex psychiatric population. The central point, however, is that the best available analysis cannot yet explain what drives outlier concentration, which is precisely why a cap premised on an understanding of that concentration is premature.
- **The cost differences that the model does explain are associated largely with facility structure and labor market.** A separate regression of daily cost across IPFs explained roughly half of the variation in cost per day and the factors that explained the most were structural characteristics (e.g. freestanding vs a hospital unit, wage index, and ownership type). Patient diagnosis contributed very little to daily cost variation in this model. To the extent the model explains daily cost differences at all, then, those differences appear to track the kind of facility and the labor market it operates in. This does not, by itself, rule out every alternative explanation, but

it provides little support for the assumption that high outlier shares reflect discretionary behavior a payment cap would appropriately discipline.

Taken together, these preliminary findings suggest that the IPFs that would be capped under the proposed policy tend to serve a meaningfully different patient population—younger patients with schizoaffective disorder and more comorbidities, with more frequent use of ECT, at substantially higher cost. If that pattern holds, these are the kinds of patient populations an outlier payment policy is designed to protect, which is precisely why CMS should confirm what is driving outlier concentration before limiting these payments.

These findings point to a more basic reason for caution. The IPF payment system already adjusts payments for facility characteristics like the wage index, rural location, teaching status, and cost of living, and it pays extra for ECT, but those adjustments scale a facility's overall payment level and were never designed to capture the full cost of the long, high-acuity stays that generate outlier payments. That is what the outlier policy exists to handle.

Our preliminary analysis suggests that much of what distinguishes high-outlier facilities is structural: whether a facility is freestanding, the labor market it operates in, and its ownership, layered on top of a more complex patient mix. These are largely characteristics a facility does not choose—whether it is freestanding, where it is located, and how sick the patients who arrive in crisis are. This pattern offers a plausible explanation for high outlier concentration that CMS has not yet ruled out: that it reflects the kinds of patients these facilities treat and structural costs they do not control, rather than behavior a cap could fairly correct. At a minimum, it is an explanation CMS should investigate before adopting a facility-level cap.

In addition to the access concern, the proposed cap raises several conceptual and operational concerns. The outlier policy was established under Section 124 of the BBRA to protect IPFs from the financial risk of treating individual patients with extraordinarily high costs, and a facility-level cap is conceptually different from that patient-level protection. The cap would also operate as a sharp cliff at 20 percent rather than as a graduated reduction, would take effect immediately without a transition or sunset, and would be settled through a cost-report-settlement mechanism the Proposed Rule does not fully describe. The 20 percent threshold itself appears to have been selected without analytic support. CMS solicits comment on alternatives of 10, 15, 25, and 30 percent without identifying why any particular level is the right one and because the set of facilities that would be capped churns substantially from year to year, the cap would not reliably target a stable, identifiable category of facilities. A payment limitation that is set at an unexplained threshold, that captures a rotating group of facilities, and that disciplines cost variation the best available analysis cannot yet explain is, in our view, premature and insufficiently refined to finalize.

FAH intends to expand on our analysis to more fully address these broader questions so that our policy recommendations to CMS are evidence-based and do not inadvertently create access issues for patients or undue financial strain on IPFs who treat the highest-acuity patients. One analysis that would be particularly informative, and that CMS should complete before acting, is an examination of the set of consistently capped providers after excluding low-volume facilities (those with 25 or fewer stays per year). Because CMS is itself considering a minimum-volume threshold, understanding whether a stable group of higher-volume facilities is consistently affected, once low-volume facilities are set aside, is essential to determining whether the cap would target an identifiable structural problem or simply a rotating set of facilities whose outlier exposure varies year to year. We look forward to the opportunity to work closely with CMS to develop a fair, financially responsible methodology as informed by the evidence.

For these reasons, FAH urges CMS to not finalize the proposed 20 percent facility-level outlier cap for FY 2027 and instead hold the outlier fixed dollar loss threshold at the FY 2026 level of $39,360 while it completes the analysis its own RFI seeks. During that period, CMS should continue to evaluate other alternatives for addressing threshold volatility. One such alternative, which FAH recommended in our FY 2026 comments, is applying the FY 2022 and FY 2023 alternative threshold methodology that excludes IPFs with costs per day three or more standard deviations from the mean. This methodology, which CMS itself has previously applied, would be yet another lever to evaluate to further moderate threshold volatility. FAH would welcome continued engagement with CMS as it works through these issues.

IV. PROPOSED CHANGES TO THE IPF QUALITY REPORTING (IPFQR) PROGRAM (Part IV)

FAH appreciates CMS's continued attention to refining the IPFQR Program to ensure that the measure set advances meaningful quality improvement while limiting unnecessary administrative burden. We offer the following comments on the IPFQR provisions of the Proposed Rule.

B. Proposed Measure Removals (Part IV.B)

1. SUB-2 and SUB-2a (Alcohol Use Brief Intervention). (Part IV.B.1)

CMS proposes to remove the Alcohol Use Brief Intervention Provided or Offered (SUB-2) and Alcohol Use Brief Intervention (SUB-2a) measures beginning with the CY 2026 reporting period and FY 2028 payment determination, citing measure removal factors 3 (the measure can be replaced by a more broadly applicable measure) and 8 (the costs associated with the measure outweigh the benefit of its continued use). CMS notes that the more broadly applicable SUB-3/3a measure will be retained and The Joint Commission also retired SUB-2/2a from its ORYX requirements effective CY 2026. FAH supports the proposed removal of SUB-2/2a. The retention of the broader SUB-3/3a measure preserves a measure of substance use disorder treatment offered at discharge while ending duplicative reporting, and the alignment with The Joint Commission's ORYX changes is consistent with the principle of harmonized measurement across overlapping reporting frameworks.

2. TOB-3 and TOB-3a (Tobacco Use Treatment at Discharge). (Part IV.B.2)

CMS proposes to remove the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and Tobacco Use Treatment at Discharge (TOB-3a) measures under measure removal factor 8, citing stable median scores between 0.58 and 0.63 from 2023 to 2025 as evidence that the measure is no longer driving improvement. CMS also solicits comment on alternative ways to address nicotine use, potentially through the proposed IPF-PAI. FAH supports the proposed removal of TOB-3/3a. Stable, non-improving performance over multiple years on a chart-abstracted measure with substantial reporting burden is consistent with measure removal factor 8.

FAH members also noted that tobacco cessation is often clinically difficult to address meaningfully during a short IPF stay focused on acute psychiatric stabilization, and discharge of patients with nicotine replacement therapy is not always feasible given limited community follow-up support. With respect to CMS's RFI on whether nicotine use should be addressed through the IPF-PAI, FAH urges CMS not to add nicotine items, or any other new content, to the IPF-PAI. For the reasons set out in our IPF-PAI comments below, the proposed instrument is not a patient assessment of psychiatric care and should not be finalized as the vehicle for additional content until it is redesigned to assess patient mental health.

PROPOSED IMPLEMENTATION OF THE IPF PATIENT ASSESSMENT INSTRUMENT (IPF-PAI) (Part IV.C)

Section 4125(b)(1) of the Consolidated Appropriations Act of 2023 (CAA, 2023) added new paragraph (E) to section 1886(s)(4) of the Social Security Act, requiring IPFs participating in the IPFQR Program to collect and submit certain standardized patient assessment data using a standardized patient assessment instrument for FY 2028 and each subsequent year. Section 1886(s)(4) is the IPF Quality Reporting Program authority, and the consequence for non-reporting under that authority is the standard 2 percentage point reduction to the annual update under section 1886(s)(4)(A). Section 4125(b)(2) separately added section 1886(s)(6), which provides that IPF-PAI data "may be considered" in future revisions to the IPF PPS payment methodology effective for RY 2031; that authority is permissive and does not require any particular payment use of the data.

CMS proposes to implement the CAA provisions requirement through a new IPF Patient Assessment instrument (IPF-PAI), with mandatory reporting under the IPFQR Program beginning October 1, 2027 and affecting the FY 2029 payment determination. The proposed instrument would be administered at admission and discharge for all patients age 18 and older, regardless of payer, with proposed compliance set at 100 percent of items completed on 80 percent of submitted assessments.

FAH recognizes that implementation of a standardized patient assessment instrument is a statutory requirement, and we share the underlying policy goal of standardized data that can support comparison of psychiatric quality and outcomes across IPFs. **The IPF-PAI as proposed, however, is not a patient assessment of mental health. It is an assortment of administrative data elements, process measures and post-acute care functional assessments of mobility, hearing, speech clarity and vision that do not assess psychiatric illness presentation, acuity, treatment needs or outcomes. The proposed instrument would not enable comparison of psychiatric care quality across IPFs, would not inform treatment planning and would not produce data useful to CMS or to the public for understanding the care that IPFs deliver. FAH urges CMS not to finalize the proposed IPF-PAI and instead work with IPF clinical experts and the broader behavioral health stakeholder community to develop a clinically meaningful patient assessment instrument that satisfies the statutory mandate.**

A central tension in the proposed IPF-PAI is that it asks IPFs to produce new data in categories where IPFs are already producing standardized, high-quality data through CMS's own quality reporting program and longstanding accreditation requirements. The statute directs CMS to develop an instrument that captures the listed categories; it does not direct CMS to disregard the data IPFs already produce in those same categories. Where existing reporting already addresses a statutory category, FAH urges CMS to design IPF-PAI items that build on that data rather than introduce parallel—and in some cases lower-quality—collection on the same topic.

Restraint and seclusion use illustrates the concern. IPFs participating in the IPFQR Program already report HBIPS-2 (hours of physical restraint use) and HBIPS-3 (hours of seclusion use). These measures have been in continuous use since the IPFQR Program's inception and produce hour-level data on the same interventions the proposed instrument would capture. The proposed IPF-PAI item operationalizes the same construct as a yes/no checkbox, which produces less information at greater burden. If CMS's goal is standardized data on special services, treatments, and interventions, that data already exists and is already standardized; the IPF-PAI item should reference or build on HBIPS-2 and HBIPS-3 rather than replace them.

Suicide risk screening tells a similar story. Screening for suicide risk is universally required of accredited IPFs under The Joint Commission's National Patient Safety Goal 15.01.01 and is a well-established part of routine IPF clinical practice. The proposed IPF-PAI item captures only whether screening occurred, which adds little to what accreditation already documents. Across the proposed instrument, the same pattern repeats: items that overlap with existing standardized data without adding clinical value, paired with the absence of items that would capture the dimensions of inpatient psychiatric care—illness presentation, acuity, treatment response and outcomes—that existing reporting does not. **CMS can satisfy the statute, reduce burden, and improve the resulting dataset by redesigning the IPF-PAI to build on what IPFs already produce and to fill the gaps that existing reporting leaves behind.**

The mismatch between the proposed items and the inpatient psychiatric setting is reflected throughout the instrument:

- The functional status item (Mobility: Chair / Bed-to-Chair Transfer) is taken from the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) and assesses physical function, which is not impaired by the acute psychiatric crises that bring patients to an IPF and does not change meaningfully during a typical IPF stay.

- The cognitive function and mental status item is operationalized as a yes/no record of whether suicide screening occurred, which is a process measure rather than a measure of cognitive function or mental status.

- The special services, treatments and interventions items duplicate the existing HBIPS-2 and HBIPS-3 measures already reported in the IPFQR Program but operationalize the construct differently, creating parallel reporting of overlapping data.

- The medical conditions item asks for a single primary medical condition category from a list categories that do not align with ICD-10 diagnostic coding and that include categories (such as delirium, dementia and amnestic disorders) that are not eligible primary diagnoses for an IPF stay.

- The impairments items (hearing, speech clarity, vision) are functional assessments more appropriate to older-adult or post-acute populations and require clinician skills that are not part of IPF clinical training.

Taken together, the proposed items would generate data on physical functional status, process documentation and broad medical categories, but would not generate data on the patient's psychiatric illness, response to treatment or change in mental health status over the course of the IPF stay.

Testing of the proposed instrument is also not adequate to support mandatory national implementation. The instrument tested in alpha testing was different from the instrument tested in beta testing, and the beta-tested instrument is not the same as the proposed IPF-PAI; CMS therefore has not tested the instrument it proposes to finalize.

Beta testing involved 16 IPFs out of approximately 1,564 nationally, in a convenience sample explicitly described in the Testing Report as not designed to be nationally representative. Within that limited sample, several items demonstrated poor or fair reliability, including Restrictive Interventions: Seclusion (Cohen's Kappa 0.13), Restrictive Interventions: Other (Kappa 0.08), Vision (Kappa 0.23) and Mobility (Kappa 0.44). The Technical Expert Panel raised similar concerns about the clinical relevance and reliability of items that the proposed rule does not appear to address.

The proposed timeline and burden estimate are also unrealistic. CMS estimates 14.7 minutes per patient and treats the IPF-PAI as comparable in burden to a single IPFQR Program measure. In practice, the IPF-PAI consists of 12 separate clinical items, nine of which must be completed at both admission and discharge, resulting in approximately 21 distinct assessment or reporting steps per patient. Several items require clinician assessment skills that are outside the scope of standard IPF clinical training, and others require new EHR infrastructure for documentation and abstraction that does not currently exist at most IPFs.

The CMS estimate also excludes implementation costs (EHR vendor work, workflow redesign, training, quality assurance) and the substantial onboarding costs associated with iQIES, FHIR API integration and the new submission environment. These costs are particularly significant given that behavioral health providers were excluded from the financial incentives for EHR adoption under the HITECH Act and that EHR adoption and interoperability in the behavioral health sector remain materially behind that of medical and surgical care. **CMS's proposal to require FHIR-based reporting to iQIES beginning October 1, 2027, with the FHIR web app not available until spring or summer 2027, asks the sector with the least mature reporting infrastructure to implement the most advanced reporting framework with little lead time and substantial payment consequences.**

Section 4125(b)(1) of the CAA, 2023 identifies the required data categories but does not specify the precise content of the instrument, the items to be collected, the reporting timeline within FY 2028, the compliance threshold or the payment year tied to first reporting. Nor does the statute require CMS to attach the full IPFQR Program payment consequence (the 2 percentage point reduction to the annual update under section 1886(s)(4)(A)) to the very first reporting period before the instrument has demonstrated reliability in the field. CMS retains substantial discretion over the content of the instrument, the form and manner of submission, the compliance threshold and the enforcement framework in how to implement the statutory requirement in a way that produces clinically meaningful, reliable and feasible data. The current proposal does not meet that standard.

For these reasons, FAH urges CMS not to finalize the IPF-PAI as proposed. Instead, CMS should engage IPF clinical experts and the broader behavioral health stakeholder community to develop a clinically meaningful patient assessment instrument that assesses psychiatric illness presentation, acuity, treatment needs and outcomes.

If CMS nonetheless proceeds with the October 1, 2027 implementation date of the IPF PAI, FAH urges CMS to use its discretion over IPFQR Program enforcement to treat the first two reporting periods as transitional. IPFs would submit IPF-PAI, but the 2 percentage point IPF QR Program payment penalty would not attach for failure to meet compliance thresholds during that period. Two reporting years of operational experience would allow IPFs, vendors, and CMS to work through the iQIES onboarding, FHIR integration, training, and workflow challenges that are foreseeable in any new assessment instrument before payment risk is introduced.