Date: June 1, 2026

Administrator Mehmet Oz, M.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1847-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted via: www.regulations.gov (File Code: CMS-1847-P)

Comment Letter: FY 2027 Inpatient Psychiatric Facility Prospective Payment System Proposed Rule

Dear Administrator Oz:

The Long-Term Post-Acute Care Health Information Technology (LTPAC Health IT) Collaborative is an invitation-only group of national associations, organizations, and subject matter experts committed to advancing meaningful, effective, and accessible health information technology policies, strategies, standards, resources, products, and services for persons with chronic and/or complex needs. Formed in 2005, the Collaborative brings together clinical, provider, information technology, and research expertise specifically representing Long-Term and Post-Acute Care (LTPAC) settings, including skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health, hospice, and behavioral health providers.

We appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the FY 2027 Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS), published in the Federal Register on April 14, 2026 (CMS-1847-P). The Collaborative is particularly invested in this proposed rule because it contains what we believe to be the first instance of CMS mandating FHIR-based patient assessment data submission for a statutory quality reporting program, a landmark development with profound implications for the broader post-acute and long-term care continuum.

Overarching Comments and Recommendations

The Collaborative is uniquely positioned to comment on this proposed rule because our member organizations represent the full post-acute and long-term care ecosystem, the settings to which patients are most frequently discharged from inpatient psychiatric facilities. Transitions of care from IPFs to skilled nursing facilities, long-term care hospitals, home health, and community-based services are common, and the quality and timeliness of health information exchange during those transitions directly affect patient safety and care quality.

We commend CMS for proposing the IPF Patient Assessment Instrument (IPF-PAI) as a foundational step in standardizing clinical assessment data collection for inpatient psychiatric

settings and for advancing FHIR-based reporting as a submission pathway. These proposals align with the broader trajectory of healthcare interoperability under the 21st Century Cures Act, the IMPACT Act, and the CMS Interoperability and Patient Access Final Rule. We offer the following comments to strengthen implementation, extend the benefits of this initiative to the broader care continuum, and address practical concerns of providers and health IT developers who will be responsible for operationalizing these requirements.

Our comments address the following priority areas:

- IPF Patient Assessment Instrument (IPF-PAI): FHIR-Based Submission and Web Application
- Data Element Library (DEL): Standardization, Expansion, and Cross-Setting Utility
- Implementation Timeline: Vendor Readiness, Provider Adoption, and Staged Milestones
- IPF-PAI Assessment Items: Cross-Setting Functional Status and Validated Screening Tools
- iQIES as Receiving Platform: Consistency with Post-Acute Care Precedent
- Scalability of the FHIR-Based Reporting Infrastructure for PAC Settings
- Education, Technical Assistance, and Support for Under-Resourced Organizations
- IPF-PAI Data Use for Future Payment Methodology Revision
- Proactive Recommendation: Advance Care Planning as a Future IPF-PAI Data Element

The Collaborative appreciates the significant policy advances proposed in the FY 2027 IPF PPS rule, particularly the introduction of FHIR-based patient assessment data submission. This milestone has the potential to reshape quality reporting not only for inpatient psychiatric facilities but for the entire post-acute and long-term care continuum. Realizing this potential requires deliberate attention to implementation infrastructure, cross-setting scalability, provider and vendor readiness, and equitable access to education and technical assistance.

We urge CMS to:

1. Extend the implementation timeline to at least 12 months, with staged milestones and early sandbox access
2. Design the FHIR infrastructure — including the web app, DEL integration, and iQIES architecture — with cross-setting scalability as an explicit design requirement
3. Expand the DEL to include additional clinical content and position it as the cross-setting interoperability backbone for patient assessment data
4. Align IPF-PAI assessment items with IMPACT Act cross-setting standards and commit to a roadmap for domain expansion
5. Require the use of validated screening tools for suicide risk assessment
6. Invest in provider and vendor education through learning hubs and direct technical assistance programs
7. Consider future inclusion of advance care planning documentation as an IPF-PAI data element

IPF-PAI FHIR-Based Submission and Web Application

Support for FHIR as the Reporting Standard

The Collaborative strongly supports CMS's proposal to implement FHIR-based submission as a pathway for IPF-PAI data reporting, using HL7 FHIR R4 (v4.0.1). This represents a historic milestone. The first time CMS has mandated FHIR for patient assessment data submission in a statutory quality reporting program. We affirm this direction and encourage CMS to treat this initiative as the foundation for a broader evolution toward FHIR-based quality reporting across all post-acute and long-term care settings.

We recommend that CMS explicitly align the FHIR implementation guides (IGs) for the IPF-PAI with the United States Core Data for Interoperability (USCDI) standards and emerging USCDI+ Behavioral Health data elements. Alignment with USCDI ensures that assessment data captured in the IPF setting can be understood, exchanged, and used by receiving providers across the care continuum in a standardized, interoperable format. We further encourage CMS to reference and build upon the work of the PACIO Project (Post-Acute Care Interoperability), which has developed FHIR IGs specifically designed to support the exchange of functional status, cognitive status, and related assessment data during care transitions. The PACIO IGs offer a proven, consensus-based foundation for expanding interoperable exchange of IPF-PAI data into and out of inpatient psychiatric settings.

The CMS-Developed Web Application: Support with Caveats

The Collaborative acknowledges the practical necessity of a CMS-developed web application as an interim submission pathway for organizations, particularly smaller, under-resourced IPFs, that lack the EHR infrastructure or vendor support to implement FHIR APIs in the near term. We recognize that the web application developed in collaboration with MITRE and using iQIES as the receiving platform reflects CMS's commitment to ensuring broad provider access to the new reporting pathway.

However, we urge CMS to address the following design and implementation concerns:

- **Workflow Integration:** Staff working in inpatient psychiatric settings should not be required to navigate between two separate platforms, their EHR and a CMS web application, to complete assessment documentation. We strongly recommend that CMS design the web application to support SMART on FHIR launch functionality, enabling clinicians to access the application directly from within their EHR workflow without leaving their primary clinical environment. Seamless integration is essential to minimize documentation burden, reduce transcription errors, and support clinical adoption.
- **Bidirectional Data Exchange:** We ask CMS to clarify whether the web application is designed exclusively for data submission to CMS, or whether it supports bidirectional data exchange, including the ability to retrieve previously submitted data, receive feedback from iQIES, and ultimately support real-time quality measure calculation and results display. The Collaborative strongly recommends that CMS design the application

with bidirectional exchange in mind from the outset. A unidirectional submission tool that cannot support call-and-response capabilities will not serve as a viable long-term infrastructure for quality improvement or care coordination.

- **Interim Solution Designation:** The Collaborative recommends that CMS explicitly characterize the web application as an interim solution, with a stated commitment to transition providers toward full FHIR API integration within a defined timeframe. This designation should be accompanied by a roadmap for full FHIR adoption, including milestones, technical assistance resources, and a sunset timeline for the web application pathway.

API Certification, Validation, and Security

The Collaborative appreciates that CMS is requiring the use of standardized, secured, and vetted APIs consistent with the 21st Century Cures Act and ONC's certification framework. We note with interest the evolving landscape of API validation, including the shift toward validation through contractual agreements with Qualified Health Information Networks (QHINs) under the Trusted Exchange Framework and Common Agreement (TEFCA). We are concerned, however, that smaller providers and vendors may face challenges in understanding their obligations and may encounter difficulties negotiating appropriate interoperability language in vendor contracts.

We recommend that CMS and ONC jointly develop and publish a clear guidance document specifying what compliance with the FHIR API requirements means in practical terms for IPF providers, including what questions to ask their EHR vendors, what contractual provisions to look for, and what recourse is available when vendors are unable or unwilling to support required functionality. Providers should not be left to independently develop contract language to ensure interoperable exchange.

We also encourage CMS to monitor the progress of ONC's efforts to establish a more formalized API validation and quality assurance process sometimes described as a "good housekeeping seal of approval" for APIs. A transparent, standardized validation mechanism would significantly benefit both providers and the interoperability ecosystem, and we recommend CMS support ONC's advancement in this direction.

Data Element Library: Standardization, Expansion, and Cross-Setting Utility

The Collaborative strongly supports CMS's use of the Data Element Library (DEL) as the foundation for standardizing terminology in IPF-PAI data collection. The DEL's role in associating standardized terminology, including LOINC and SNOMED codes, with assessment instrument items is a critical step toward enabling consistent, computable data across care settings.

We recommend the following expansions and enhancements to the DEL as part of this rulemaking and future iterations:

- **Expand DEL to Include Broader Clinical Content:** The DEL currently focuses primarily on assessment instrument items. We recommend that CMS consider expanding the DEL to incorporate additional clinical content, including primary medical condition coding, comorbidity data, and relevant care plan information, to better support real-time data exchange and longitudinal quality measurement. Assessment data alone is insufficient to support the full range of cross-setting care coordination and research use cases.
- **Use the DEL as a Foundation for Cross-Setting Transitions of Care:** The IPF-PAI provides a timely opportunity to establish the DEL as the authoritative, cross-setting reference for standardized data elements used in transitions of care. We urge CMS to explicitly position the DEL as the interoperability backbone for patient assessment data exchange across inpatient psychiatric, skilled nursing, long-term care hospital, inpatient rehabilitation, home health, and hospice settings. The use of common data element definitions and terminologies across these settings would dramatically improve the quality and utility of referral packets, discharge summaries, and care transition documents.
- **Support Bidirectional Sharing via the DEL:** We ask CMS to describe how DEL-standardized data elements will support bidirectional data sharing, including transitions of care, referrals, and longitudinal quality measurement, and to align this work with the PACIO Project's FHIR IGs for functional status and cognitive status exchange.
- **Pilot Expansion of the DEL with Medical Information and Coding:** We recommend that CMS initiate a pilot program to test the expansion of the DEL with additional medical information and coding (e.g., daily notes, progress notes, structured clinical documentation) to evaluate the feasibility and value of a more clinically comprehensive data element standard. Broader DEL adoption across settings and data types would accelerate the vision of longitudinal, interoperable health records for persons with complex needs.

Implementation Timeline: Vendor Readiness, Provider Adoption, and Staged Milestones

The Collaborative is concerned about the proposed implementation timeline. Publication of the FHIR implementation guide at least six months before reporting begins is insufficient to support the level of vendor development, testing, provider training, and workflow redesign required for successful adoption, particularly for smaller and under-resourced organizations.

Based on our members' extensive experience with health IT implementation across LTPAC settings, we recommend the following:

- **Extend the Implementation Guide Publication Timeline to at Least 12 Months Prior to Mandatory Reporting:** Twelve months is a more realistic minimum for vendors to develop, test, certify, and deploy updated software; for providers to complete procurement, training, and workflow redesign; and for CMS to identify and address early implementation challenges before mandatory reporting begins. Six months is routinely insufficient even for well-resourced acute care hospitals, for inpatient psychiatric

facilities, many of which are smaller and operate with limited IT staff, this timeline poses serious compliance risks.

- **Require Production-Like Sandbox Availability:** CMS should require that a production-like sandbox testing environment be available to vendors and providers no later than 18 months before mandatory reporting begins. Early sandbox access enables vendors to begin development and testing against realistic data environments and allows providers to validate workflows before the go-live date.
- **Establish a Staged Milestone Framework:** We recommend that CMS publish a formal staged implementation roadmap with defined milestones, including:
    - FHIR IG publication and sandbox availability;
    - Voluntary submission period open to all providers;
    - Technical assistance and training completion targets; and
    - Mandatory reporting commencement.
    - This structured approach, modeled on successful implementations in other CMS programs, distributes the implementation burden over time and reduces the risk of widespread non-compliance at go-live.
- **Establish an Exemption or Exception Process:** CMS should establish a documented exception or hardship process for facilities that, despite good-faith efforts, are unable to meet reporting requirements within the initial mandatory timeline due to vendor unreadiness or limited IT capacity. This process should not be a substitute for adequate timelines, but should serve as a safety valve for exceptional circumstances.
- **Compliance Threshold Alignment:** Before finalizing the 80% compliance threshold proposed for FY 2029, we recommend that CMS confirm the precise definition and measurement methodology of the threshold and align it with precedents established for PAC assessment programs. We also recommend that technical assistance supports be tied to compliance threshold targets, so that providers approaching but not meeting the threshold receive prioritized outreach.

IPF-PAI Assessment Items: Cross-Setting Functional Status and Validated Screening Tools

Cross-Setting Functional Status Standardization

The Collaborative strongly supports CMS's inclusion of a functional status item (Mobility: Chair/Bed-to-Chair Transfer) in the IPF-PAI. We note that this item reflects the same conceptual domain as functional status items used in other post-acute care assessment instruments, the IRF-PAI, MDS 3.0, and OASIS, and represents an important step toward the cross-setting standardization of functional status data envisioned by the IMPACT Act of 2014.

We urge CMS to explicitly affirm, in the final rule, its commitment to aligning the IPF-PAI functional status item(s) with the cross-setting data standards established under the IMPACT Act. We further recommend that CMS commit to expanding the IPF-PAI's functional status domain over time, using future rulemaking to add IMPACT Act-aligned domains such as Activities of Daily Living (ADLs), cognitive status, pain assessment, skin integrity, and other

domains currently collected in IRF-PAI, MDS, and OASIS to enable meaningful cross-setting quality comparisons and population health research.

The current IPF-PAI proposal captures only a single functional status item. While we recognize this reflects the initial phase of implementation, the Collaborative recommends that CMS publish a planned roadmap for PAI domain expansion, with a specific timeline for adding additional IMPACT Act-aligned functional status and cognitive status elements in future payment years.

Suicide Screening: Validated, Industry-Standard Tools

The Collaborative affirms the clinical relevance and urgency of including a suicide screening item in the IPF-PAI's cognitive and mental status domain. Inpatient psychiatric facilities serve patients at elevated risk of self-harm, and standardized, systematic screening is essential to patient safety and quality improvement.

We recommend that CMS specify, either in the final rule or accompanying sub-regulatory guidance, that the suicide screening item be completed using a validated, industry-standard tool, such as the Columbia Suicide Severity Rating Scale (C-SSRS). Use of a validated, widely adopted instrument ensures clinical relevance, supports comparability of data across facilities, and aligns with evidence-based practice. We caution against the use of non-validated screening approaches that may produce inconsistent or clinically unreliable data across facilities.

Sensory and Communication Items

The Collaborative affirms CMS's inclusion of hearing, vision, and speech clarity items in the IPF-PAI at admission. We note alignment with analogous sensory items in the MDS and IRF-PAI and support continued cross-setting consistency in how these items are defined and coded.

iQIES as Receiving Platform: Consistency with Post-Acute Care Precedent

The Collaborative strongly supports the use of iQIES as the receiving platform for IPF-PAI data. iQIES is already the established submission and data management infrastructure for MDS (SNF), IRF-PAI (IRF), LCDS (LTCH), and OASIS (Home Health) data — and the use of this shared platform for IPF-PAI data represents a meaningful step toward a unified, consistent post-acute and behavioral health quality data infrastructure.

We encourage CMS to articulate a longer-term vision for iQIES that includes not only data receipt but also real-time feedback, quality measure calculation, and a call-and-response architecture that enables providers to query their own data, receive calculated quality measure results, and use the platform as a tool for internal quality improvement not merely a regulatory reporting endpoint. We recommend that CMS publish a roadmap for iQIES capability expansion, including timelines for implementing real-time calculation and feedback features, so that providers and vendors can plan accordingly.

Scalability of FHIR-Based Reporting Infrastructure for Other PAC Settings

The Collaborative views the IPF-PAI FHIR-based reporting initiative as more than an IPF-specific program enhancement it is, potentially, the first instance of a scalable, replicable infrastructure for FHIR-based patient assessment data submission that can and should be extended to other post-acute care settings: skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health, and hospice.

We strongly recommend that CMS design the IPF-PAI FHIR infrastructure with explicit scalability in mind, so that the FHIR IGs, web application, iQIES receiving architecture, DEL integration, and compliance framework can serve as a replicable template for other PAC settings. Building isolated, setting-specific infrastructure that cannot be leveraged across settings would result in duplicative investment, fragmented data infrastructure, and missed opportunities for cross-setting interoperability.

We specifically recommend that CMS:

- Document the architectural design decisions for the IPF-PAI FHIR infrastructure in a publicly available technical report
- Convene a cross-setting working group, including representatives from IPF, SNF, IRF, LTCH, home health, and hospice settings, to evaluate the applicability of the IPF-PAI model to other settings
- Commit in the final rule to a cross-setting scalability evaluation prior to the mandatory reporting start date

This investment will ensure that the IPF-PAI implementation is not a bridge that dead-ends, but rather a bridge that connects the full post-acute and behavioral health care continuum.

Education, Technical Assistance, and Support for Under-Resourced Organizations

The Collaborative is concerned about the capacity of smaller, under-resourced IPF facilities to implement FHIR-based reporting without significant education and technical assistance. Many inpatient psychiatric facilities, particularly independent, rural, or community-based providers, have limited IT staff, limited resources for vendor negotiations, and limited familiarity with FHIR standards and API implementation.

We recommend that CMS and ONC jointly develop and disseminate:

- **Provider-Facing FHIR Education Toolkits:** Practical, plain-language guides explaining what FHIR reporting means for IPF providers, what questions to ask their EHR and software vendors, and what steps are required to prepare for mandatory reporting. These resources should be available well in advance of the mandatory reporting date.
- **Vendor Guidance on Standardized, Secure API Implementation:** CMS and ONC should publish technical guidance for EHR and software vendors on the specific API

requirements for IPF-PAI FHIR submission, including conformance expectations, security requirements, and testing criteria. Clear vendor guidance reduces the risk of fragmented, non-interoperable implementations.

- **Learning Hub or Consultation Model for Smaller Providers:** We recommend that CMS explore the establishment of a consultative learning hub or technical assistance program, potentially operated through existing entities such as Mathematica (which currently leads Quality Payment Program technical assistance work) or other qualified organizations with expertise in post-acute care health IT, to provide hands-on support to under-resourced IPF providers. This model, analogous in spirit to the HITECH Regional Extension Centers, would provide targeted, setting-specific guidance to organizations that cannot navigate implementation independently.
- **State Association Limitations:** The Collaborative recognizes that many state associations have limited staff capacity and resources, making it impractical to rely on state affiliates as the primary vehicle for scaling implementation education. Federal investment in direct technical assistance programs, rather than routing resources solely through state associations, is essential to ensure that the benefits of this initiative reach small and under-resourced providers equitably.

IPF-PAI Data Use for Future Payment Methodology Revision

Section 4125(b) of the Consolidated Appropriations Act of 2023 (CAA 2023) requires CMS to use IPF-PAI data to revise the IPF PPS payment methodology by FY 2031. The Collaborative supports this data-driven approach to payment reform and offers the following recommendations:

- **Transparent, Data-Driven Methodology:** CMS should publish detailed, transparent analyses of IPF-PAI data as the basis for any payment methodology revisions, consistent with the approach used for IMPACT Act-aligned payment reforms in other PAC settings.
- **Public Data Availability:** We recommend that CMS make IPF-PAI data publicly available — similar to the public release of MDS and OASIS data sets — to support independent research, quality benchmarking, and policy analysis by the broader healthcare community.
- **Cross-Setting Alignment:** We encourage CMS to align the IPF payment reform timeline and methodology with cross-setting interoperability goals, so that IPF payment policy leverages the same interoperable data infrastructure being built for PAC settings under the IMPACT Act.

Proactive Recommendation: Advance Care Planning as a Future IPF-PAI Data Element

While the FY 2027 IPF PPS proposed rule does not include a specific Request for Information on Advance Care Planning (ACP), the Collaborative notes that the IPF-PAI development process includes a provision for the Secretary to add "other categories as determined appropriate" to the assessment instrument. We respectfully recommend that CMS consider the

future inclusion of goals of care and advance care planning documentation status as an IPF-PAI data element in future rulemaking.

Patients receiving inpatient psychiatric care frequently have complex, chronic medical conditions alongside their behavioral health needs. Systematic documentation of ACP status at admission, including whether an advance directive exists and is accessible, would support person-centered care, improve transitions of care to post-acute and palliative settings, and align with the Collaborative's longstanding advocacy for ACP documentation across all care settings. This recommendation is also consistent with USCDI Behavioral Health priorities and the broader national effort to improve goals-of-care documentation for persons with complex needs.

Conclusion

As stated in the Overarching Recommendations section at the beginning of comments, the LTPAC Health IT Collaborative appreciates the significant policy advances proposed in the FY 2027 IPF PPS rule, particularly the introduction of FHIR-based patient assessment data submission. This milestone has the potential to reshape quality reporting not only for inpatient psychiatric facilities but for the entire post-acute and long-term care continuum. Realizing this potential requires deliberate attention to implementation infrastructure, cross-setting scalability, provider and vendor readiness, and equitable access to education and technical assistance.

We respectfully urge CMS to:

8. Extend the implementation timeline to at least 12 months, with staged milestones and early sandbox access
9. Design the FHIR infrastructure, including the web app, DEL integration, and iQIES architecture, with cross-setting scalability as an explicit design requirement
10. Expand the DEL to include additional clinical content and position it as the cross-setting interoperability backbone for patient assessment data
11. Align IPF-PAI assessment items with IMPACT Act cross-setting standards and commit to a roadmap for domain expansion
12. Require the use of validated screening tools for suicide risk assessment
13. Invest in provider and vendor education through learning hubs and direct technical assistance programs
14. Consider future inclusion of advance care planning documentation as an IPF-PAI data element

The Collaborative looks forward to continued engagement with CMS and ONC on these issues. We would welcome the opportunity to meet with the relevant program staff to discuss our recommendations in greater detail.

For further information or dialogue, please contact Michelle Dougherty, LTPAC Health IT Collaborative Convener, at leaders@ltpachit.org.

Sincerely,

The LTPAC Health IT Collaborative

For a list of LTPAC Health IT Collaborative members, please visit www.LTPACHIT.org