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Advancing Health in America

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June 1, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations; the 43,000 healthcare leaders who belong to our professional membership groups; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and, especially, the 111 psychiatric hospitals and 825 hospitals with dedicated behavioral health beds, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2027.

IPFs are an essential part of the continuum of behavioral healthcare services, stabilizing and treating patients with acute and often complex clinical needs. Given the persistent shortages of IPF beds and growing demand for IPF services, it is critical that IPFs have a reimbursement and regulatory environment that supports their viability.

For these reasons, we are concerned that CMS' proposed market basket update is inadequate to ensure continued support of the vital services IPFs provide to their communities. **We urge the agency to revisit its market basket proposal and work with Congress to reduce the high productivity adjustment. Furthermore, we urge CMS to delay its proposed implementation of the IPF patient assessment instrument (PAI). In its current form, the IPF-PAI would result in enormous burden and cost for psychiatric providers with minimal value to patient care, and respectfully, we believe the instrument would not achieve the aims of the Consolidated Appropriations Act (CAA) of 2023 that mandated its development and implementation.** Instead, we encourage the agency to continuing using the existing IPF quality reporting requirements while developing a more meaningful instrument.

Our detailed comments follow.

PROPOSED IPF PAYMENT UPDATES

CMS proposes to increase payments to IPFs by a net 2.3%, or $50 million, in FY 2027 compared to FY 2026. This payment update includes a 3.1% market basket update, minus a 0.8 percentage point productivity cut as required by the Affordable Care Act.

Market Basket Update. The AHA is concerned that CMS' proposed annual market basket update of 3.1% is not keeping pace with real-world cost growth. In recent years, CMS' market basket forecasts have consistently come in below broader inflation, let alone medical inflation, which has exceeded growth in the overall economy. Layered on top of that, the productivity adjustment, proposed to be 0.8 percentage points for FY 2027, further erodes the update, leaving Medicare payments increasingly out of sync with the cost of care. **We urge CMS to revisit its market basket forecast and to work with Congress to reduce the magnitude of the productivity adjustment, as well as consider their combined effect on reimbursements for hospitals.**

IPFs are vulnerable to growing input costs due to their already very low margins. In its June 2023 Report to Congress (the most recent evaluation of payment adequacy of the IPF PPS), the Medicare Payment Advisory Commission (MedPAC) determined that Medicare has failed to cover the cost of caring for patients in hospital-based and freestanding nonprofit IPFs since at least calendar year (CY) 2016.[1] Notably, aggregate Medicare margins across all IPFs were -9.4% in CY 2021 and an astounding -28.3% for hospital-based nonprofit IPFs that same year. These data demonstrate the critical financial pressures that IPFs face, largely related to skyrocketing labor and supply costs.

For example, a recent report from the AHA finds that total hospital expenses grew 7.5% in 2025.[2] Much of this increase reflects labor costs, which CMS notes account for nearly 80% of the IPF market basket, and the AHA analysis found that workforce costs rose by 5.6% in 2025.[3] Further, advertised salaries for registered nurses have averaged 5.5% growth over the last two years — more than double the rate of inflation — according to the same AHA analysis.[4] Finally, the AHA has expressed concern that recent actions, such as changes to federal student loan limits that exclude nurses and other clinicians from enhanced borrowing limits, will exacerbate workforce shortages, which contribute to higher costs for labor. IPFs feel these increased costs acutely as they struggle to maintain highly skilled staff in the form of psychiatrists, psychiatric mental health nurses, mental health technicians, clinical social workers, psychologists and therapists.

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[1] MedPAC. (June 2023). Congressional Request: Behavioral Health Services in the Medicare Program (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch6_MedPAC_Report_To_Congress_SEC.pdf).
[2] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).
[3] Id.
[4] Id.

Cost pressures, however, extend well beyond labor. Like other hospitals, IPFs are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies, and these costs also continue to climb. An AHA analysis showed that in 2025 supply costs rose 9.9%, while drug costs rose a staggering 13.6%.[5] In addition, a report from the Department of Health and Human Services found that list prices for nearly 2,000 drugs increased by an average of 15.2% from 2017 through 2023 — outpacing general inflation.[6] These cost challenges strain IPFs, which, like other hospitals, must be prepared to provide treatment for a wide range of conditions and comorbidities while patients undergo their intensive course of treatment.

Hospitals also are absorbing escalating administrative costs that are not reflected in payment updates. In particular, most Medicare Advantage plans require prior authorization for IPF admissions, and IPFs must devote substantial time and resources to navigating these processes. A 2024 Premier study found that hospitals spend just under $20 billion annually appealing denials.[7] Indeed, the AHA estimated that about 6.5% of total hospital employment was for administrative staff dedicated to functions relating to claim denials and prior authorization.[8] Since plans do not reimburse these administrative expenses, IPFs must absorb them while caring for a growing share of Medicare Advantage patients.

Viewed collectively, these increases in staffing, drugs, and other essential supplies and services are placing significant strain across the healthcare continuum. They also are forcing hospitals, including IPFs, to redirect resources that otherwise could be used to support patient care, adopt new technologies and make other efficiency-enhancing investments. IPF market basket increases are at most half, and sometimes less than half, of the cost increases observed by hospitals. In addition, and as discussed further below, these pressures amplify the negative impact of the productivity adjustment by limiting hospitals' ability to fund the very investments that can drive operational efficiencies.

The Productivity Adjustment Exacerbates Insufficient Market Basket Updates

Under the Affordable Care Act, the IPF PPS payment update is reduced each year by a productivity factor equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). For FY 2027, CMS proposes a productivity cut of 0.8 percentage points. The private nonfarm business TFP is intended to reflect gains from new technologies, economies of scale, business acumen, managerial skill and changes in production. In effect, it assumes the

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[5] Id.
[6] ASPE. (October 2023). Changes in the List Prices of Prescription Drugs, 2017-2023 (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs).
[7] Premier. (March 2024). Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims (https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims).
[8] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).

hospital field can achieve productivity gains comparable to those realized by private nonfarm businesses. However, as discussed in more detail below, hospitals and the broader healthcare field cannot mirror these gains. As a result, we believe it is not an appropriate or reliable proxy for hospital productivity. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment**.

A core problem is that the productivity construct embedded in the private nonfarm business TFP is a poor fit for measuring hospital productivity. TFP outputs are measured based on the total quantity and prices of goods and services produced in private nonfarm businesses. In industries that sell tangible products, outputs can often be measured in relatively straightforward and standardized ways. Hospital outputs, however, do not operate in the same manner. For example, hospital "quantity," such as volume of visits or procedures, is not necessarily an appropriate proxy for output; it may instead reflect the underlying disease burden in a community. More hospital volume — i.e., more quantity — does not equate to higher productivity in the way it can for private nonfarm businesses.

Further, hospitals often cannot adjust prices per unit of service in response to changes in demand or quality in the way private nonfarm businesses can. Much of hospitals' reimbursement is paid through fixed payment systems, such as the IPF PPS, which limits providers' ability to alter prices. Similar constraints apply in the commercial market: Hospitals and health systems do not unilaterally set their rates, and prices for commercially insured patients are established through negotiations that frequently lock in rates for multiple years. Accordingly, applying a TFP output framework based on quantity and prices — as experienced in the commodity goods markets — to hospitals is problematic because that output function does not translate to the hospital field.

In addition, the TFP approach does not reflect the operational realities that constrain hospitals' ability to generate productivity gains at rates seen elsewhere in the economy. The private nonfarm business sector includes industries with relatively stable and predictable production processes. Hospitals, by contrast, operate in a highly complex environment with variable patient volumes, rising input costs they have limited ability to control and shifting acuity — as well as disruptions from natural disasters and pandemics. Hospitals also must meet extensive regulatory requirements that far exceed those faced by many other industries. Private nonfarm businesses rarely encounter these same challenges and obligations and if they do, they often have other mitigation options available to them, including to cease or scale back operations in ways hospitals cannot without severe societal consequences.

CMS itself has acknowledged that hospitals are not positioned to achieve productivity gains comparable to the broader economy over the long run. Specifically, CMS found that hospitals can achieve productivity gains equal to only one-third of those seen in the

private nonfarm business sector.[9] Accordingly, using the private nonfarm business TFP to adjust the market basket is inappropriate.

Finally, we continue to find it especially troubling that the productivity adjustment appears to be applied only when it *reduces* Medicare payments. For example, in FY 2021 the 10-year moving average growth of the productivity factor forecasted by IGI was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage points. However, the agency set the productivity factor at 0, stating that it is required to reduce — not increase — the hospital market basket by changes in economy-wide productivity.[10] Put simply, the agency uses the productivity factor only when it lowers Medicare spending.

The cumulative, compounding effect of these annual reductions — coupled with the asymmetric treatment of periods of declining economy-wide productivity — has widened the gap between payments and the cost of providing services, leaving hospitals increasingly underfunded. In light of this, the AHA continues to have serious concerns about the proposed productivity cut, particularly given the extraordinary pressures under which hospitals and health systems continue to operate.

Outlier Payments. CMS applies an outlier payment for IPF stays that are extraordinarily costly — specifically, when the IPF's estimated total cost for a case exceeds payments plus a fixed-dollar loss threshold. According to CMS' analysis of recent data, the proportion of stays qualifying for the outlier payment has declined over time; however, outlier payments have become concentrated among a small number of facilities. The agency states that this suggests that providers with large shares of outlier payments tend to have higher daily routine charges that are not entirely explained by differences in case mix. Therefore, to minimize the impact that a small number of high-cost IPFs could have on the outlier threshold, CMS proposes to limit total outlier payments to no more than 20% of a facility's total IPF PPS payments. It also proposes a low-volume exception that would exclude certain facilities with relatively few cases from the application of the cap. CMS proposes to apply this cap beginning with discharges occurring in cost reporting periods beginning on or after Oct. 1, 2026.

The AHA appreciates CMS' focus on ensuring that outlier payments are appropriately targeted. However, the available evidence does not provide sufficient clarity regarding why outlier payments have become concentrated among a small number of facilities. More analysis is needed. Accordingly, the AHA recommends that CMS not implement its proposed 20% cap on outlier payments for FY 2027.

[9] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf).
[10] 85 Fed. Reg. 58797 (Sept. 18, 2020).

We appreciate that CMS has conducted initial analyses examining the concentration of outlier payments and has identified several important patterns, including that a small number of facilities account for a large share of outlier payments and that these facilities tend to have higher routine costs and longer lengths of stay. The agency further states that its analysis suggests that observed case-mix differences alone do not fully explain these cost patterns. However, it also has acknowledged uncertainty regarding the underlying drivers of these differences and explicitly solicited comments on key questions, including the roles of patient acuity, facility characteristics, labor markets, and potential incentives related to utilization and cost. **As such, while the analysis raises important considerations, it does not yet provide clear evidence regarding the extent to which outlier concentration reflects patient complexity, structural cost differences, or other factors.**

To better understand the potential drivers of outlier payment concentration, the AHA, the Federation of American Hospitals and the National Association for Behavioral Healthcare, have begun analyzing recent IPF claims data. We found that facilities with higher outlier shares differ across several dimensions, including teaching status, geographic location, and the provision of intensive services such as electroconvulsive therapy, along with other facility and patient characteristics. These characteristics are consistent with the treatment of more complex and resource-intensive patient populations. However, the evidence does not clearly distinguish the extent to which these patterns reflect patient acuity and treatment needs versus other factors, such as practice patterns or structural cost differences. **Therefore, further analysis is needed to better understand the underlying drivers of these patterns.**

Importantly, even comprehensive statistical modeling explains only a limited share of the variation in outlier payment patterns, again suggesting that the primary drivers of these differences are not yet well understood. In addition, our analysis indicates substantial year-to-year variation in the facilities that would be subject to the cap, with only a small number of providers consistently exceeding the threshold across multiple years. This lack of stability suggests that the proposed policy would not target a clearly defined or persistent group of providers. This pattern further suggests that elevated outlier payments may be driven more by year-to-year variation in patient characteristics and case mix than by persistent differences in facility cost structures. It also remains unclear how CMS' proposed low-volume exemption would affect the composition of capped facilities and whether it would meaningfully improve the targeting of the policy or simply shift its effects to a different set of providers. **The AHA would welcome the opportunity to work collaboratively with CMS to further evaluate these questions and potential modifications to the outlier policy.**

We recognize that CMS is required to maintain total outlier payments at 2.0% of total estimated aggregate IPF PPS payments. To do so without the proposed cap would result in a significant increase in the fixed-dollar loss threshold. We also recognize that this increase — to almost $43,000 — could disadvantage facilities serving high-cost and high-complexity patients. **Given these uncertainties, the AHA urges CMS to maintain the outlier fixed-dollar loss threshold at its FY 2026 level of $39,360**

while it works with the AHA and other stakeholders to further evaluate the drivers of outlier payments. Maintaining the FY 2026 threshold would provide stability while allowing additional time for more comprehensive analysis. Importantly, CMS has precedent for this approach within the same rulemaking cycle: In the FY 2027 LTCH PPS proposed rule, the agency proposes to maintain the LTCH PPS outlier threshold at its FY 2026 level to provide stability during other policy changes. A similar approach here would allow CMS to better understand the underlying drivers of outlier payments before implementing a policy that could have significant implications for access to care and payment adequacy, particularly for facilities serving complex patient populations.

Wage Index Policies and Request for Information on IPF-Specific Wage Index

For FY 2027, CMS proposes to continue to use the inpatient PPS wage index to adjust IPF payments, specifically employing the relevant pre-floor, pre-reclassification inpatient hospital wage index. However, the agency also solicits comments on whether it should consider using alternative data sources, such as IPF cost reports or Bureau of Labor Statistics (BLS) wage data, to construct an IPF-specific wage index for potential use in future years.

The AHA has conducted extensive policy work on the wage index. It is a difficult issue without a consensus solution. For example, using IPF cost reports to construct an IPF-specific wage index would be very burdensome, both to IPFs as well as CMS itself. It also would create a system that is circular and self-perpetuating. Specifically, using only IPF data in setting the wage index would mean that IPFs have the ability to influence their own wage index values. This could lead to a problem where IPFs with low wage indices may be unable to increase wages to become competitive in the labor market.

Policymakers also have considered using BLS data to calculate the wage index. The AHA and our members have examined these data closely and found that, while their collection and use may be significantly less burdensome, they have critical shortcomings. For example, BLS data excludes the cost of benefits. However, benefits are an important component of the wage index because the portion of total compensation attributable to benefits varies by market. If benefits were excluded, the wage index would be understated in areas where benefits account for a greater portion of compensation; it would similarly be overstated in areas where they account for a lower portion. Therefore, any adjustments made to include benefit costs would have to be market-specific. In addition, if hospital-specific benefit information is to be added, it would have to be collected on CMS' Medicare cost report. Yet doing so would add regulatory burden as well as some degree of circularity back into the system.

In addition, BLS data are derived from voluntary surveys and a sample of employers. Estimates using a sampling methodology like the BLS approach would be less reliable than using the entire universe of cost reports. Additionally, CMS' current process in calculating the inpatient PPS wage indices, and therefore presumably any new process for IPF wage indices, allows for extensive public scrutiny of the data while the BLS approach does not. Unlike CMS' public process for review and correction of cost report

wage data, BLS has a strict confidentiality policy. Hospitals would thus be unable to verify the accuracy of the data.

BLS data also include data on the wages of healthcare workers employed in all industries. For example, healthcare sector data from hospitals, physician practices, skilled-nursing facilities, ambulatory surgical centers, home health agencies and hospices are all included. Yet, IPFs differ from the universe of all employers in terms of the wage levels necessary to recruit and retain qualified employees, the percentage of compensation paid in benefits, the likelihood of unionization and other factors that affect compensation rates.

Finally, we urge CMS to consider whether it would need to create a system for reclassifications of IPFs to a different labor market. Labor markets cannot realistically be defined as hard boundaries, and certain adjustments to the wage index may be necessary to accurately capture differences in labor costs across IPFs. However, our members have expressed concern that the number of reclassifications and exceptions permitted under the current inpatient PPS is complex and confusing.

IPFQR PROPOSALS

Proposed Measure Removals. CMS proposes to remove the Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a) Measure beginning with the CY 2026 reporting period. This measure assesses whether patients who screened positive for unhealthy alcohol use received or refused a brief alcohol use intervention during their IPF stay. The agency cites the inclusion of another measure, Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge/Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB-3/3a), in its rationale that the SUB-2/2a measure is redundant and less useful than the SUB-3/3a measure which captures a broader patient population.

In addition, CMS proposes to remove the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) measure on the same timeline. This measure assesses whether patients were offered evidence-based outpatient counseling and a prescription for Food and Drug Administration-approved cessation medication upon discharge. The agency has found that performance on the measure has remained stable over time with no indication of improvement and thus proposes to remove it from the IPFQR.

The AHA agrees and supports the removal of the SUB-2/2a and TOB-3/3a measures, as we did when CMS first proposed its removal in the FY 2022 IPF PPS Proposed Rule. While the prevalence of alcohol and tobacco use are relevant to the IPF patient population, these measures do not provide meaningful insight into quality of care at IPFs and thus should not remain in the IPFQR.

Proposal to Implement the IPF-Patient Assessment Instrument (IPF-PAI). The CAA of 2023 required IPFs to collect and submit standardized patient assessment data using

a standardized instrument beginning in FY 2028. In this proposed rule, CMS proposes implementation of the tool it has developed, the IPF-PAI. If finalized, IPFs would be required to administer the IPF-PAI for all patients age 18 and older at admission and discharge (with specific exceptions).

The AHA urges CMS to delay implementation indefinitely in order to engage in the investigation, development and testing of a standardized patient assessment instrument that would provide meaningful and useful data that can be used to fulfill the intent of the CAA. Furthermore, we believe existing IPF quality reporting requirements can serve as a bridge to meet CMS' statutory obligations while it further refines the IPF-PAI.

The proposed IPF-PAI is not well matched to the workflows of IPFs. Most of the items in the proposed PAI are based on retrospective data abstraction rather than patient assessment. That is, rather than being informed by real-time clinical evaluations (which IPF providers already perform), items would be informed by additional steps of reading through medical charts and administrative data to fetch information and rewrite it on this standard form. This requirement would only interrupt and add to the already intense workflows of clinical staff without providing new and actionable information to the treatment team.

The items in the proposed tool lack clinical relevance for inpatient psychiatric care. The provisions of the CAA that mandate the development and implementation of the IPF-PAI are the same as those in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 that dictated the development of standardized patient assessment data elements (SPADEs) for use in post-acute care settings. CMS also stated in the aforementioned RFI that it “considered similar legislatively derived PAIs previously implemented for certain post-acute care providers to inform the goals and guiding principles for the IPF-PAI because of similarities of [the CAA] to the [IMPACT Act].” Yet, as its name connotes, the IMPACT Act is specific to post-acute care settings including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), and home health agencies; that law does not address or mention psychiatric care in any way.

Second, most of the items included in the PAI are simply SPADEs repurposed for the inpatient psychiatric setting. In other words, these are existing items that were developed and tested for post-acute care settings without any consideration of psychiatric conditions or treatment. Certain items, such as Hearing, Speech Clarity, and Vision, would be unlikely to provide particularly relevant information for psychiatric treatment (as individual patient characteristics are already captured in the course of existing patient assessment processes), but others, such as Bed-to-Chair Transfer, are wholly irrelevant for this setting due to the complete lack of alignment with clinical practice. IPFs are not comparable to post-acute care facilities in patient mix, services, length of stay or many other characteristics, and thus it is inappropriate to use data elements developed for post-acute settings to assess patients in an IPF. In addition to declining to move forward with the proposals in this rule, **we encourage CMS to work**

with Congress to amend the categories of patient assessment data required as part of the CAA so that they are relevant to psychiatric facilities.

The elements in the tool are inadequately developed. Leaving aside the lack of clinical relevance of the items in the proposed PAI, the March 2026 Testing Report from CMS contractors demonstrates that the items themselves performed poorly in regard to validity, reliability and feasibility. Of the items that CMS tested in the alpha and beta phases, most have only fair or moderate reliability, and some have poor reliability. These results suggest that the items are not interpreted or applied consistently by staff, further weakening their relevance and usefulness. In addition, several of the proposed items had qualitative feedback labeling them as “confusing” or “not very important,” or noting that collecting the information “did not fit with the usual assessment practice” or were “already collected through another instrument or assessment.” Further, CMS proposes to include several items that were not tested, including nearly every administrative element and the revised Suicide Screening element.

Perhaps most concerning, however, is that beta testing was conducted with only 16 facilities across 51 participants — this represents just 1% of the 1,564 IPFs in the United States and is hardly a representative sample of staff. CMS aimed to include 20 facilities in its testing, with 60-80 staff members completing 200 hypothetical case studies and 80 patient forms (40 upon admission and 40 upon discharge); the beta test only included 44 staff completing 117 hypothetical case studies, and 20 staff completing 73 patient forms (41 upon admission and 32 upon discharge). Even if the items performed well under testing, the small sample of results would not statistically support the implementation of the tool across all facilities and patients in the nation.

The implementation requirements would be unduly challenging and extremely costly. CMS estimates that completing the proposed IPF-PAI would take 14.7 minutes per patient based on the beta test, which found that the median time to complete the assessment was 15 minutes upon admission and 10 minutes for discharge. This would result in an annual increase in burden of 514,228 hours, according to CMS’ calculations. This is an incredible burden for already overworked IPF staff; however, we think that this is an *underestimate* of increased burden, considering that the Testing Report calculated a mean time of 20-25 minutes and maximum of 79-183 minutes per hypothetical case study or observational field test. That means that, using CMS’ own calculation methodology assuming a total of 2,098,888 patients, this proposal would more likely add 699,629 to 874,537 hours of work annually. This equates to between 343 to 429 new full-time employees at a time when IPF, like other healthcare providers, are struggling to recruit sufficient staff to manage the existing workload.

Psychiatric providers are willing to take on increases in burden for clinically appropriate purposes that will improve care for their patients. However, CMS has not demonstrated that the proposed IPF-PAI would result in better treatment or outcomes, and thus the increased time IPF staff would spend completing this tool would directly diminish time spent helping patients.

The proposed tool would not achieve the goals of the CAA. Section 4125 of the CAA is titled “Improvements to Medicare Prospective Payment System for Psychiatric Hospitals and Psychiatric Units” and directs the development of the PAI in section (b), titled “Improvements Through Standardized Patient Assessment Data.” The intent of the collection of this data under the statute is, as described in section (6) titled “Additional considerations for diagnosis-related group classifications,” to “implement revisions to the methodology for determining the payment rates under the system described in paragraph (1) for psychiatric hospitals and psychiatric units, as the Secretary determines to be appropriate, to take into account the patient assessment data described in paragraph (4)(E)(ii).”

In short, Congress clearly intended patient assessment data to be used to describe and categorize patients with similar clinical conditions and resource needs for the purpose of making the IPF PPS more accurate. The elements in the proposed PAI provide little to no information that can be used to fulfill that purpose. The Technical Report shows that certain elements glean nearly identical results for all patients in the testing sample (for example, 94% of patients demonstrated total independence on the Bed-to-Chair Transfer item); the Active Diagnoses item is actually *less* specific than the current list of MS-DRGs used to categorize IPF patients for payment purposes. In short, implementing this tool would not improve the accuracy of the IPF PPS, and could serve to reduce the accuracy of payments if CMS relied upon these data elements to inform case-mix groupings.

CMS can meet its statutory obligations under the CAA by collecting standardized data that IPFs already submit, as it has done in the past. The statute allows for the Secretary’s discretion in implementing revisions to the IPF PPS as deemed to be appropriate; we believe that the information provided above demonstrates that using this information to revise payment rates would be inappropriate. However, we understand that CMS may feel beholden to other sections of the statute directing facilities and units to submit data via a standardized assessment instrument. In that vein, there is precedent that CMS can reference to meet its statutory duty to implement a PAI by FY 2028 without the implementation of the IPF-PAI as proposed.

In the FY 2018 proposed rules for the IRF, SNF and LTCH PPS, CMS proposed to adopt dozens of SPADEs into the patient assessment tools for all three settings to comply with the mandates of the IMPACT Act. However, in response to the AHA and many other stakeholders voicing concerns on the administrative burden and lack of clinical utility of the proposed SPADEs, CMS declined to finalize its original proposals. Instead, the agency determined that the data elements used to calculate current quality measures in the quality reporting programs for all three settings met the definition of “standardized patient assessment data” with respect to the Functional Status and Medical Conditions and Comorbidities domains. Thus, CMS deemed successful reporting of that data for admissions and discharges in CYs 2018 and 2019 as sufficient to satisfy the statutory requirements of the IMPACT Act. This allowed CMS to engage in further development and testing of potential data elements.

We urge CMS to take a similar course of action with the IPF-PAI as it did for the SPADEs under IMPACT Act. CMS can establish that data elements already collected and reported by IPFs in a standardized fashion through other means are sufficient for meeting the statutory requirements under the CAA for the foreseeable future, allowing for more time to develop and test elements that would fulfill the purposes of the law. For example, in the IPFQR, reporting the Screening for Metabolic Disorders measure requires documentation of testing for blood pressure, blood glucose/HbA1C and lipid panel, indicators of potential comorbidities. In addition, the Alcohol Use Brief Intervention Provided or Offered (SUB-2) measure indicates a special service, treatment and intervention for a psychiatric condition.

In summary, the AHA, its members, and its partners at other advocacy agencies that represent IPF providers and patients are eager to help CMS improve the IPF PPS to ensure accessible and high-quality psychiatric care. We believe the proposed IPF-PAI would not achieve this shared goal, and CMS should not implement it.

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org or (202) 626-2267.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President, Policy Analysis and Development