UnityPoint Health

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June 1, 2026

Administrator Mehmet Oz, MD
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1847-P
P.O. Box 8010
Baltimore, MD 21244–8010

RE: CMS–1847-P - Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update; published at Vol. 91, No. 66 Federal Register 17720-17756 on April 7, 2026.

*Submitted electronically via* http://www.regulations.gov

Dear Administrator Oz,

UnityPoint Health appreciates this opportunity to provide comments on this proposed rule related to Inpatient Psychiatric Facilities (IPF) rates and quality reporting. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 31,000 employees and our relationships with more than 420+ physician clinics, 35 hospitals in urban and rural communities, 13 home care areas of service, and 5 community mental health centers across our 8 regions, UnityPoint Health provides care throughout Iowa, central Illinois, southeast South Dakota, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through more than 8 million patient visits.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed rule. We respectfully offer the following comments limited to quality reporting.

## INPATIENT PSYCHIATRIC FACILITIES QUALITY REPORTING (IPFQR) PROGRAM

*CMS proposes to remove two measures beginning with the CY 2026 reporting period/FY 2028 payment determination: the Alcohol Use Brief Intervention Provided or Offered (SUB-2) and subset Alcohol Use Brief Intervention (SUB-2a) measure and the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and subset Tobacco Use Treatment at Discharge (TOB-3a) measure. CMS also proposes to implement a standardized IPF patient assessment instrument (IPF-PAI), and IPFs will have the option to submit IPFPAI data through a CMS-developed web application or using Application Programming Interfaces (APIs).*

**Comment: UnityPoint Health supports the proposed removal of the two quality measures related to alcohol use and tobacco use.**

As for the new IPF-PAI, we support the general aim of reducing variance in assessment methods across facilities and states; however, **with any new instrument and particularly with an inpatient psychiatric**

**population, CMS must carefully consider time and effort, patient survey fatigue, avoiding duplicative data collection, data completeness standards, and phased-in implementation standards (i.e. initial pay for reporting transitioning into pay for performance)**. For integrated health systems, we urge CMS to consider the cumulative time and effort needed to comply with quality measurement and assessment changes across care settings (IPF, IRF, SNF, Hospice, IPPS, ERSD, Home Health, OPPS, and PFS/QPP), which strain resources and highlight the need for realistic implementation timeframes. The operational burden of adding a new IPF-PAI tool includes the need to build new workflows, potential EMR system changes, the challenge of manual data collection and aggregation, internal validation, and staff/provider training. Once IPF-PAI is implemented, the data collection burden for IPFQR alone is estimated at an 0.8 FTE equivalent and the IPF-PAI comprises 328 hours, or more than 2 months for an FTE equivalent. This data collection burden is underestimated and does not take into account IT resources, mapping, and internal validation requiring costly vendor resources. In this context, we request that CMS consider the following:

- Provide Clear and Consistent Definitions. This will help accurately data capture and build reports as needed. We do appreciate when the same measure constructs are used across care settings when possible.
- Assure Data Completeness Accounts for Patient Participation and Capacity. When a patient declines to answer or is incapable of responding, IPFs should not be penalized for those responses / non-responses.
- Delay IPF-PAI until January 1, 2028. CMS proposes to begin mandatory reporting October 1, 2027, with quarterly manual submissions required for all patients, transitioning to calendar year reporting after the initial period. If the intent is to report on a calendar-year basis, we recommend that CMS not require an initial one-quarter, partial-year reporting period.
- Release Web App at least Six Months Before Implementation. CMS states that the free web app will be “available in spring or summer 2027, prior to the start of the proposed reporting period that would begin October 1, 2027, to allow time for IPFs to gain familiarity with the web app and for CMS to provide training.” While we appreciate this gesture, the “spring or summer 2027” timeframe for the finalized app does not provide assurance that there will be adequate time to become familiar with the web app prior to the submission window. Time is needed to determine how to collect the data manually so that our IPFs in turn can aggregate this data for manual reporting.
- Limit FHIR Changes. For FHIR technology to be easily adaptable and capable of expanding health information exchange in the desired manner, FHIR technology needs to be standardized and consistent across EMR vendors, healthcare facilities, and those identified entities receiving the data, such as public health agencies and CMS. The speed and frequency of FHIR change is dizzying and makes it difficult to get users on the same page. Every change whether methodological or technical requires work and administrative burden for providers on the backend.
- Streamline Quality Reporting Overall. Annually, CMS regularly issues various Medicare payment update regulations for different care settings. This piecemeal approach reinforces

care setting silos and makes it easier to perpetuate disparate quality reporting programs. But when taken as a whole, the cumulative burden of even small or technical changes is overwhelming. Any "big picture" efforts by CMS to reduce this burden would be welcomed.

## STAR RATINGS FOR IPFs

*In last year's proposed IPF rule, CMS sought input on the development of a five-star methodology for IPFs. While CMS did not include a star ratings proposal in this rule, last year's final rule stated that CMS will "continue to develop policies for future rulemaking."*

**Comment:** UnityPoint Health is appreciative that CMS is seeking stakeholder feedback and has expressed a willingness to partner with providers during this development process. We reiterate our comments from last year as inpatient psychiatric beds continue to dwindle, further compromising access to this vital service. In 2002, 50 percent of states reported a shortage of psychiatric beds, but in 2025, that increased to 90 percent of responding states (43 of 48 states).[1] And more specifically, 38 states reported a shortage of psychiatric inpatient beds in non-state hospitals – 28 states experienced acute psychiatric bed shortages, while 19 states reported longer term psychiatric bed shortages.[2] Downstream impacts include increased wait times, ED boarding, and treatment delays.

Foremost, UnityPoint Health believes quality is our best strategy. **When instituting Star Ratings for IPFs, we urge caution and care so as not to inadvertently impact access to acute behavioral health services**. IPFs serve vulnerable patients in crisis situations and, with tightening inpatient operating margins, IPFs are often the first services to close. Should Star Ratings miss their mark, we are concerned for patient access.

Generally, Star Ratings help Medicare beneficiaries compare quality and performance to assist with care decisions. While beneficiaries have some degree of choice in seeking IPF services, patients admitted to IPFs often enter during times of crisis, limiting their ability to make informed choices or comparison shop. In that same vein, the underlying mental condition of IPF patients may also influence subjective assessments related to the quality of and satisfaction with their IPF services. Additionally, IPF populations are not homogeneous – for instance, some include more involuntary commitments, or some include more patients with conditions that are prone to outward manifestations of violence. These factors may skew ratings. While we recognize the importance of quality transparency, the audience and purpose of the IPF Star Ratings should be the primary focus when undertaking and developing this system.

Criteria for measure selection

**When developing an IPF Star Rating system, we recommend that CMS consider**:

- **Established Data**: We encourage CMS to utilize data that has been publicly available for at least a year. This ensures reliability and consistency in the data used for Star Ratings.
- **Sufficient Sample Size**: We encourage CMS to use data with sufficient sample size to ensure the data is representative of the entire population.

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[1] NRI 2025 State Profiles, "Use of State Psychiatric Hospitals, 2025." Accessed at https://nri-inc.org/media/4bofjpqy/smha-use-of-state-psychiatric-hospitals-july-2025-final.pdf

[2] Id, p2.

- **Inclusion of Safety, Quality, and Care Coordination Measures**: We encourage CMS to include safety, quality, and care coordination categories to ensure Star Ratings are representative of overall patient care and have a quality focus.
- **Rating Methodology**. We recommend that CMS use the Star Ratings methodology consistent with inpatient hospital stays, which has been tested over time.
- **Phased Implementation with Preview Periods**: Star Ratings, like the start of any new measurement program, should be phased in over time to ensure measures are accurately collected and reported. In particular, we encourage CMS to consider having a Star Rating preview year allowing for IPFs to review the ratings and provide feedback to CMS before publicly displaying.

Future use of additional data for an IPF Star Rating System

The PIX survey is live and mandatory for the FY 2028 payment determination. **Although UnityPoint Health supports the idea of gathering patient feedback, we recommend against including PIX data in the Star Ratings**.

- IPF Nuances: The PIX survey focuses on capturing patients' perspectives of their inpatient stay, and given the patient makeup, survey results may be influenced by their medical condition and mental state and not by the conditions and quality of their stay. Different states have significantly different laws relating to involuntary civil commitment for mental health conditions. Within our footprint, Iowa and Wisconsin are examples of how involuntary commitments differ. Iowa has the fewest state inpatient psychiatric beds per capita in the country. As such, almost all court commitments are directed towards private hospitals, many of which are classified as IPFs. In Wisconsin, its State detention facilities provide immediate evaluation and treatment for most involuntary patients; however, private hospitals will occasionally treat a court committed patient in an IPF. This typically occurs when the patient arrives at the ED or is admitted to the IPF voluntarily, but then during the inpatient stay the admission becomes involuntary usually due to their condition deteriorating or the patient wanting to leave against medical advice (AMA) and doing so would pose an imminent health and safety risk to the patient or others. When evaluating our internal patient satisfaction system, UnityPoint Health has seen a large variance in satisfaction results between voluntary patients versus involuntary patients – the latter generally have a lower level of patient satisfaction. We are concerned that a national Star Rating for IPFs would not be able to tease out these nuances within PIX Survey results.
- PIX Survey is Untested: It is premature to rely on the PIX survey results. Given this is a new survey, many organizations need time to develop effective workflows and best practices for its administration. Results in the first several years may not be reliable. Also, the PIX survey is distributed onsite in person (i.e., physically distributing a paper version of the survey to the patient while inpatient). This distribution method is extremely challenging. We not only anticipate that responses will be delayed, but overall response rates will likely suffer. And because surveys are de-identified, should they be returned with a complaint, there is no mechanism to follow up. The jury is still out on the efficacy of the PIX survey and data.

- PIX Sample Size: We request that CMS monitor return rates for these surveys, as we are concerned that sufficient sample size may not be achieved.

We are pleased to provide input on this proposed rule and its impact on our IPFs, patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,

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