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June 1, 2026

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The Honorable Dr. Mehmet Oz, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
File Code CMS- 1847-P  
Baltimore, MD 21244-8010

RE: Medicare Program: Fiscal Year 2027 Inpatient Psychiatric Facilities  
Prospective Payment System—Rate Update CMS- 1847-P

Dear Administrator Oz:

The American Psychiatric Association (APA), the national medical specialty society representing over 40,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the Medicare Program: Fiscal Year 2027 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.<sup>1</sup> Today, amidst a mental health crisis, psychiatric inpatient beds are too often not available when needed and staffing is in short supply. 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.**

**We strongly recommend CMS work with APA and others to identify options for how to address tobacco use with the removal of measure TOB3/3a.** As our comments reflect below, APA has serious concerns about the proposed Patient Assessment Instrument (PAI). **We urge CMS to convene a meeting with the APA and other mental health leaders to ensure concerns are addressed prior to implementation. We also recommend that implementation of the PAI be delayed beyond October 1, 2027.**

### **Quality Reporting**

#### **Measures Proposed for Removal**

- 1) Proposed Removal of the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) Measure

The APA conditionally supports removal of TOB3/3a in its current form; however, we are concerned that removing any metric regarding tobacco cessation will have unintended consequences. CMS states that they recognize that smoking and other forms of tobacco use are common among IPF patients, the adverse health consequences of smoking are well documented, and they acknowledge that removing this measure does not diminish the importance of asking about tobacco use and offering cessation interventions. Smoking is a major contributor to increased mortality in individuals with serious mental illness, who are already at risk. Additionally, clinicians are still required to track cardiac metrics, which will be impacted by the continued use of tobacco products.

Addressing tobacco cessation with patients who are in the inpatient setting for short lengths of stay is difficult. Also, inpatient psychiatric hospitalizations can have meaningful state-by-state variation in involuntary treatment criteria, thus resulting in variations in the ability of IPFs to incorporate tobacco cessation medication treatments.

CMS notes that there is no indication of improvement in performance data for the measure. The current measure, however, has many flaws. The measure does not allow for tracking patient refusal, and hospitals have had to create work arounds to report accurate data. The measure also does not provide data for improvement and has served solely as a “check the box” measure. Additionally, most hospitals do not have a way to provide cessation counseling after discharge.

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<sup>1</sup> 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>

Though the burden for reporting the measure is high, there is strong concern that removing it entirely would impact the number of clinicians asking about tobacco use. Rather than completely removing all metrics related to tobacco use, **APA recommends that a better measure be developed or that the measure be revised to provide better data.** Hospital measures are often still “pay for reporting,” whereas pay for performance or improvement would provide a bigger incentive for moving the needle on these metrics. APA would welcome an opportunity to participate in that process. Finally, **APA encourages CMS to support more resources for community programs that are needed to help reduce the amount of tobacco use once IPF patients are discharged.**

### **Implementation of the Patient Assessment Instrument (PAI)**

The APA is concerned about the implementation of the statutorily mandated Patient Assessment Instrument (PAI) which, as proposed, fails to meet any of CMS’ stated objectives in developing a tool where:

- Topics are clinically relevant to patient care in IPFs
- Data, that when transmitted to CMS, are likely to inform CMS’ understanding of resource use or costs of care
- Items are feasible and relatively low burden to collect

Despite serious concerns about high administrative burden and poor results of implementation of a similar PAI in the post-acute care setting, the proposed instrument was developed with limited input from psychiatrists who are traditionally the clinical leaders of the inpatient treatment team and the primary clinicians responsible for patient assessment. Despite efforts by CMS to ensure interoperability, our clinicians report that data to complete this instrument will be nearly impossible to retrieve from current EHRs. Reporting will require manual entry and will add significant burden to already understaffed inpatient units, potentially offsetting any relief from removing measures, and without adding significant value. More meaningful data from similar measurements is already being collected. Clinicians cannot substitute the PAI for existing tools to reduce burden because those existing tools are still needed for other required measures or statutory mandates. The testing conducted does not seem to be sufficient or representative, with only 16 IPFs and 51 participants, and using only hypothetical case data, not actual assessments of real patients in crisis. It is also unlikely that this PAI will lower costs as the metrics are not relevant to outcomes that can be improved in a short inpatient stay.

While APA understands that development of the IPF PAI is statutorily mandated, **we strongly recommend that CMS convene a meeting with the APA and other mental health leaders to ensure concerns are addressed prior to implementation. We also recommend that implementation be delayed beyond October 1, 2027. At a minimum, we suggest implementing it for 2 informational or optional years before payment is tied to reporting.**

Comments on specific metric categories are below.

#### *Functional Status Category*

Function is an important metric in inpatient psychiatric care; however, the proposed metric *Mobility: Chair/Bed-to-Chair Transfer*, is not a meaningful measure in psychiatry/behavioral health and will not improve behavioral health-related outcomes.

#### *Special Services, Treatments, and Interventions for Psychiatric Conditions Category*

APA has concerns about monitoring ECT utilization (brain stimulation) as these data are subject to major privacy considerations. Though ECT use is evidence-based, recommended by health care organizations, and the most effective known treatment for depression, there are advocacy groups that support the elimination of ECT. Publicly available data sets could be abused to help eliminate an effective, non-pharmacologic treatment option.

Seclusion and restraint use (another intervention proposed to be assessed in the PAI) are already tracked in their own measures, outside of the PAI, and any attempts to track this should align with those measures.

#### *Medical Conditions and Comorbidities Category*

CMS proposes the assessment item *Primary Medical Condition* for the Medical Conditions and Comorbidities category of the proposed IPF-PAI. This assessment item captures the category of the primary diagnosis associated with the IPF stay. As currently proposed, assessors would select their response from the list of diagnostic categories (for example, anxiety disorders, mood disorders, schizophrenia and other psychotic disorders); however, these broad diagnostic categories aren't aligned with ICD-10. This misalignment will require additional mapping to the categories with the ICD-10 diagnosis. Additionally, a claim typically has an ICD-10 code tied to the admission, but there may be a different diagnosis at discharge, which would make this mapping even more challenging. Finally, appropriate reasons for admission that align with ICD-10 may cross these diagnosis groups (e.g., suicidal ideation, catatonia) and would be inaccurately coded as "other".

#### *IPF-PAI Impairments Category*

Speech/Hearing and Vision Screenings may be very tough to conduct at intake if patients are in crisis. Additionally, assessment of these impairments may be confounded by symptoms associated with the patient's reasons for admission (e.g., hallucinations).

#### *Reporting Structure*

Though APA recognizes CMS is offering flexibility in reporting by allowing both a web interface and FHIR API, it is puzzling that IPFs would be the first facility type to utilize FHIR API reporting when behavioral health was left out of the EHR Incentive program. Many IPFs still utilize paper charting and thus would be unable to report via FHIR.

Thank you for the opportunity to provide comments. In summary, this PAI will not add value, will increase burden significantly, and is wasteful; all counter to the administrations' interest in increasing value and eliminating waste. APA would like to work with CMS to development a meaningful tool that will align with the stated objectives. Please contact Becky Yowell ([qualityandpayment@psych.org](mailto:qualityandpayment@psych.org)), Senior Director for Reimbursement and Quality.

Sincerely,

A handwritten signature in black ink, appearing to read "Kristin Kroeger", is placed over a white rectangular background.

Kristin Kroeger  
Vice President, Advocacy, Policy & Practice Advancement  
American Psychiatric Association