

LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

payment**basics**

Revised:
October 2024

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 cases.¹ About 58,000 Medicare beneficiaries had approximately 63,000 LTCH stays in 2022.² That year, Medicare program payments to LTCHs, exclusive of beneficiary cost sharing, were about \$2.8 billion.

Beneficiaries pay no additional deductible when transferred to an LTCH from an acute care hospital but are responsible for a deductible—\$1,632 in calendar year 2024—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—\$408 per day in calendar year 2024—is required for the 61st through 90th days. 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.³

Defining the care that Medicare buys

Under Medicare's prospective payment system (PPS), Medicare pays LTCHs per discharge rates intended to cover the operating and capital costs that efficient providers are expected to incur in furnishing covered services during an LTCH stay.

The Pathway for SGR Reform Act of 2013 further defined the LTCH care that

Medicare covers by establishing criteria for cases to be paid under the LTCH PPS. LTCH cases 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 3 or more days in an intensive care unit or the LTCH case includes mechanical ventilation services for at least 96 hours. Discharges 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 PPS (IPPS) or 100 percent of the cost of the case.⁴

Setting the LTCH PPS standard federal payment rates

Payments to cases that qualify for the LTCH PPS rates are determined by adjusting a base payment rate for geographic differences in market area wages and for case mix. In fiscal year 2025, the LTCH PPS base rate is \$49,383.26. The base rate for LTCHs that fail to provide data on specified quality indicators is reduced by 2 percentage points. To adjust payments for differences in market area wages, the labor-related portion of the base rate—72.8 percent in 2025—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion (Figure 1).⁵ 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 cases.⁶ Patients are assigned to MS-LTC-DRGs based on their principal diagnosis, secondary diagnoses, procedures, age, sex, and discharge status.

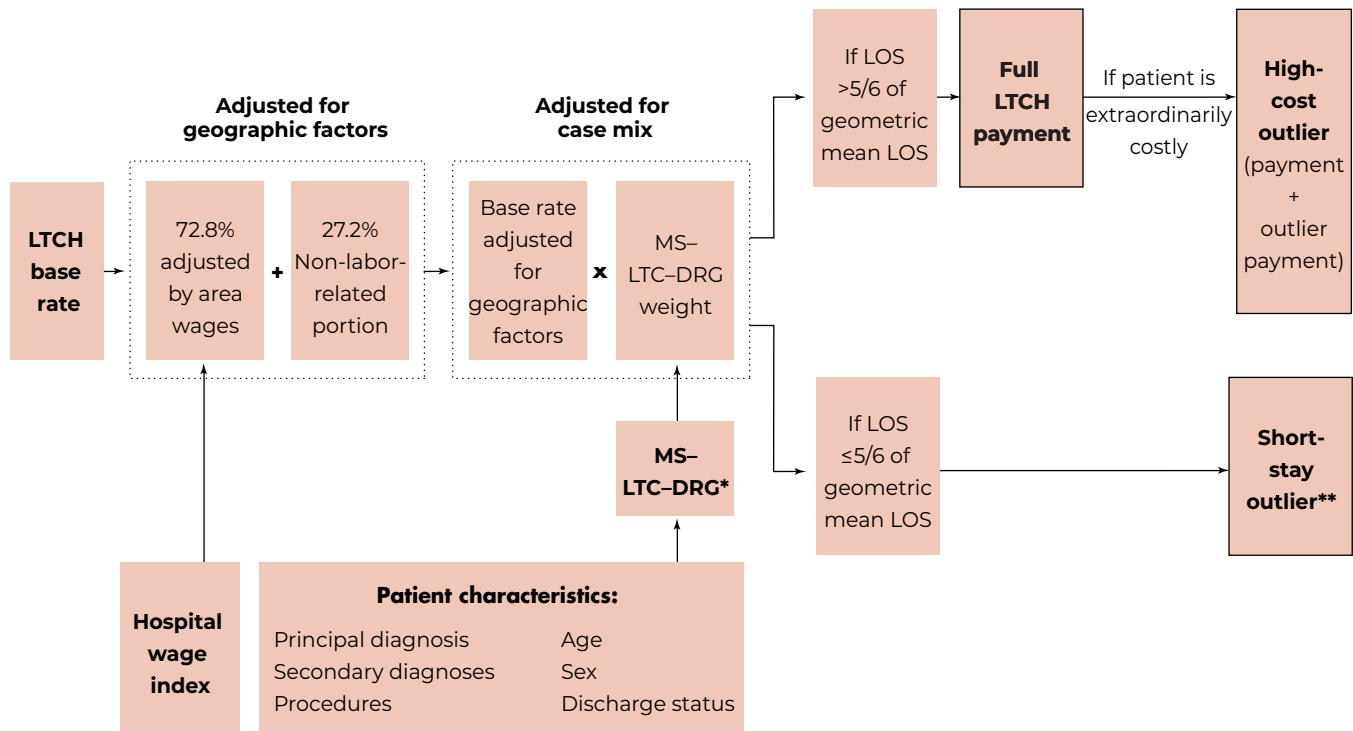
Short-stay outliers—LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs)

The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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Figure 1 Payment for cases under the long-term care hospital prospective payment system, FY 2025



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 fiscal year 2016, cases in LTCHs must meet certain criteria to receive payment under the LTCH prospective payment system. These cases are admitted immediately following an acute care hospital stay if (a) that stay included at least 3 days in an intensive care unit or (b) the LTCH case receives a principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours. All other cases are paid an amount based on Medicare's acute care hospital payment rates under the inpatient prospective payment system (IPPS) or 100 percent of the cost of the case, 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.

* MS-LTC-DRGs comprise base DRGs subdivided into one, two, or three severity levels.

** Payments generally are reduced for short-stay patients.

are cases 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 cases are identified by comparing their costs to a threshold that is the MS-LTC-DRG payment for the case plus a fixed loss

amount. Medicare pays 80 percent of the LTCHs' costs above the fixed loss amount, which is \$77,048 in 2025. High-cost outlier payments are funded by reducing the base payment amount for all cases 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), 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

Cases 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 case, including any applicable outlier payments, or 100 percent of the cost of the case, whichever is lower.⁷

High-cost outliers—LTCHs receive outlier payments for site-neutral cases that are extraordinarily costly. Site-neutral high-cost outlier cases are identified by comparing their costs to a threshold that equals the site-neutral payment amount plus the IPPS fixed loss amount. In 2025, the IPPS fixed loss amount is \$46,152. Medicare pays 80 percent of the LTCH's costs above the threshold. High-cost outlier payments are funded by reducing the payment amount for cases paid under the site-neutral rate by 5.1 percent.

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

Payment updates

CMS updates the LTCH PPS payment rates annually based on the applicable market basket index (which measures the price increases of goods and services LTCHs buy to provide patient care). The Affordable Care Act of 2010 requires that any annual update to the LTCH payment rates beginning in fiscal year 2012 be reduced by an adjustment for productivity. Payments to LTCHs for cases paid the site-neutral rates are updated statutorily by the inpatient market basket index as adjusted by productivity. ■

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 acute care hospital PPS until its DPP reaches 50 percent or higher.

- 2 Medicare beneficiaries enrolled in Medicare Advantage plans are not included in these totals.
- 3 Beneficiaries are liable for a higher copayment for each lifetime reserve day—\$816 per day in calendar year 2024.
- 4 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.
- 5 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.
- 6 MS-LTC-DRGs with fewer than 25 cases are grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups are determined based on the average charges for the MS-LTC-DRGs in each of these groups.
- 7 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.