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June 8, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Re: Medicare Program; Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes; 91 Fed. Reg. 19,312 (April 14, 2026).

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, including approximately 230 long-term care hospitals (LTCHs); our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') fiscal year (FY) 2027 LTCH prospective payment system (PPS) proposed rule. We are submitting separate comments on the rule's inpatient PPS and Comprehensive Care for Joint Replacement Expanded Model proposals.

LTCHs care for some of the most complex and severely ill Medicare beneficiaries. As CMS points out in this rule, approximately 93% of Medicare patients are dependent on a ventilator when arriving at an LTCH, have spent three or more days in an intensive care unit, or both. These patients have high rates of complex wounds, chronic illness and other factors that make the LTCH patient population a uniquely resource-intensive group. For these reasons, LTCHs maintain a deeply specialized expertise that enables them to care for these patients and maximize their chances of recovery. Indeed, many acute care hospitals rely on LTCHs as partners to care for patients with these specific high-acuity needs.

As such, the AHA urges CMS to strengthen the FY 2027 LTCH payment update by revisiting the market basket forecast and working with Congress to reduce the

magnitude of the productivity adjustment. Current market basket increases, especially when reduced by the productivity adjustment, do not reflect hospitals' rising labor, drug, supply and administrative costs. The AHA also urges CMS to finalize its proposed freeze to the high-cost outlier (HCO) fixed-loss amount (FLA). Additionally, we continue to be troubled by continued increases in the FLA and urge the agency to make additional policy changes to avoid disruptions to care.

Our detailed comments follow.

PROPOSED FY 2027 LTCH PPS PAYMENT UPDATES

The combination of rising costs due to inflation and the novel dual-rate payment system imposed on LTCHs has challenged the field, with many hospitals unable to continue to operate under the pressures created by the confluence of these factors. Indeed, more than 100 LTCHS — nearly a quarter of these hospitals — have closed since 2016, when the dual-rate payment system went into effect. This loss of important hospital capacity creates strain on the continuum of care for Medicare beneficiaries, as well as upstream acute-care hospitals and other providers. We therefore urge CMS to take action to increase reimbursement for LTCHs, avoid further closures in the field and help maintain access to this critical care for Medicare beneficiaries. **Specifically, we urge the agency to revisit its market basket forecast, work with Congress to reduce the magnitude of the productivity adjustment and continue to work on policy solutions to lower the level of the HCOFLA.**

Impact of the Dual-rate Payment System on LTCHs

Over the last decade, the dual-rate payment system has fundamentally altered the LTCH field.[1] Nearly one-quarter of LTCHs have closed, patient volume has fallen sharply, cases have become concentrated in a relatively small number of diagnosis-related groups (DRGs), and the remaining patient population is more clinically acute. Specifically, since FY 2016, when the dual-rate system took effect, standard-rate LTCH cases have dropped by more than 40% — from about 74,000 in FY 2016 to about 41,000 in FY 2025 — and by roughly 70% from the peak reached under the legacy payment system. The patients who remain are more costly to treat and increasingly concentrated in a limited set of DRGs.[2] Even within those DRGs, patient severity varies significantly, and actual treatment costs vary accordingly. As a result, more cases are qualifying for high-cost outlier payments to compensate for the current DRG structure's limited precision, as discussed further below.

In addition to declining discharges, roughly 7% of Medicare LTCH discharges nationwide are paid at the inpatient PPS-equivalent rate, and those cases remain

[1] AHA. (Dec. 29, 2023). Medicare's LTCH Outlier Policy Needs Reforms to Protect Extremely Ill Beneficiaries (https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries).
[2] Id.

materially underpaid. In fact, a prior AHA analysis found that reimbursement for these cases covered only 46% of the cost of care.[3]

Taken together, these dynamics have placed the LTCH field under substantial financial pressure. From FY 2011 through FY 2013, LTCHs' aggregate average Medicare margin ranged from 6.6% to 7.4%.[4] By FY 2017 through FY 2019, however, that aggregate Medicare margin had deteriorated to a range of -0.5% to -2.2%.[5] Even after numerous closures across the field, the LTCHs that remain have continued to struggle under Medicare payments that fail to cover the costs of care. In fact, the most recent year for which the Medicare Payment Advisory Commission evaluated LTCH margins was FY 2022 and it found that their overall Medicare margin was -1.3%, despite the temporary waiver of the dual-rate payment system during the COVID-19 public health emergency. With the expiration of those waivers, margins have declined further, contributing to more contraction in the field.[6]

Rising Costs of Care Continue to Strain Hospitals and Health Systems

Hospitals, including LTCHs, continue to face sustained inflationary pressures. As detailed in our comments on the FY 2026 LTCH proposed rule, inflation has continuously pushed up labor, drug, supply and other core operating costs. A recent AHA report found that total hospital expenses increased by 7.5% in 2025 alone.[7] Much of this increase reflects labor costs, which CMS notes account for approximately three-quarters of the LTCH market basket. Indeed, an AHA analysis found that workforce costs rose by 5.6% in 2025.[8] Further, advertised salaries for registered nurses have averaged 5.5% growth over the last two years — more than double the rate of inflation.[9] These dynamics have an especially pronounced effect on LTCHs given the labor-intensive nature of the care needs of LTCH patients. Finally, the AHA has expressed concern that recent actions, such as changes to federal student loan limits that exclude nurses and other clinicians from enhanced borrowing limits, will exacerbate workforce shortages, which contribute to higher costs for labor.

Cost pressures, however, extend well beyond labor. Like other hospitals, LTCHs are increasingly caring for sicker and more complex patients, requiring additional and more

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[3] AHA. (June 21, 2019). Letter to CMS (https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf).
[4] MedPAC. (March 2015). Report to Congress, ch. 11, p. 275, (https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-11-long-term-care-hospital-services-march-2015-report-.pdf).
[5] MedPAC. (March 2022). Report to Congress, ch. 11, p. 351, (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).
[6] MedPAC. (July 2024). Health Care Spending and the Medicare Program, ch. 8, p. 122 (https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf).
[7] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).
[8] Id.
[9] Id.

costly drugs and supplies, and these costs also continue to climb. An AHA analysis showed that in 2025, supply costs rose 9.9%, while drug costs rose a staggering 13.6%.[10] In addition, a report from the Department of Health and Human Services (HHS) found that list prices for nearly 2,000 drugs increased by an average of 15.2% from 2017 through 2023 — outpacing general inflation.[11] These cost challenges strain LTCHs, which must be prepared to provide treatment for a wide range of conditions and comorbidities for their particularly high-acuity patients.

Hospitals also are absorbing escalating administrative costs that are not reflected in payment updates. In particular, most Medicare Advantage plans require prior authorization for LTCH admissions, and LTCHs must devote substantial time and resources to navigating these processes. The HHS Office of Inspector General found that many post-acute care prior authorization requests were denied inappropriately, requiring LTCHs and other hospitals to expend significant resources appealing erroneous denials.[12] In addition, a 2024 Premier study found that hospitals spend just under $20 billion annually appealing denials.[13] Indeed, the AHA estimated that about 6.5% of total hospital employment was for administrative staff dedicated to functions relating to claim denials and prior authorization.[14] Since plans do not reimburse these administrative expenses, LTCHs must absorb them while caring for a growing share of Medicare Advantage patients.

Viewed collectively, these cost increases for staffing, drugs, and other essential supplies and services — including cybersecurity, which the AHA estimates cost hospitals more than $30 billion in 2025 — are placing significant strain across the healthcare continuum. They also are forcing LTCHs to redirect resources that otherwise could be used to support patient care, adopt new technologies and make other efficiency-enhancing investments. LTCH market basket increases are at most half, and sometimes less than half, of the cost increases observed by hospitals. In addition, and as discussed further below, these same pressures amplify the negative impact of the productivity adjustment by limiting hospitals' ability to fund the very investments that can drive operational efficiencies.

The Productivity Adjustment Exacerbates Insufficient Market Basket Updates

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[10] Id.
[11] ASPE. (October 2023). Changes in the List Prices of Prescription Drugs, 2017-2023 (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs).
[12] HHS OIG. (April 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/).
[13] Premier. (March 2024). Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims (https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims).
[14] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).

Under the Affordable Care Act, the LTCH PPS payment update is reduced each year by a productivity factor equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). The private nonfarm business TFP is intended to reflect gains from new technologies, economies of scale, business acumen, managerial skill and changes in production. As such, it effectively assumes that the hospital field can achieve productivity gains comparable to those realized by private nonfarm businesses. However, as discussed in more detail below and in a report shared last year, hospitals and the broader healthcare field cannot mirror these gains.[15] As a result, it is not an appropriate or reliable proxy for hospital productivity. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment**.

A core problem is that the productivity construct embedded in the private nonfarm business TFP is a poor fit for measuring hospital productivity. TFP outputs are measured based on the total quantity and prices of goods and services produced in private nonfarm businesses. In industries that sell tangible products, outputs can often be measured in relatively straightforward and standardized ways. Hospital outputs, however, do not operate in the same manner. For example, hospital "quantity," such as volume of visits or procedures, is not necessarily an appropriate proxy for output; it may instead reflect the underlying disease burden in a community. More hospital volume — i.e., more quantity — does not equate to higher productivity in the way it can for private nonfarm businesses.

Further, hospitals often cannot adjust prices per unit of service in response to changes in demand or quality in the way private nonfarm businesses can. Much of hospitals' reimbursement is paid through fixed payment systems, such as the LTCH PPS, which limits providers' ability to alter prices. Similar constraints apply in the commercial market: Hospitals and health systems do not unilaterally set their rates, and prices for commercially insured patients are established through negotiations that frequently lock in rates for multiple years. Accordingly, applying a TFP output framework based on quantity and prices to hospitals is problematic because that output function does not translate to the hospital field.

In addition, hospitals also differ from many private nonfarm industries because hospital services are inherently labor-intensive. As discussed further in the report referenced above, economic literature has long recognized that sustained productivity gains are difficult to achieve in labor-intensive service industries because labor cannot be scaled or automated in the same way as in other sectors. In this respect, hospitals are more comparable to fields such as education and social assistance, which tend to experience lower total factor productivity rates. For example, Bureau of Labor Statistics data show rates ranging from -0.4 for educational services to -0.1 for social assistance, compared

[15] AHA. (June 2025). Letter to CMS (https://www.aha.org/lettercomment/2025-06-10-aha-comments-cms-long-term-care-hospital-fy-2026-proposed-payment-rule).

with 1.9 to 4.9 for industries such as mining, oil and gas, information, and professional services.

CMS itself has acknowledged that hospitals are not positioned to achieve productivity gains comparable to the broader economy over the long run. Specifically, CMS found that hospitals can achieve productivity gains equal to only one-third of those seen in the private nonfarm business sector.[16] Accordingly, using the private nonfarm business TFP to adjust the market basket is inappropriate.

Finally, we continue to find it especially troubling that the productivity adjustment appears to be applied only when it *reduces* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecasted was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage point. However, the agency set the productivity factor at 0, stating that it is required to reduce — not increase — the hospital market basket by changes in economy-wide productivity.[17] Put simply, the agency uses the productivity factor only when it lowers Medicare spending.

The cumulative, compounding effect of these annual reductions — coupled with the asymmetric treatment of periods of declining economy-wide productivity — has widened the gap between payments and the cost of providing services, leaving hospitals increasingly underfunded. In light of this, the AHA continues to have serious concerns about the proposed productivity cut, particularly given the extraordinary pressures under which hospitals and health systems continue to operate.

The Need for LTCH Payment Reform

These persistent financial and operational pressures underscore the need for a broader set of LTCH reforms. This is why the field has coalesced around and agreed upon a set of reform principles to stabilize the LTCH field and protect beneficiary access to appropriate care. As described in the reform principles document, targeted policy changes are necessary not only to address the harms caused by the current dual-rate payment system, but also to preserve access to the specialized, high-acuity, long-stay hospital care that other post-acute settings generally cannot furnish.

The case for reform is especially strong because the same dynamics described in this letter are compounding one another. When LTCHs are underpaid for medically complex patients who fall outside the current standard-rate criteria, when inflation updates fail to keep pace with costs, and when outlier thresholds climb as volume declines, the result is a system that weakens access for precisely the beneficiaries for whom LTCHs were designed. Reform should therefore focus on updating payment policy so that it better

[16] CMS. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf).
[17] 85 Fed. Reg. 58797 (Sept. 18, 2020).

aligns with current patient acuity, current patterns of care, and the continued role of LTCHs in relieving pressure on short-term acute care hospitals and preserving capacity across the continuum.

Accordingly, the reform principles that the field has agreed upon provide an appropriate roadmap for strengthening the LTCH PPS and protecting access to care. These consensus principles include actions that would ensure access to certain high-acuity beneficiaries by expanding the dual-rate payment criteria; reforms to the LTCH DRGs that would provide more accurate payment for standard-rate discharges; modernizations to the 25-day length of stay criteria; and changes to the outlier system, among other actions. Taken together, they respond directly to the struggles outlined above and would help restore a payment framework that supports medically necessary LTCH care rather than undermining it. Absent reform, continued closures, constrained capacity and misaligned payment policies will further erode access for some of Medicare's most medically fragile beneficiaries.

Average Length of Stay (ALOS) of 25 Days. One of the reform principles is to consider changes to the 25-day ALOS requirement. Specifically, to qualify as an LTCH under the law, a hospital must have an ALOS of greater than 25 days. This requirement was created in 1983 to distinguish LTCHs as hospitals that care for patients requiring proportionally longer stays than those cared for in general, acute care hospitals. However, 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%. 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.

LTCHs care for some of the most complex and severely ill Medicare beneficiaries. Despite their best efforts, however, not every patient will be able to recover and return home. Some will enter hospice as they reach the end of life; others will, unfortunately, pass away in the LTCH. **We urge CMS to exclude these short-stay cases from its ALOS calculation.** Doing so would avoid penalizing LTCHs for factors they cannot control. It also would facilitate clinically appropriate discharges. Indeed, CMS has already recognized that excluding certain types of admissions from the 25-day ALOS calculation is appropriate. Specifically, it excludes non-Medicare, Medicare Advantage, and site-neutral cases from the calculation. Further, it implemented these exclusions under its own regulatory authority.

Proposed HCO FLA

CMS proposes to set the FY 2027 LTCH PPS standard-rate FLA at $78,936, the same level as in FY 2026. In determining this proposal, the agency stated that it considered, among other factors, recent measures of charge inflation. However, it indicated that

those charge inflation measures may not be fully reliable at this time because of the implementation of a new outlier reconciliation policy that is expected to change hospital behavior and the inflation rate of charges. Specifically, in Transmittal 12594, CMS recently expanded the circumstances under which outlier payments will be reconciled at cost report settlement to account for differences between the cost-to-charge ratio (CCR) used at the time of claims payment and the CCR determined at final settlement of the cost reporting period. Due to this new policy, CMS believes providers may refrain from inflating charges at the same rate going forward to avoid triggering the reconciliation process. This, according to the agency, creates uncertainty as to the rate of inflation of charges going forward. Thus, it chose to propose to maintain the same FLA to promote stability while it gains additional experience under the reconciliation policy and continues to monitor updated data and projections.

The AHA continues to be troubled by recent increases in the FLA; indeed, it has increased more than 300% since FY 2016. **Therefore, we thank CMS for proposing and urge it to finalize a freeze in the FLA for FY 2027. Moreover, we continue to urge the agency to make additional policy changes, as recommended below, to avoid disruptions to care.**

The purpose of the HCO policy is to "reduce the financial losses that would otherwise be incurred by hospitals when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients."[18] However, it is not reasonable to conclude that a hospital losing almost $79,000 on a patient would effectively accomplish this goal. On the contrary, it will likely be cost-prohibitive for some hospitals to continue to care for these patients. This underpayment seriously threatens access for the sickest Medicare beneficiaries — those requiring long stays in LTCHs.

The AHA has analyzed the underlying causes and the impacts of the rising FLA in a detailed white paper.[19] To summarize, LTCH volume has dropped severely since the implementation of the dual-rate payment system. In accordance with this volume decrease, the acuity of cases has increased, making the average case more costly. Therefore, a much higher proportion of total cases (and thus payments) are high-cost patients that qualify for HCO payments. However, in an effort to continue targeting paying 7.975% of total payments as outliers, CMS has continually raised the FLA. In addition to increasing the losses that must be incurred for HCO cases, this has resulted in more cases that once would have qualified for an HCO payment now not qualifying. Thus, LTCHs must now absorb additional losses not only for cases that would have previously qualified for HCO payment with a lower FLA but no longer do, but also for

[18] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; 80 Fed. Reg. 49325, 49,617 (Aug. 17, 2015).
[19] AHA. (Dec. 29, 2023). Medicare's LTCH Outlier Policy Needs Reforms to Protect Extremely Ill Beneficiaries (https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries).

cases that do qualify for HCO payment, but require LTCHs to absorb a much higher loss due to the increased FLA.

These phenomena are not surprising to providers who cautioned that the dual-rate payment system likely would have such an effect. Indeed, in the FY 2016 and 2017 rulemakings, CMS noted increases in the FLA and said it believed that they were due to the new dual-rate payment system. [20] However, it stated that it "expect[s] annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure."[21] However, that stabilization has not materialized.

The AHA again offers recommendations, included in more detail in our white paper referenced above and our comments on last year's proposed rule, that we strongly urge CMS to adopt as it continues to analyze this issue: [22]

- Utilize a market-basket-based methodology.[23]
- Implement a permanent annual cap on increases to the FLA.
- Implement an extended transition for the FLA.
- Rescind Transmittal 12594 and incorporate reconciliation into outlier projections.

Keeping the FLA to a reasonable level will help ensure that the HCO policy serves its intended purpose. As such, it also will help maintain access to the most appropriate care for some of the sickest, most severely ill patients.

LTCH QUALITY REPORTING PROGRAM

Removal of COVID-19 Vaccination Measures. Beginning with the FY 2028 LTCH Quality Reporting Program (QRP), CMS proposes to remove two measures related to vaccination against COVID-19: Coverage Among Healthcare Personnel and Percent of Patients/Residents Who Are Up To Date. The AHA supports the removal of these measures from the program, as it would align the LTCH QRP with other CMS quality reporting programs from which these measures have already been removed.

Revision of Data Submission Timeline. Beginning with the FY 2029 LTCH QRP, CMS proposes that LTCHs must complete their data submissions and make corrections to their LTCH Continuity Assessment and Record of Evaluation Data Set (LCDS) assessment data as necessary no later than the 15th day of the second month after the

[20] FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49621 (Aug. 17, 2015).
[21] FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57305 (Aug. 22, 2016).
[22] https://www.aha.org/lettercomment/2025-06-10-aha-comments-cms-long-term-care-hospital-fy-2026-proposed-payment-rule
[23] CMS can implement any of these recommendations in a non-budget-neutral manner. As CMS noted in its FY 2025 rulemaking, it believes the budget neutrality requirement for the LTCH PPS HCO policy "applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003)."

end of the calendar quarter. If this day falls on a Friday, weekend or federal holiday, the date would be delayed until 11:59 p.m. EST on the next business day. Currently, LTCHs have approximately 4.5 months (135 days) after the end of each quarter to submit LTCH QRP data; this proposal would allow for approximately 45 days for data submission for both assessment-based data and data submitted through the National Healthcare Safety Network (NHSN).

The AHA's members work hard to meet the existing data submission deadlines, and, as CMS notes in its analysis, CMS estimates that 98.36% of LCDS assessments were submitted to CMS within a 45-day timeframe, and 88% of all LTCHs submitted NHSN data within a 45-day timeframe. We believe that the shortened timeframe for data submission is likely sufficient; however, to ensure consistency and clarity, we suggest that CMS instead consider a clearer deadline. For example, requiring submission by the "last business day of the month," rather than the "15th day of the month," would be simpler for facilities to interpret. In addition, we urge CMS to monitor patterns of data submission leading up to the new deadline and provide adequate notice and assistance to facilities approaching the deadline without having submitted data; for example, reminding them of their options for extraordinary circumstances exceptions.

We appreciate your consideration of these issues. Please contact me if you have questions, or feel free to have a member of your team contact Jonathan Gold, AHA senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
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