LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

paymentbasics

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The policies discussed in this document were current as of September 30, 2025. This document does not reflect proposed legislation or regulatory actions.

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While most chronically critically ill patients—those with profound debilitation of multiple systems, frequently with ongoing respiratory failure—are treated in acute care hospitals, some receive care in long-term care hospitals (LTCHs). To qualify for Medicare payment as an LTCH, a facility, which can be freestanding or colocated with other hospitals, must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for qualifying stays.[1] Coverage of LTCH stays is subject to Medicare's limits on inpatient hospital care; thus, beneficiaries treated in LTCHs are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.

Beneficiaries pay no additional deductible when transferred to an LTCH from an acute care hospital but are responsible for a deductible at the first admission during a spell of illness when admitted from the community. If a beneficiary's hospital stay (whether in an acute care hospital, an LTCH, or combined) extends beyond 60 days during a spell of illness, an additional copayment is required for the 61st through 90th days. Beneficiaries are also liable for a higher daily copayment for lifetime reserve days used beyond the 90th day of a spell of illness.[2]

In fiscal year 2023, the fee-for-service Medicare program and 56,000 beneficiaries spent $3.0 billion on 59,000 inpatient stays at 330 LTCHs.

Defining the care that Medicare buys

Medicare's LTCH prospective payment system (PPS) primarily pays LTCHs a predetermined rate per inpatient stay for the operating and capital costs of furnishing that stay.

The Pathway for SGR Reform Act of 2013 further defined the LTCH care that Medicare covers by establishing criteria for stays to be paid under the LTCH PPS standard federal rate. LTCH stays that immediately follow an acute care hospital stay are paid the LTCH PPS standard federal rate if the LTCH stay is not a psychiatric or rehabilitation case and if the preceding hospital stay included three or more days in an intensive care unit or the LTCH stay includes mechanical ventilation services for at least 96 hours. Stays that do not qualify for the LTCH PPS rate are paid the site-neutral rate, which is the lower of Medicare's acute care hospital payment rate under the inpatient PPSs (IPPS) or 100 percent of the cost of the stay.

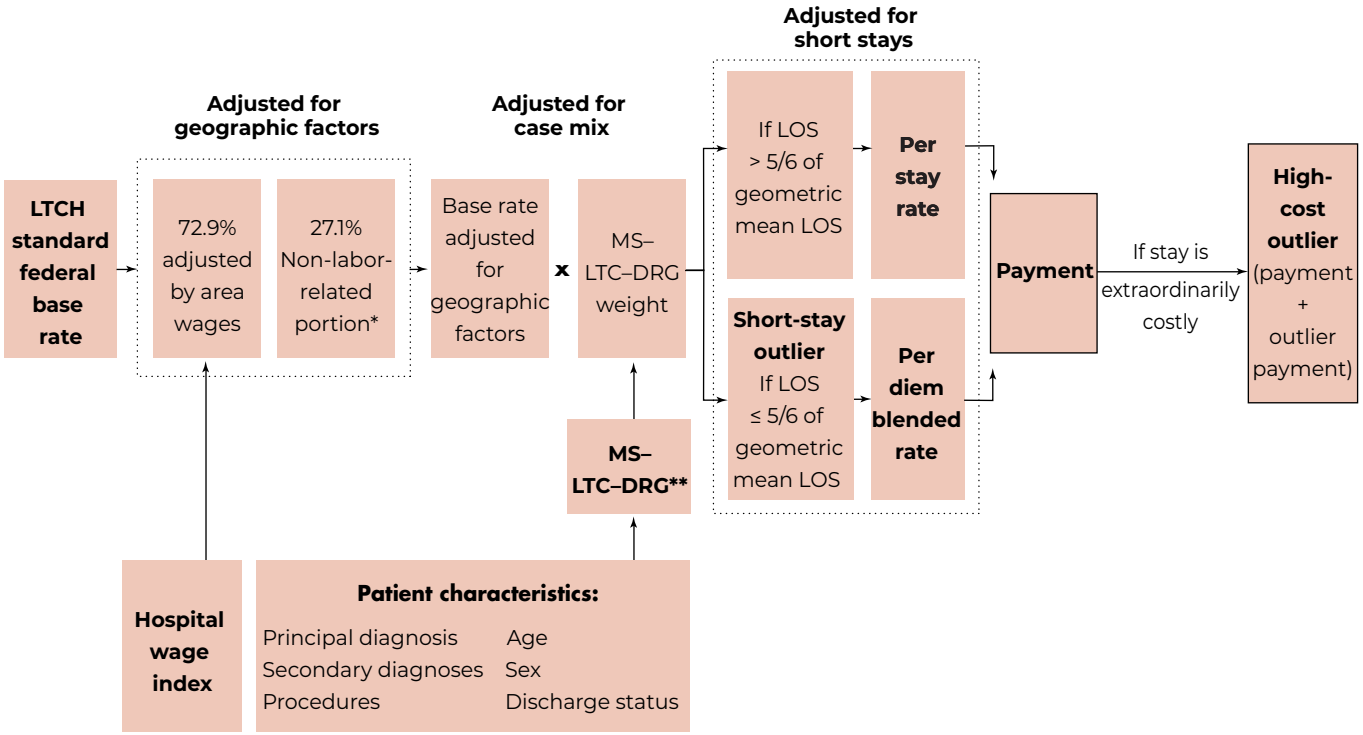
Setting the LTCH PPS standard federal payment rates

Payments for stays that qualify for the LTCH PPS standard federal rates are determined by adjusting a base payment rate for geographic differences in market area wages and for case mix (Figure 1). In fiscal year 2026, the LTCH PPS standard federal base rate is $50,824.51.

Adjustment for geographic factors—To adjust payments for differences in market area wages, the labor-related portion of the base rate—72.9 percent in 2026—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[3]

Adjustment for case mix—The wage-adjusted payment rate is then adjusted for case mix using Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs). The MS–LTC–DRGs are the same groups used in the IPPS but with relative weights determined using LTCH PPS stays.[4] Patients are assigned to MS–LTC–DRGs based on their principal diagnosis, secondary diagnoses, procedures, age, sex, and discharge status.

Figure 1 Payment for stays under the standard federal long-term care hospital prospective payment system, FY 2026



Note: FY (fiscal year), LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term care diagnosis-related group), LOS (length of stay). Beginning in FY 2016, stays in LTCHs must meet certain criteria to receive payment under the LTCH prospective payment system. These stays are admitted immediately following an acute care hospital stay if (1) that stay included at least three days in an intensive care unit or (2) the LTCH stay receives a principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours. All other stays are paid an amount based on Medicare's acute care hospital payment rates under the inpatient prospective payment systems (IPPS) or 100 percent of the cost of the stay, whichever is lower. The Bipartisan Budget Act of 2018 specified that the IPPS-comparable amount shall be reduced by 4.6 percent for fiscal years 2018 through 2026.
* LTCHs located in Alaska or Hawaii receive a cost-of-living adjustment to the non-labor-related portion of the base rate.
** MS–LTC–DRGs comprise base DRGs subdivided into one, two, or three severity levels.

Short-stay outliers—LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are stays with a length of stay less than or equal to five-sixths of the geometric average length of stay for the MS–LTC–DRG. For SSOs, LTCHs are paid a rate equal to an amount that is a blend of the IPPS amount for the MS–DRG and 120 percent of the LTCH per diem payment amount up to the full LTCH PPS standard federal payment rate. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

High-cost outliers—LTCHs receive outlier payments for patients who are extraordinarily costly. High-cost outlier stays are identified by comparing their costs to a threshold that is the MS–LTC–DRG payment for the stay plus a fixed loss amount. Medicare pays 80 percent of the LTCHs' costs above the fixed loss amount, which is $78,936 in 2026. High-cost outlier payments are funded by reducing the base payment amount for all stays paid under the LTCH PPS by about 8 percent.

Interrupted stays—LTCHs receive one payment for "interrupted-stay" patients. An interrupted stay is when an LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF),

the patient stays for a maximum specified period, then goes back to the same LTCH. The maximum specified period is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. For interrupted stays lasting three days or less, the LTCH is responsible for paying for the services provided by the intervening acute care hospital, IRF, or SNF.

Setting the site-neutral payment rates

Stays that do not meet the specified criteria for payment under the LTCH PPS are paid an amount comparable to Medicare's IPPS rate for the same type of stay, including any applicable outlier payments, or 100 percent of the cost of the stay, whichever is lower.[5]

High-cost outliers—LTCHs receive outlier payments for site-neutral stays that are extraordinarily costly. Site-neutral high-cost outlier stays are identified by comparing their costs to a threshold that equals the site-neutral payment amount plus the IPPS fixed loss amount. In 2026, the IPPS fixed loss amount is $40,397. Medicare pays 80 percent of the LTCH's costs above the threshold. High-cost outlier payments are funded by reducing the payment amount for stays paid under the site-neutral rate by 5.1 percent.

Interrupted stays—Medicare applies the same interrupted-stay policy to LTCH stays paid the site-neutral payment rate as under the LTCH PPS payment rate.

Payment updates

CMS updates the LTCH PPS standard federal payment rates annually based on the applicable market basket index (which measures the increases in the price of goods and services that LTCHs buy to provide patient care) and estimates of changes in productivity.[6] Payments to LTCHs for stays paid the site-neutral rates are updated consistent with the IPPS. For 2026, the update to the IPPS operating base rate was 2.6 percent, and the update to the IPPS capital base rate was 2.8 percent. ■

1 For cost-reporting periods beginning on or after October 1, 2019, to be paid the LTCH prospective payment system (PPS) rate, a facility must have maintained a discharge payment percentage (DPP) of at least 50 percent. An LTCH's DPP is its ratio of fee-for-service discharges that qualify for the LTCH PPS rate to the LTCH's total number of Medicare discharges. LTCHs that have not maintained the required DPP are paid under the inpatient PPS until their DPP reaches 50 percent or higher. During the COVID-19 public health emergency, all stays were counted as qualifying under the LTCH IPPS and were paid the LTCH PPS standard federal payment rate.

2 In calendar year 2025, the inpatient deductible is $1,676 for a spell of illness and the daily copayments are $419 from the 61st to 90th day of a spell of illness. Beneficiaries are liable for a higher copayment for each lifetime reserve day—$838 per day in calendar year 2025.

3 The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification. The nonlabor portion of LTCHs in Alaska and Hawaii is adjusted by a cost-of-living adjustment (COLA) and added to the labor-related portion. The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in Alaska and Hawaii. It increases the nonlabor portion of the payment by as much as 25 percent.

4 MS–LTC–DRGs with fewer than 25 stays are grouped into five categories based on their average charges; relative weights for these five case-mix groups are determined based on the average charges for the MS–LTC–DRGs in each of these groups.

5 The IPPS-comparable amount shall be reduced by 4.6 percent for fiscal years 2018 through 2026, in accordance with the Bipartisan Budget Act of 2018.

6 LTCHs that fail to provide data on specified quality indicators receive a reduction of 2 percentage points to the annual LTCH PPS standard federal payment rate.