



The Honorable Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

June 1, 2026

Re: Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update; CMS-1847-P

Dear Dr. Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare, and affiliated health system members, including 19 behavioral health hospitals, we appreciate the opportunity to comment on the Fiscal Year (FY) 2027 Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) proposed rule.

Our comments focus on the market basket update and the outlier payment policy.

MARKET BASKET UPDATE

AzHHA is concerned that the proposed market basket update does not adequately reflect the cost structure of inpatient psychiatric facilities or the ongoing financial pressure facing providers. While CMS estimates a labor-related share of approximately 79% for IPFs, these facilities continue to face workforce challenges that make it difficult to achieve the productivity gains assumed under the Affordable Care Act (ACA).

Behavioral health providers rely on highly specialized staff, including psychiatrists, behavioral health nurses, and support personnel, many of whom remain in short supply. This continues to drive wage growth, reliance on contract labor, and higher recruitment and retention costs. IPFs also serve patients with complex behavioral health and co-occurring medical and social needs. These patients often require more intensive staffing and longer lengths of stay, limiting operational flexibility and increasing per-patient costs in ways not fully reflected in the update.

While national margins may appear stable, that does not reflect the experience of many hospital-based psychiatric units and safety-net providers operating on narrow margins with

limited ability to absorb sustained cost increases. Over time, even small gaps between payment updates and actual cost growth compound and can affect staffing, bed capacity, and access to care.

We recognize CMS is constrained by statute in calculating the annual update. However, we encourage CMS to continue evaluating whether the current methodology reflects real-time labor market conditions and the unique cost drivers of behavioral health care, and to consider recommendations to Congress as appropriate.

OUTLIER PAYMENT POLICY

AzHHA is concerned that the proposed 20% facility-level cap on outlier payments may have unintended consequences for access to inpatient psychiatric care, particularly for providers serving high-acuity and complex patient populations.

We appreciate CMS's analysis showing that outlier payments are concentrated among a relatively small number of providers. However, we caution against the conclusion that these higher payments are primarily driven by facility-level cost structures rather than patient complexity.

IPFs often serve individuals with significant clinical and social complexity, including serious mental illness (SMI), co-occurring substance use disorders, medical comorbidities, and challenges related to housing instability or lack of community-based supports. Providers that serve a disproportionate share of these patients—often safety-net or public hospital systems—frequently experience higher costs driven by longer lengths of stay, more intensive staffing, and limited discharge options.

Certain patient populations, including those receiving court-ordered evaluation or treatment, also have lengths of stay and resource needs driven by legal requirements and system constraints, not just clinical factors. These patients often cannot be discharged based solely on clinical readiness, resulting in extended stays and higher costs outside the facility's control.

More broadly, many of the providers identified as having higher outlier payments serve as key access points for individuals with the most complex behavioral health needs, including those involved in the criminal justice system or those who cannot be placed in lower levels of care. In these cases, extended stays are often driven by gaps in community capacity, including limited residential treatment and supportive housing.

At the same time, behavioral health providers continue to face workforce shortages, particularly for psychiatrists and specialized nursing staff, which further increases the cost of care and is not fully reflected in current payment adjustments.

We are concerned that a facility-level cap—especially one that eliminates outlier payments once the cap is reached—could disproportionately impact providers serving these populations. Over time, this may create disincentives to care for the most complex patients and further

strain access to inpatient behavioral health services.

We encourage CMS to consider alternative approaches, including:

- Refining the outlier methodology to better account for patient complexity and resource use
- Evaluating whether additional adjustments are needed before implementing a cap
- Considering modifications or exceptions for providers that serve a disproportionate share of high-acuity or safety-net populations

We also encourage CMS to continue working with stakeholders to better understand the drivers of higher costs in IPFs, including workforce constraints, patient acuity, legal requirements, and system-level limitations.

We appreciate CMS's efforts to refine the IPF PPS and improve program integrity. However, we urge the agency to carefully consider how these policies, taken together, affect providers' ability to maintain access to inpatient psychiatric care.

Thank you for the opportunity to comment. Please feel free to reach out with any questions.

Sincerely,



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