May 27, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically to www.regulations.gov

**RE: Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update**

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to provide input to the Centers for Medicare and Medicaid Services (CMS) on federal fiscal year (FFY) 2027 inpatient psychiatric facilities (IPF) prospective payment system proposed rule. Psychiatric mental health nurses play a critical role in providing high quality care and ensuring patient safety.[1]

While we appreciate CMS' thoughtful proposals, ANA urges the agency to consider our comments on the following topics as it finalizes its rulemaking:

- the Inpatient Psychiatric Facility Patient Assessment Instrument (IPF-PAI),
- the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) Measures, and
- outlier payments.

ANA represents the interests of the nation's over 5 million registered nurses (RNs) through its constituent and state member associations, organizational affiliates, and individual members. ANA advances the nursing profession by championing nurses, fostering rigorous standards of nursing practice, promoting safe and ethical work environments, bolstering nurses' health and wellness, and advocating on the healthcare issues that impact both nurses and their patients. ANA seeks to ensure that nurses' voices, interests, and perspectives are represented and heard in policymaking discussions. ANA's membership consists of both RNs and Advanced Practice Registered Nurses

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[1] Johnson, C., Delaney, K. R., Cirpili, A., Marriott, S., & O'Connor, J. (2024). American Psychiatric Nurses Association position: Staffing inpatient psychiatric units. *Journal of the American Psychiatric Nurses Association, 30*(5), 886–895. https://doi.org/10.1177/10783903231198247

(APRNs)—nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

Nursing is a profession grounded in critical thinking, scientific rigor, and evidence-based practice. Nurses form the backbone of the American healthcare system and serve across full spectrum of healthcare settings in multiple direct care, care coordination, research, and administrative leadership roles. Nurses provide and coordinate patient care, educate patients and the public about self-care and various health conditions, and offer counsel and emotional support to patients and their family members. As the most trusted profession, nurses play a critical role in treating patients and influencing health behaviors.[2] **Accordingly, we urge CMS to consider the nursing perspective in its rulemaking regarding payment for IPFs under the Medicare program.**

1. CMS should refine the Inpatient Psychiatric Facility Patient Assessment Instrument to collect more comprehensive data.

The Consolidated Appropriations Act of 2023 (CAA) requires all IPFs participating in the IPF Quality Reporting Program (QRP) to collect and submit standardized patient assessment data using a uniform patient assessment instrument beginning in Rate Year (RY) 2028 and onwards. The CAA requires that CMS's instrument collect data on the following categories: functional status, cognitive function and mental status; impairments; medical conditions and comorbidities; and special services, treatments, and interventions. In the proposed rule, CMS proposes its new standardized data collection instrument, the Inpatient Psychiatric Facility Patient Assessment Instrument (IPF-PAI), to be used to meet this requirement. **While the proposed IPF-PAI provides a strong foundation, ANA believes that CMS can strengthen its data collection by refining its questions on impairments and on cognitive function and mental status, as well as by creating a comparable instrument for pediatric populations.**

a. CMS must expand criteria to better assess impairments.

The CAA requires CMS to systematically capture data on a patient's impairments that could impact psychiatric care, treatment planning, and outcomes. As proposed, Section B of the draft IPF-PAI seeks to meet this requirement through data collection on a patient's hearing (B0200), speech clarity (B0600), and vision (B1000).[3] **ANA believes that this is not sufficient, and that CMS must expand the impairments section to include urinary incontinence, bowel incontinence, and dysphagia.** Both incontinence and dysphagia can increase patient complexity and require time-

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[2] Brenan, M. (2026, January 12). Nurses continue to lead in honesty and ethics ratings. Gallup. https://news.gallup.com/poll/700736/nurses-continue-lead-honesty-ethics-ratings.aspx

[3] Centers for Medicare & Medicaid Services. (n.d.). *Inpatient Psychiatric Facility Patient Assessment Instrument (IPF-PAI): Admission*. U.S. Department of Health and Human Services. https://qualitynet.cms.gov/files/69cd291f6c16b5dc32991be4?filename=IPF-PAI_Admission.pdf

intensive, labor-heavy responses or interventions.[4, 5, 6] As a result, dysphagia and incontinence are impairments that pose major impacts on both nursing workload and on what constitutes adequate staffing. Therefore, adding a measure for dysphagia and incontinence on the IPF-PAI will provide CMS with more comprehensive data regarding some of the impairments that impact psychiatric care.

Additionally, CMS has proposed that the functional impairment section is to be assessed only at admission, and not at discharge, on the basis that hearing, speech clarity, and vision will not change greatly during the timing of an IPF stay. Although hearing and vision will likely not change drastically across a short period of time, speech clarity can differ greatly during an IPF stay. For example, in patients experiencing psychosis, thought disorder symptoms—also known as disorganized speech—have been found to decrease by the time of discharge.[7] **Therefore, it is essential that the IPF-PAI should assess speech clarity at both admission and discharge.**

b. CMS must refine assessments for cognitive function and mental status for more accurate data collection.

CMS is required by the CAA to systematically capture data on a patient's cognitive function and mental status affecting their psychiatric care, treatment, and outcomes. CMS proposes to meet this requirement through a suicide screening measure (D1000) under Section D of the draft IPF-PAI. As proposed, there are three answer choices to a question asking whether a patient has been screened for suicide risk. The only *not screened* answer choice is written as "No—Patient declined to respond or patient unable to be assessed."[8] We believe that the ability to decline suicide screening and being physically unable to respond are highly different markers of mental status. Thus, **CMS should split the *No* answer choice into two separate *not screened* answer choices: one for *decline* and one for *unable to respond***. This would allow for more accurate data collection with minimal change to the question being asked.

c. CMS must develop a comparable instrument for patients of all ages.

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[4] Mandl, M., Halfens, R. J. G., & Lohrmann, C. (2015). Incontinence care in nursing homes: A cross-sectional study. *Journal of Advanced Nursing, 71*(9), 2142–2152. https://doi.org/10.1111/jan.12676
[5] Seedat, J., & Strime, N. (2021). "Finishing that plate of food ...": The role of the nurse caring for the patient with dysphagia. *South African Journal of Clinical Nutrition*. https://doi.org/10.1080/16070658.2021.1940717
[6] Nielsen, A. H., Kaldan, G., Nielsen, B. H., Kristensen, G. J., Shiv, L., & Egerod, I. (2023). Intensive care professionals' perspectives on dysphagia management: A focus group study. *Australian Critical Care, 36* (4), 528–535. https://doi.org/10.1016/j.aucc.2022.04.004
[7] Tang, S. X., Spilka, M. J., John, M., Birnbaum, M. L., Saito, E., Berretta, S. A., Behbehani, L. M., Liberman, M. Y., Malhotra, A. K., Simpson, W., & Kane, J. M. (2025). Automated speech and language markers of longitudinal changes in psychosis symptoms. *NPP–Digital Psychiatry and Neuroscience, 3* (1), Article 13. https://www.nature.com/articles/s44277-025-00034-z
[8] Centers for Medicare & Medicaid Services. (n.d.). *Inpatient Psychiatric Facility Patient Assessment Instrument (IPF-PAI): Admission*. U.S. Department of Health and Human Services.

CMS proposes using the IPF-PAI for all patients 18 years and older, and it currently does not plan to expand the IPF-PAI to children or adolescents. **ANA believes that quality data must be collected for patients of all ages, and that CMS must develop a comparable instrument to the IPF-PAI for children and adolescents enrolled in Medicare needing inpatient psychiatric care.** Having an instrument and collecting data for adolescents and children is of particular importance since many of the pediatric or adolescent patients enrolled in Medicare qualify due to end-stage renal disease, which can pose additional care needs.

2. CMS should not remove the Tobacco Use Treatment Provided or Offered at Discharged (TOB-3/3a) measures from the IPF QRP.

Due to an increased burden of tobacco usage and tobacco-related health conditions among the IPF patient population, tobacco cessation offerings are an important component of well-rounded, patient-centered care in IPFs. However, CMS proposes removing both the Tobacco Use Treatment Provided (TOB-3) measure and the Tobacco Use Treatment Offered at Discharge (TOB-3a) subset from the IPF QRP, citing that TOB-3 performance data has remained stable over time. CMS believes, based on that data, that the TOB-3/3a measures are no longer driving IPF facilities to increase their offerings of tobacco cessation interventions. Even though the performance data has been relatively stable with TOB-3/3a in place, the removal of TOB-3/3a could reduce facilities' compliance in offering tobacco cessation interventions by no longer incentivizing the practice.

The IPF patient population is disproportionately more likely to use tobacco than the general public. For example, American adults in serious psychological distress are twice as likely to use tobacco products as those who are not undergoing serious psychological distress.[9] Certain psychiatric conditions have higher rates of tobacco usage, such as schizophrenia, where over 70% of persons diagnosed with schizophrenia use tobacco, with hypotheses for why ranging from self-medication to the potential role of tobacco in developing the disease.[10] As a result of this increased tobacco usage, persons diagnosed with schizophrenia have higher rates of tobacco-related health harms, such as tobacco-related cardiovascular or respiratory conditions.[11]

Given the disproportionate tobacco usage among IPF patients and the impact that it has on psychiatric patients' overall health, incentivizing IPFs to provide tobacco cessation is of particular importance for patient health, psychiatric care providers, and for the overall goals of the Medicare

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[9] Cornelius, M. E., Loretan, C. G., Jamal, A., Davis Lynn, B. C., Mayer, M., Alcantara, I. C., & Neff, L. (2023). Tobacco product use among adults — United States, 2021. *Morbidity and Mortality Weekly Report, 72* (18), 475–483. https://doi.org/10.15585/mmwr.mm7218a1

[10] Ding, J. B., & Hu, K. (2021). Cigarette smoking and schizophrenia: Etiology, clinical, pharmacological, and treatment implications. *Schizophrenia Research and Treatment, 2021,* Article 7698030. https://doi.org/10.1155/2021/7698030

[11] Callaghan, R. C., Veldhuizen, S., Jeysingh, T., Orlan, C., Graham, C., Kakouris, G., Remington, G., & Gatley, J. (2014). Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. *Journal of Psychiatric Research, 48* (1), 102–110. https://doi.org/10.1016/j.jpsychires.2013.09.014

program. Therefore, **ANA opposes the removal of TOB-3/3a from the IPF QRP due to the disproportionate burden of tobacco usage among the IPF patient population and due to the need to continue to incentivize offering tobacco cessation treatment for IPF patients.**

3. CMS must consider the nursing perspective in any actions regarding outlier payments.

CMS is soliciting comment on factors that contribute to higher costs at facilities receiving high shares of outlier payments. In particular, CMS asks whether facilities are incentivized to provide longer lengths of stay to receive outlier payments, especially when there is bed capacity. *Psychiatric-Mental Health Nurse Practitioners do not feel pressured into or incentivized by their facility to hold a patient for longer than medically necessary for larger payments; in fact, doing so would go against the Code of Ethics for Nurses.*[12] Instead, longer length of stay (LOS) at an IPF can often be the result of long waits for placement to a safe and appropriate facility for a patient's needs, thus requiring a patient's LOS to be extended.[13, 14]

An IPF patient who needs long-term inpatient care will frequently need to be discharged to a state facility or a skilled nursing facility. It often takes weeks or months for beds to become available at state-run psychiatric facilities, resulting in the IPF holding the patient for longer despite the patient being ready for discharge.[15] Thus, IPFs having higher rates of outlier payments could be due to an insufficient number of beds at nearby continuing care facilities. Relatedly, in states where there are very few state IPF beds for civil commitments—like Hawaii and Missouri, where state hospitals almost exclusively provide care to forensic patients—IPFs can become de facto long-term care facilities for certain individuals with chronic mental illness whose symptoms have not adequately responded to available treatments, who experience difficulty sustaining outpatient care, or whose symptoms worsen in the context of housing instability and limited access to community-based resources.[16]

Another potential cause for higher outlier rates for certain facilities is an individual IPF's admission criteria. Although CMS analyses suggest that case-mix differences alone do not appear to fully

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[12] American Nurses Association. (2025). Code of ethics for nurses with interpretive statements (2nd ed.). American Nurses Association. https://www.nursingworld.org/coe

[13] American Psychiatric Association. (2022). *The psychiatric bed crisis in the U.S.: Understanding the problem and moving toward solutions* (APA Presidential Task Force on the Assessment of Psychiatric Bed Needs in the United States). https://www.psychiatry.org/getmedia/81f685f1-036e-4311-8dfc-e13ac425380f/APA-Psychiatric-Bed-Crisis-Report-Full.pdf

[14] Massachusetts Health & Hospital Association (2023, January). *Psychiatric patient access to continuing care services*. https://www.mhalink.org/reportsresources/bh-continuingcare-report/

[15] Massachusetts Health & Hospital Association, & Massachusetts Association of Behavioral Health Systems. (2023, January 12). *Psychiatric patient access to continuing care services*. https://assets.informz.net/mhalink/data/images/22-01-12ADVPsychiatric%20Patient%20Access%20to%20Continuing%20Care%20Services.pdf

[16] Treatment Advocacy Center. (2023). *Prevention over punishment: The unmet mental health treatment need in America's jails and prisons*. https://www.tac.org/wp-content/uploads/2024/01/Prevention-Over-Punishment-Full-Report.pdf

explain the substantial difference in per diem routine charges, they are a major contributing factor. Some IPFs may not allow involuntary admissions, or they may limit geriatric patients, or even exclude patients with developmental disabilities and medical needs. For example, if a facility allows involuntary admissions, an involuntary patient may wait days for a scheduled commitment hearing. Then, the patient may need a medication panel, an appeal of the medication panel, and would then need time to respond to medication and stabilize. Therefore, admission criteria are impacting longer LOS—a factor that CMS believes is behind much of the high outlier rates for certain facilities.

CMS is also inquiring whether beneficiaries perceive differences in quality, outcomes, or value between higher-cost and lower-cost facilities. On a purely economic basis, higher-cost psychiatric facilities draw in more funds due to their higher costs, and these costs can go towards staffing and provider wages. The reverse would apply to lower-cost facilities, who take in less money, and are therefore more likely to struggle with both recruiting staff and maintaining adequate staffing than a nearby higher-cost facility.

Evidence shows that appropriate nurse staffing is associated with improved patient outcomes, greater satisfaction for patients and nurses, reductions in preventable events, shorter LOS, and reduced patient mortality, thus positively impacting overall care quality.[17, 18, 19, 20, 21] Meanwhile, inadequate nurse staffing can cause major physical, emotional, and psychological stress on nurses, placing a strain on the healthcare system overall and can negatively impact the care that facilities and their providers give.[22, 23] Appropriate staffing can reduce nurse fatigue and burnout, which can improve nurse retention.[24] In turn, improved retention increases the amount of nursing

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[17] American Nurses Association. (n.d.). *Nurse staffing*. https://www.nursingworld.org/practice-policy/nurse-staffing/

[18] Needleman, J., Liu, J., Shang, J., Larson, E. L., & Stone, P. W. (2020). Association of registered nurse and nursing support staffing with inpatient hospital mortality. *BMJ Quality & Safety, 29*(1), 10–18. https://doi.org/10.1136/bmjqs-2018-009219

[19] Kane, R. L., Shamliyan, T. A., Mueller, C., Duval, S., & Wilt, T. J. (2007). The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. Medical Care, 45(12), 1195–1204. https://doi.org/10.1097/MLR.0b013e3181468ca3

[20] Aiken, L. H., Cerón, C., Simonetti, M., Lake, E. T., Galiano, A., Garbarini, A., Soto, P., Bravo, D., & Smith, H. L. (2018). Hospital nurse staffing and patient outcomes. *Revista Médica Clínica Las Condes, 29*(3), 322–327. https://doi.org/10.1016/j.rmclc.2018.04.011

[21] American Nurses Association. (n.d.). *The nurse staffing crisis*. https://www.nursingworld.org/practice-policy/nurse-staffing/nurse-staffing-crisis/

[22] Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA, 288*(16), 1987–1993. https://doi.org/10.1001/jama.288.16.1987

[23] Kanai-Pak, A., Aiken, L. H., Sloane, D. M., & Poghosyan, L. (2008). Poor work environments and nurse inexperience are associated with burnout, job dissatisfaction and quality deficits in Japanese hospitals. *Journal of Advanced Nursing, 61*(3), 307–316. https://doi.org/10.1111/j.1365-2702.2008.02639.

[24] American Nurses Association. (n.d.). Shaping the Future—Nurse Staffing Task Force. ANA. https://www.nursingworld.org/test-landing/nurse-staffing-task-force/

experience in a facility, which is linked to quality of care, and this is of particular concern for IPFs since behavioral health was the nursing specialty with the highest RN turnover in 2025. [25, 26] Altogether, if certain higher-cost facilities have better staffing than lower-cost facilities, beneficiaries would be likely to perceive differences in care due to actual care quality differences associated with adequate staffing. **As such, CMS must consider the importance that adequate staffing has on the quality of IPF care and on a patient's LOS when making changes to outlier payments.**

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ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with CMS on shared priorities. Please contact Tim Nanof, ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,

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Chief Nursing Officer

cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer

[25] Kanai-Pak, A., Aiken, L. H., Sloane, D. M., & Poghosyan, L. (2008). Poor work environments and nurse inexperience are associated with burnout, job dissatisfaction and quality deficits in Japanese hospitals. *Journal of Advanced Nursing, 61*(3), 307–316. https://doi.org/10.1111/j.1365-2702.2008.02639.
[26] NSI Nursing Solutions. (2026). 2026 NSI National Health Care Retention & RN Staffing Report. https://www.nsinursingsolutions.com/documents/library/nsi_national_health_care_retention_report.pdf