AMERICAN PSYCHIATRIC ASSOCIATION

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June 9, 2026

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code CMS-1849-P
Baltimore, MD 21244–8010

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1849-P)

Dear Administrator Oz:

The American Psychiatric Association (APA), the national medical specialty society representing over 40,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and Requirements for Quality Programs for FY 2027.

We urge the Administration to consider policies that support not only the sustainability of psychiatric inpatient units, which furnish medically necessary care for individuals with mental illness, but also adequate funding for the full continuum of psychiatric services. Current reimbursement for inpatient psychiatric units does not cover the full cost of care, contributing to the well-documented decline in the number of acute psychiatric inpatient beds over the past several decades. In addition, inadequate reimbursement for the full range of outpatient psychiatric services limits available treatment options both as an appropriate alternative to hospitalization and as essential follow-up care after discharge. As a result, patients often seek care in emergency departments (EDs), experience longer hospital stays or be discharged prematurely without adequate services.

RFI on Timeliness of Admission from the ED
Measuring Emergency Care Access and Timeliness in the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs—Request for Information

Boarding in the ED for psychiatric patients is a significant problem and provides a negative experience for both the staff and patients. The reason for the shortage of inpatient psychiatric beds are numerous and out of the control of the inpatient units and individual psychiatrists. Patients with mental illness should receive care in the least restrictive, medically necessary setting which will reduce the burden on EDs. CMS should provide increased reimbursement

or other incentivization for outpatient services (e.g., crisis services, intensive outpatient services, partial hospitalization, residential care), to ensure patients get access to appropriate treatment and do not continue to cycle in and out of EDs for care.

APA does not support using any version of the proposed Emergency Care Access and Timeliness metric in the Hospital Inpatient Quality Reporting Program. If CMS decides to move forward with this metric in the inpatient setting, we request that psychiatric units be excluded from the measure due to the concerns outlined below.

What are some of the key barriers and challenges faced by inpatient providers in supporting process changes that improve bed availability and reduce ED boarding?

Optimally, mental health systems include a continuum of care that meets people's needs in the most accessible, least restrictive environment, including crisis services, accessible outpatient care, partial hospitalization and intensive outpatient programs, rehabilitation and recovery supports, and inpatient psychiatric care. APA's May 2022 report, The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions, found that this continuum does not exist in most communities.[1]

A report by Ellison, Jansen, Nguyen et al in 2022[2] found that only 46% of the 4,812 Medicare registered hospitals surveyed had even some inpatient psychiatric services available. A measure that examines inpatient psychiatric bed availability would be far more relevant than a measure penalizing the few inpatient units that do admit psychiatric patients.

Psychiatric patients often spend more time in the ED than other patients. For those who need inpatient hospitalization, delays can result from insurance authorization, medical clearance requirements, and limited bed availability. For patients who do not need inpatient admission, prolonged ED stays are often driven by the lack of appropriate lower-level care or insufficient capacity in existing programs, including rehabilitation and skilled nursing facilities. Using SMART medical clearance can help reduce unnecessary testing and shorten ED stays.

Inpatient units must assess available capacity, unit safety, and staffing resources when making admission decisions. Not every unit has the staffing, security support, or specialized expertise needed to manage the most agitated or clinically complex patients. In some cases, units may be able to safely treat multiple patients with lower-acuity needs rather than one patient requiring 1:1 observation, enhanced safety measures, or other intensive interventions. These higher-acuity cases increase costs, including unreimbursed staffing (estimated at $1,500 per patient per day) and safety expenses, and can contribute to staff turnover.

Additionally, cuts to state hospitals have reduced the number of placements for patients with the most severe needs. Many states lack sufficient locked bed capacity for patients who cannot safely

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[1] APA Report on "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions", May 2023. https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report

[2] Ellison A, Jansen L, Nguyen F et al. Specialty Psychiatric Services in US Emergency Departments and General Hospitals: Results From a Nationwide Survey Mayo Clinic Proceedings, 2022; 97, 862-870.

live in the community. Special units for higher-acuity patients require added staffing, specialized training, and stable funding; without them, some patients will continue cycling among the ED, inpatient psychiatric units, and other acute settings.

There are additional barriers for patients with further complex needs. The use of antipsychotics for dementia patients has been contentious. Many patients can only receive care in a skilled nursing facility (SNF) or inpatient hospital unit. Palliative care approaches for patients with severe dementia allow them to receive antipsychotics and be cared for in SNFs rather than remaining in the hospital for long periods of time. However, the present measurement and star rating structure for SNFs restricts the use of antipsychotics without a diagnosis of schizophrenia, Huntington's Disease, or Tourette syndrome, despite FDA approval of at least one antipsychotic for use in agitation in dementia.

For patients with intellectual/developmental disabilities or autism spectrum disorder, there is a lack of specific programs to treat adults who need care. Some hospitals have invested in board certified behavioral analysts to train nurses to administer therapy, but this training is expensive. We recommend CMS provide payment for this training so more hospitals could adequately train staff to handle these patients.

Finally, it is extremely difficult to find a discharge placement that can meet the needs of medically complex psychiatric patients. This is even more challenging for younger patients who cannot qualify for SNFs. Preadmission Screening and Resident Review (PASRR) is a federal requirement for all Medicaid-certified SNFs to ensure individuals with serious mental illness (SMI), intellectual disabilities, or related conditions are not placed in nursing homes inappropriately and receive necessary specialized services. While this is meant to ensure appropriate placement, it may make discharge more difficult overall.

APA is open to discussing strategies that can improve ED boarding, but the larger system issues, especially inadequate community resources and downstream placement capacity, must be addressed rather than focusing measures on inpatient psychiatric units.

What are the best practices for providers within inpatient departments to actively engage with colleagues in other departments, as well as other settings that impact bed availability (for example, post-acute care facilities)? What barriers do providers face, especially rural providers, in establishing protocols for bi-directional communication?

APA recommends several proven best practices that can impact bed availability:

- Allow for payment for social workers or case managers with extensive experience navigating the system to transfer patients to other settings, like SNFs and specialized psych care, improve patient outcomes[3]. This work takes intensive training, research, and knowledge of community resources, and is often not reimbursed. Social workers and case managers must thoroughly understand the patient and their medical record to "make the case" for the patient

[3] Penzenstadler L, Machado A, Thorens G, Zullino D, Khazaal Y. Effect of Case Management Interventions for Patients with Substance Use Disorders: A Systematic Review. Front Psychiatry. 2017 Apr 6;8:51. doi: 10.3389/fpsyt.2017.00051. PMID: 28428761; PMCID: PMC5382199.

at the receiving facilities. Many hospitals do not have adequate numbers of social workers or case managers and much of their time is spent on short-term discharge planning for less complex patients. Incentivizing this work through appropriate payment would improve the care transitions between the hospitals and other facilities.

- Incentivize hospitals to implement units such as EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing). These units, as outlined in 2025 SAMHSA model guidelines, are specialized, calm, and open-floor hospital spaces designed to rapidly stabilize behavioral health emergencies without boarding patients in chaotic EDs. Research[4],[5],[6],[7] shows that these services prevent ED visits, as well as reducing boarding, inpatient admissions, and readmissions.

- Address the lack of reimbursement for community-based crisis facilities and other reimbursement challenges such as higher fees for ambulance transport to non-ED settings.

Additionally, rural hospitals face unique challenges due to the high number of geriatric patients who comprise the majority of hospitalized patients and the lack of availability of SNFs beds when patients are ready for discharge. Furthermore, if the patient was already in an SNF prior to hospitalization, that SNF is not required to take them back after discharge. Finally, the SNF may be required to conduct a utilization review, which is often seen as a reason to refuse psychiatric patients outright. These policies are driven by state mental health laws and vary but must be addressed to help rural communities.

Thank you for the opportunity to provide comments. The ED boarding issue will continue until there is sufficient funding for and access to the full continuum of care for patients with mental health disorders. We hope to work collaboratively with CMS to address this important issue. Please contact Becky Yowell (qualityandpayment@psych.org) with any questions or for more information.

Sincerely,

Kristin Kroeger
Vice President, Advocacy, Policy & Practice Advancement
American Psychiatric Association

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[4] 2022 pre-post EmPATH implementation study showing 53% reduction in inpatient admissions, 70% reduction in boarding times, and 25% improvement in 30 day return visits

[5] A 2022 systematic review and meta-analysis of short-stay crisis units pooled data from 12 studies across 6 countries with 67,505 patients and found significant reductions in emergency department length of stay and inpatient psychiatric admissions.

[6] A 2024 study comparing emergency department utilization across 5 states found a reduction in behavioral health related emergency department visits in ZIP codes containing a walk-in crisis stabilization facility.

[7] A 2024 study of patient flow through the Arizona crisis system (where our most established facilities are located) found that most patients received emergency psychiatric care via mobile crisis or crisis facilities rather than emergency departments and inpatient units.