



May 29, 2026

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: FY 2027 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update (**CMS-1847-P**)

Submitted electronically via Regulations.gov

Dear Administrator Oz:

On behalf of American Psychological Association Services Inc. (APA Services), please accept the following comments in response to your Proposed Rule concerning the Inpatient Psychiatric Facilities (IPF) prospective payment system (CMS-1847-P), published in the [Federal Register](#) on April 7, 2026. APA Services is the companion organization of the American Psychological Association (APA), which is the largest scientific and professional organization representing the discipline and profession of psychology, as well as over 190,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

While APA Services supports measures in this proposed rule to address low reimbursement levels for mental health treatment, APA Services hopes the Administration will carry that support for improved behavioral health care access into other settings and levels of care. Behavioral health treatment exists along a spectrum of care and should be furnished in the least restrictive environment appropriate to the patient's needs and responsive to other patient-specific factors, including the patient's age, symptoms, and level of acuity. Optimally, this includes crisis services, accessible outpatient services (i.e., partial hospitalization programs and intensive outpatient services), rehabilitation and recovery support services, as well as the kind of short-term intensive inpatient care addressed in this proposed rule.

However, research consistently demonstrates that in most communities, this continuum of care simply does not exist.¹ Patients experiencing a crisis may remain in local emergency departments for long periods of time because it is unsafe to discharge them to a lower level of care, either because there is no such treatment available nearby or there are insufficient spaces in these programs to accommodate patients needing longer term care that does not rise to the level of inpatient hospitalization. There is also a shortage of rehabilitation services and skilled nursing beds with staff sufficiently trained in managing patients with mental health disorders. Insurance-

¹ American Psychiatric Association (May 2022), The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions, <https://www.psychiatry.org/getmedia/81f685f1-036e-4311-8dfc-e13ac425380f/APA-Psychiatric-Bed-Crisis-Report-Full.pdf>.



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related issues and workforce shortages also contribute significantly to delays in admitting patients, even when beds are available.

Facilitating coverage and treatment for behavioral health services, whether through a public or private health insurance plan, is a key investment in providing early screening and intervention services to individuals exhibiting minor symptoms of mental distress before they escalate into more severe and more costly mental health crises.² By some estimates, a \$1 investment in prevention and early intervention for mental illness and substance use disorder programs is estimated to yield anywhere between \$2 to \$10 in savings in health care costs, as well as other societal costs.³ In communities across the country, that translates into tangible budget savings from averting unnecessary hospitalizations and lower rates of police resource use in managing acute mental health crises. Given the interrelated nature of behavioral health and medical health,⁴ a moderate investment in behavioral health access also yields cost savings through averting unnecessary medical costs.

Proposed Changes to Collection of Information Requirements

APA Services is concerned about the proposed removal of quality measures about the offering and provision of treatment for tobacco and alcohol use without improved measures that better reflect the reality of inpatient treatment and yield better quality data to replace them. APA Services agrees that the current quality reporting measures are duplicative of other similar quality measures, only adding to the clinician's administrative burden in capturing and reporting the necessary information.

Inpatient psychiatric care is only meant to be a short-term intervention to manage and stabilize an individual's acute mental health crisis before discharging them to a lower level of care. Meaningfully addressing cessation of tobacco and alcohol use with patients who are in an inpatient setting for short lengths of stay is difficult, and there is no mechanism to ensure that patients can receive continued support for cessation efforts once they are discharged, meaning that patients will likely resume such use shortly after discharge. Additionally, medical complications can arise from sudden cessation, withdrawal, and resumption of tobacco or alcohol use, particularly if they are prescribed medication to assist with cessation efforts.

Moreover, the current quality measure only adds to the clinician's administrative burdens; for example, the measure does not allow for tracking patient refusal of tobacco and alcohol cessation, and health systems have had to create elaborate workaround processes to accurately report this

² Le LK, Esturas AC, Mihalopoulos C, Chiotelis O, Bucholz J, Chatterton ML, Engel L. Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLoS Med.* 2021 May 11;18(5):e1003606. doi: 10.1371/journal.pmed.1003606. PMID: 33974641; PMCID: PMC8148329.

³ Steinberg Institute, Fact Sheet: The Cost Benefits of Early Intervention in Mental Illness, <https://steinberginstitute.org/fact-sheet-cost-benefits-early-intervention-mental-illness/>.

⁴ Julius Ohrnberger, Eleonora Fichera, Matt Sutton, The relationship between physical and mental health: A mediation analysis, *Social Science & Medicine*, Volume 195, 2017, Pages 42-49, ISSN 0277-9536, <https://doi.org/10.1016/j.socscimed.2017.11.008>.



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data. The current measures also do not track patient progress or improvement in their cessation process, meaning that the current quality measures have become another “check the box” exercise in the admission and discharge process.

However, removing this quality measure without an improved alternative may have unintended consequences. Tobacco and alcohol use are common behaviors among patients with serious mental illnesses, and removing this quality reporting measure without a replacement may decrease clinicians’ ability to discuss this serious issue with their patients during the admission and discharge processes. Tobacco and alcohol use are linked to increased mortality among patients with serious mental illness, and continued use can limit the effectiveness of long-term recovery efforts. APA Services recommends that the agency delay its proposed removal of these quality reporting measures and work alongside clinicians and other stakeholders to develop improved quality reporting measures that meaningfully address these concerns while minimizing the administrative burdens imposed on health systems and clinicians.

Proposed Implementation of Patient Assessment Instrument (PAI) Tool

APA Services is deeply concerned about the proposed implementation of the Patient Assessment Instrument (PAI) tool, as described in this proposed rule. CMS states that its intention in developing this tool was to select topics that are clinically relevant to patient care in IPFs, use data that are more likely to inform the agency of the costs of care, and request only data that is feasible and impose a relatively minor burden on practitioners to collect. However, the PAI tool described in this proposed rule falls short of meeting these objectives, and APA Services recommends that CMS work collaboratively with provider organizations and health systems to develop an improved standardized assessment instrument that captures data more relevant to and better reflects the reality of inpatient treatment.

From the outset, we fear that adoption of the PAI tool described in this proposed rule will only add to the administrative burden of clinicians and health systems. Our understanding from clinicians is that the data needed to complete this instrument will be nearly impossible to retrieve from current electronic health records (EHR) systems, despite CMS’ good faith attempts to ensure interoperability across different EHRs. As a result, reporting this data, if it is even available, will require manual entry from already understaffed units, offsetting any administrative relief from other measures outlined in this proposed rule. To reduce this burden, clinicians cannot substitute the PAI for existing tools because those existing tools are still needed for other required measures.

As described in this proposed rule, the PAI is based on a post-acute model of care and is not appropriate for an acute inpatient psychiatric treatment setting. As a result, it selects reporting measures that are an inappropriate fit for acute inpatient psychiatric treatment while ignoring other more appropriate metrics. For example, while a patient’s overall function is an important metric in inpatient psychiatric care, the only metric with a high degree of reliability is *Mobility: Chair/Bed-to-Chair Transfer*, which is not a meaningful measure in psychiatry/behavioral health and will not improve behavioral health-related outcomes. At the same time, this assessment does not include suicidal thoughts and behaviors as a reason for intake, which is a very common reason for a patient to be admitted to an IPF. Speech/Hearing and Vision Screenings, while relevant to patient care,



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may also be exceptionally difficult to conduct at intake if patients are in an active mental health crisis.

As currently proposed, assessors would select their response from the list of common diagnostic categories like anxiety disorders, mood disorders, or schizophrenia and other psychotic disorders. However, these broad diagnostic categories are not aligned with those described in the ICD-10 diagnostic codes. This misalignment will require additional mapping to the categories with the actual 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.

APA Services understands that implementation of a standardized assessment tool is a statutory mandate. However, taking the time to develop a standardized assessment instrument with the input of clinical psychologists and other health care providers will yield a more efficient and reliable product that better meets the objectives of both CMS and Congress. If CMS intends to engage in this process, APA Services would be more than happy to be a participant in it, bringing the expertise and experience of our clinical psychologists to bear on this topic.

Thank you for the opportunity to weigh in on this proposal. APA Services shares the Administration's goal of supporting access to the complete spectrum of behavioral health treatment, including early and preventative behavioral health treatment, which can avert the need for more intensive treatment and reduce overall costs to the health care and social service systems. To the extent that clinical psychologists can serve as a resource to the Administration on the multitude of settings and modalities of behavioral health treatment, please feel free to reach out to Stephen R. Gillaspie, PhD, Deputy Chief of Health Policy and Healthcare Financing, at sgillaspie@apa.org, or Andrew Strickland, Senior Legislative and Regulatory Officer, at astrickland@apa.org.

Sincerely,

A handwritten signature in black ink, which appears to read "Katherine B. McGuire". The signature is fluid and cursive, with a long horizontal stroke at the end.

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association Services, Inc.