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June 9, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code CMS-1831-P
Baltimore, MD 21244–8010

RE: Medicare Program: Fiscal Year 2026 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update CMS-1831-P

Dear Administrator Oz,

The American Psychiatric Association (APA), the national medical specialty society representing over 39,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the FY 2026 Medicare Program: Fiscal Year 2026 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update. Our comments focus primarily on provisions related to measurement in the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

With a record number of Americans struggling with mental health, including substance use disorders, we strongly urge you to prioritize strengthening healthcare's ability to respond to increasing demand for psychiatric services, especially for children. Untreated mental illness, including substance use has a resounding impact in our communities resulting in poor educational attainment, unstable housing, higher unemployment, poverty, and trauma. Early intervention, prevention, and treatment lead to cost savings for individuals, health insurers, government, and society. This includes ensuring the presence of a full range of services - a care continuum - to meet people's needs in the most accessible, least restrictive environment. This continuum should offer a spectrum of services including screening and early identification, accessible outpatient care, crisis intervention, rehabilitation and recovery support, and inpatient psychiatric treatment.

Inpatient psychiatric beds are a crucial foundation of local mental health systems, providing essential services for individuals experiencing mental illness, much like inpatient medical care supports those with acute medical needs. They offer a vital level of care, helping adults and young people receive treatment and stabilize during a crisis.

Unfortunately, the number of psychiatric beds across private and public sectors has dropped significantly in the past 60 years.[1]

Today, amidst a mental health crisis, psychiatric inpatient beds are too often not available when needed. As a result, people with mental illnesses end up staying in emergency departments or being discharged prematurely. In worst-case scenarios, inaccessible treatment results in homelessness or involvement with the criminal justice system. **We ask that the Administration ensure that psychiatric facilities have sufficient funding to support the availability of inpatient beds in a timely manner for any individual for whom inpatient care is needed.**

Measures Proposed for Removal

CMS has proposed removing the following measures related to health equity:

- Facility Commitment to Health Equity (FCHE)
- Screening for Social Drivers of Health measure (Screening for SDOH)
- Screen Positive Rate for Social Drivers of Health measure (Screen Positive)

APA agrees that the FCHE measure is burdensome to report and not needed. The same purpose is served by existing measures, such as The Joint Commission's National Patient Standard NPSG.16.01.01: Improving health care equity for the [organization's] patients is a quality and safety priority. Hospitals are already required to be compliant with this standard, and we encourage CMS to align measures with existing standards.

While APA supports reducing physician burden, we are concerned that the removal of all three of these measures will mean that the remaining measures focus too exclusively on diagnosed conditions at the expense of whole-person care and could unintentionally increase healthcare disparities. Social Drivers of Health (SDOH) are substantial contributors to the need for mental health services[2]. Engaging community resources for those who have an identified lack of housing, food access, transportation, and medication access, will have a direct impact on improving mental health and access to care, which in turn will result in lower long-term healthcare costs[3]. The Make America Healthy Again campaign[4] states "It shall be the policy of the Federal Government to aggressively combat the critical health challenges facing our citizens, including the rising rates of mental health disorders, obesity, diabetes, and other chronic diseases." Identifying SDOH through screening will help psychiatrists develop a comprehensive treatment plan integrating social support services and addressing SDOH

[1] APA Report on "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions", May 2023. https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report

[2] Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Soneson E, Steare T, Wright T, Griffiths SL. The social determinants of mental health and disorder: evidence, prevention and recommendations. World Psychiatry. 2024 Feb;23(1):58-90. doi: 10.1002/wps.21160. PMID: 38214615; PMCID: PMC10786006.

[3] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers BD. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. ASPE Report April 2022. HP-2022-12. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

[4] White House. Establishing the President's Make America Healthy Again Commission. February 2025. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.

in ways that are tailored to an individual's needs and preferences. With the provision of a whole-person treatment plan, care is more likely to be sustained and result in improved outcomes.

For individuals who are admitted to psychiatric inpatient facilities, systematic screening for SDOH is critical as they commonly contribute to mental health crises. By addressing issues such as housing instability, food insecurity, and trauma exposure, these facilities can connect patients to community resources that reduce the risk of readmission and support long-term recovery. Data on SDOH are also important in determining community resource needs. Furthermore, SDOH screening and connection to resources is aligned with the recently stated Center for Medicare and Medicaid Innovation priority of promoting evidence-based prevention[5].

CMS also states a preference for clinical outcome measures over structural or process measures as a reason for removing some of these measures. Although clinical outcome measures are ideal, many outcomes are not measurable in the one-year period that CMS currently mandates for the performance period. For example, APA developed a measure on recovery. Unfortunately, this measure was not approved in the QPP program due to the long time period needed to show improvement between the index assessment and reassessment, which would have limited the number of patients to which it could apply. Showing improvement in outcomes from assessment to reassessment would be even harder to achieve in this setting given the limited amount of time patients are hospitalized in inpatient psychiatric facilities. **Structural measures and process measures at least demonstrate that systems are in place to help achieve improved long-term clinical outcomes and are not dependent on a patient's time in care and recommend retaining Screening for SDOH, and the Screen Positive measures.**

RFI for Star Ratings

APA does not support a Star Ratings system for IPF settings and encourages CMS to not adopt this proposal.

The concept of a star rating system for psychiatric facilities is flawed in several respects. The handful of existing measures are highly circumscribed and do not reflect overall quality. The current Medicare star rating system for nursing facilities is often at odds with clinical impressions of the actual quality of care delivered, and a star rating system for psychiatric facilities would be similarly problematic. If star ratings incorporate measures such as restraint use, hospitals may be less willing to accept patients with a history of aggression. This type of unintended consequence was seen when the initiation of star ratings for cardiac surgery led surgeons to refuse to treat the sickest patients. Similarly, if star ratings are based on measures such as length of stay or readmission rates, hospitals may be less willing to accept patients with severe chronic illness or with significant SDOH that are known to influence those metrics.

[5] CMS.gov. CMS Innovation Center Strategy to Make America Healthy Again. 2025. https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again#:~:text=and%20CHIP%20programs.-,Promote%20Evidence%2DBased%20Prevention,new%20provider%20and%20beneficiary%20incentives.

Often, star rating approaches are proposed as a way for patients and families to make more informed choices about their care. However, with admission to psychiatric facilities, a star rating system would have limited utility because of the paucity of available inpatient beds, thus limiting patient choices regardless of rating If stars are used, they should be risk adjusted according to patient population, which is difficult to do, and should focus on metrics such as staff to patient ratios that are concrete and not dependent on factors such as SDOH.

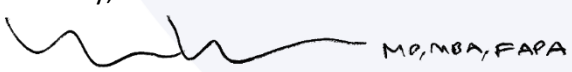
The APA would also like to highlight that the role of an inpatient facility for psychiatric care is different from the role of inpatient hospital care for general medical care, although psychiatry is not the only specialty where this is the case. The goal of inpatient admission, for most patients, is to stabilize an acute danger or crisis and then transition patients back to outpatient care. It is more akin to an intensive care unit than a general medical or surgical unit. The measures that are the most meaningful for patients in inpatient psychiatric facilities, and where there is the most differentiation, relate to patient safety, are already tracked closely by The Joint Commission. The real healing, for most patients, is in the outpatient setting, and this is where differences in quality of care matter the most. **If CMS adopts a star rating system to help patients choose where to receive their care, the APA encourages application of this idea to systems where outpatient care is the predominant modality.**

RFI on Well-Being and Nutrition Measures

Well-being and nutrition are difficult concepts to measure in inpatient psychiatric facilities, which care for individuals across the life span. If such measures move forward, APA respectfully requests to be involved in their development. Patients hospitalized for mental illness are typically in crisis and severely symptomatic. Safety and improvement in well-being are key reasons for care, not secondary outcomes. However, the treatment planning process is already aimed at matching the appropriate interventions to the patient's current needs. Education about well-being and nutrition could be appropriate for some patients, but a majority of patients are not able to focus on these issues while acutely ill. Even straightforward tasks such as journaling are often restricted because of prohibitions against writing implements on inpatient psychiatric units. Assessing nutritional status in psychiatric inpatients is important in identifying food-related SDOH and malnourishment. However, metrics related to nutritional status for psychiatric facilities should be the same as those for general medical services to avoid having conflicting or differing metrics within a given hospital system. Furthermore, changes to metrics cause significant burdens in creating or revising electronic health record components to meet new requirements.

Thank you for the opportunity to provide comments. We look forward to working with you on continuous improvement of quality care for people with mental illness, including substance use disorder. Please contact Becky Yowell (qualityandpayment@psych.org) with any questions or for more information.

Sincerely,



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