

## Long-term Care Hospital Reforms

**Reforms are urgently needed to ensure that care continues to be available for Medicare beneficiaries who need specialized, high-acuity and long-stay care.** To that end, the field has agreed that the following reforms are needed to stabilize the long-term care hospital (LTCH) field:

- ▶ **ENSURE ACCESS FOR CERTAIN HIGH-ACUITY BENEFICIARIES.** As noted, the dual-rate payment system requires certain criteria to be met for a beneficiary's care to qualify for full LTCH prospective payment system (PPS) payment. However, these criteria have had the effect of excluding certain high-complexity beneficiaries who need long-term hospitalization from receiving the full LTCH rate for their care. We support reforms that will expand the dual-rate PPS payment criteria to include these beneficiaries.
- ▶ **IMPROVE THE ACCURACY OF THE LTCH PPS.** In addition to expanding access for high-acuity beneficiaries, a more comprehensive examination of the payment system may be warranted. For example, the Centers for Medicare & Medicaid Services (CMS) continues to rely on the same diagnosis-related groups (DRGs) used in the inpatient PPS. In addition, beneficiaries have become concentrated into a limited number of DRGs, resulting in underpayment for the highest-acuity cases, which make up a very high proportion of some LTCHs' discharges. Further, inflation adjustments have not kept pace with LTCHs' cost increases. The AHA found that since 2020, missed forecasts have resulted in CMS underpaying LTCHs \$120 million annually.<sup>1</sup> Revisiting the DRGs and weighting used in the LTCH PPS, as well as the adequacy of the standard payment rate, would ensure that LTCHs do not consistently carry negative margins on such a high proportion of severely ill cases.
- ▶ **CONSIDER CHANGING THE 25-DAY AVERAGE LENGTH OF STAY (ALOS) REQUIREMENT.** The 25-day ALOS requirement was created in 1983 to distinguish LTCHs as hospitals that cared for patients requiring proportionally longer stays than those cared for in general, acute care hospitals. Since that time, medicine and care delivery have changed dramatically, resulting in patients requiring shorter hospital stays. For example, from 1983 through 2020, the ALOS for inpatient PPS discharges decreased by 30%.<sup>2</sup> However, the LTCHs' ALOS requirement has remained at the same threshold. A proportionally lower ALOS requirement would still adequately distinguish LTCHs from general, acute care hospitals, while also allowing LTCHs to take advantage of advances in care that facilitate an earlier discharge for some beneficiaries.

- ▶ **RESTRUCTURE THE LTCH OUTLIER SYSTEM.** The high-acuity, long-term stay care that LTCHs provide makes outlier payments a critical feature of the PPS. Specifically, Medicare pays an additional amount once the cost of the case has exceeded a certain threshold above the payment for the case, known as the fixed-loss amount (FLA). However, as LTCH volume has declined, the proportion of cases qualifying for outlier payments has increased, resulting in the FLA increasing by more than 300% in the last 10 years. This means that LTCHs must absorb tens of thousands of additional dollars in losses before receiving any additional reimbursement for these beneficiaries, running contrary to the goal of the dual-rate payment system of incentivizing care for the sickest beneficiaries in LTCHs. As such, reforms should include additional reimbursement for high-cost outlier beneficiaries, helping to ensure beneficiaries continue to have access to LTCHs.
- ▶ **EXPAND RURAL ACCESS TO LTCHS.** The dual-rate payment system does not allow beneficiaries admitted to LTCHs from certain types of rural facilities, such as critical access hospitals, to qualify for full payment under the LTCH PPS. Congress should modify the LTCH PPS criteria so that beneficiaries from these facilities are eligible to receive full payment. This will help preserve beneficiaries' access to LTCHs.
- ▶ **REIN IN HARMFUL MEDICARE ADVANTAGE (MA) PRACTICES.** Compounding the issues facing LTCHs is the behavior of some MA plans. Specifically, these plans often refuse to add any LTCHs to their provider networks and drastically limit admissions through inappropriate prior authorization practices. Congress should reform MA rules to require LTCHs and other intensive post-acute care providers to be included in MA networks where available, and to ensure that these plans do not use admission practices that result in limited access for MA beneficiaries compared to their traditional Medicare counterparts.

## THE IMPORTANCE OF LTCHS

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LTCHs play a unique role in the care continuum by providing care for the most severely ill Medicare beneficiaries who require extended hospitalization. These specialized hospitals offer a uniquely intensive level of care that is not generally available in other post-acute care settings. For example, beneficiaries discharged to LTCHs, on average, have higher rates of multiple organ failure, ventilator use, and comorbidities and complications compared to beneficiaries discharged to other care settings.<sup>3</sup> Many LTCH beneficiaries depend on ventilators due to respiratory failure or similar ailments, which require highly specialized care.

LTCHs provide essential hospital capacity for beneficiaries needing intensive care who may be too complex to be discharged to skilled nursing facilities or to home health. This alleviates the burden on acute-care hospitals that otherwise may struggle to keep up with care needs as these long-term patients remain in their intensive care units (ICUs). This additional capacity is critical as the country faces a growing hospital bed shortage.<sup>4</sup>

The LTCH field is under severe stress despite its vital role, largely attributable to the dual-rate payment system implemented in 2016. This new system limits full payment under the LTCH PPS to beneficiaries who have either spent three days in an ICU prior to admission or received at least 96 hours of ventilator care in the LTCH. Beneficiaries that do not meet this criterion receive a payment equivalent to what is paid to short-term acute care hospitals, which is well below the cost of LTCH care.

It has become clear that the dual-rate payment system has gone beyond its intended effect of realigning incentives toward more complex beneficiaries and has instead jeopardized the financial stability of the LTCH field. For example, Medicare fee-for-service spending on LTCH care decreased by a cumulative \$11 billion from 2016 to 2022 (the first seven years of the dual-rate system) due to the dual-rate payment system. The level of reduction in LTCH spending exceeded the savings projected by the Congressional Budget Office of \$3 billion over 10 years.<sup>5</sup> Today, annual Medicare spending on LTCH care is about 45% lower than it was prior to the dual-rate payment system, resulting in more than 25% of the nation's LTCHs closing in the last 10 years.<sup>6</sup> In addition, the loss of volume has caused cases to become highly concentrated in a small number of payment groups. Within these categories, the highest acuity cases are not adequately reimbursed.<sup>3</sup>

**The continued loss of LTCH beds will exacerbate growing hospital and post-acute capacity concerns in markets throughout the country.**

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<sup>1</sup> [aha.org/lettercomment/2025-06-10-aha-comments-cms-long-term-care-hospital-fy-2026-proposed-payment-rule](https://aha.org/lettercomment/2025-06-10-aha-comments-cms-long-term-care-hospital-fy-2026-proposed-payment-rule)

<sup>2</sup> FY 1984 and 2021 inpatient PPS proposed rules.

<sup>3</sup> KNG Health. Medicare Payment Policy for Long-Term Acute Care Hospitals: An Assessment of Patient Complexity and Payment Accuracy. [cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/ltach\\_roundtabley\\_01052024.pdf](https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/ltach_roundtabley_01052024.pdf)

<sup>4</sup> Leuchter RK, Delarmente BA, Vangala S, Tsugawa Y, Sarkisian CA. Health Care Staffing Shortages and Potential National Hospital Bed Shortage. JAMA Netw Open. 2025. [jamanetwork.com/journals/jamanetworkopen/fullarticle/2830387](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830387)

<sup>5</sup> KNG Health Consulting analysis of data from MedPAC July 2024 Data Book and CMS Program Statistics - Medicare Inpatient Hospital. LTCH spending reduction estimated based on historical trends of LTCH spending equal to 4% of total Medicare fee-for-service hospital spending (excluding LTCH spending) prior to dual-rate payment system.

<sup>6</sup> AHA analysis of CMS' claim files.