The Honorable Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

June 8, 2026

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 Dr. Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, including long-term care hospitals (LTCHs), we appreciate the opportunity to comment on the Fiscal Year (FY) 2027 Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule (April 10, 2026) (Proposed Rule).

Our comments focus on payment policies, structural challenges within the LTCH payment system, and proposed changes to the LTCH Quality Reporting Program (QRP).

LTCHs care for some of the most complex and severely ill Medicare beneficiaries. As CMS recognizes, the majority of patients treated in LTCHs require prolonged intensive care services, including ventilator support or extended ICU stays. These patients often present with multiple chronic conditions, complex wounds, and other complications that make this population uniquely resource-intensive.

Caring for these patients requires highly specialized clinical staff, infrastructure, and care coordination. LTCHs play a critical role in the care continuum, serving as essential partners to acute-care hospitals by accepting patient transfers who require extended recovery and advanced clinical management.

However, longstanding Medicare payment dynamics and structural features of the LTCH payment system have contributed to a contraction in the field. As capacity has declined, patient acuity has increased, with remaining providers caring for increasingly complex cases. This trend not only reduces access for high-need patients but also places additional strain on acute-care hospitals and the broader healthcare system.

Against this backdrop, AzHHA is concerned that the FY 2027 Proposed Rule does not adequately address the structural and financial challenges facing LTCHs. Our detailed comments follow.

MARKET BASKET UPDATE

AzHHA is concerned that the proposed payment update does not adequately reflect the financial pressures facing LTCHs. CMS estimates that LTCH standard rate payments will increase by approximately 2.3% in FY 2027. However, this modest update—driven by a 3.2% market basket increase, reduced by a 0.8-percentage-point productivity adjustment—continues to fall short of real-world cost growth.

The LTCH cost structure is heavily driven by labor and the needs of high-acuity patients, which limits providers' ability to achieve the productivity gains assumed under current law. As a result, even small gaps between payment updates and underlying cost growth can have a meaningful operational impact.

LTCHs continue to face sustained cost pressures, including workforce shortages requiring higher wages and contract labor, elevated pharmaceutical and supply costs, and increasing patient acuity. These factors have contributed to a growing disconnect between Medicare payments and the actual cost of care.

While aggregate payment updates may appear sufficient, they do not account for cumulative underpayment in prior years or the compounding effect of below-cost updates over time. For many LTCHs operating on narrow margins, these shortfalls directly affect staffing, service capacity, and long-term sustainability.

We recognize CMS is constrained by statute in calculating the annual update. However, **we encourage the agency to continue evaluating whether the current methodology reflects the realities of LTCH care and to consider recommendations to Congress, as appropriate, to better align payment updates with providers' actual cost experience.**

HIGH COST OUTLIER POLICY

AzHHA supports CMS' proposal to maintain the high-cost outlier (HCO) fixed-loss amount at the FY 2026 level. In light of the uncertainty surrounding charge inflation and the implementation of the outlier reconciliation policy, maintaining the current threshold promotes needed stability for LTCH providers.

We recognize CMS' statutory obligation to set the fixed-loss amount to achieve its outlier target and appreciate the agency's consideration of the wide range of potential outcomes. Holding the

threshold flat is a reasonable and measured approach while CMS continues to evaluate evolving data and provider behavior.

We encourage CMS to continue monitoring outlier trends and to ensure future updates reflect LTCH cost structures and patient complexity.

STRUCTURAL CHALLENGES IN THE LTCH PAYMENT SYSTEM

Beyond annual payment updates, AzHHA remains concerned with structural features of the LTCH payment system that continue to constrain access to LTCH care and place strain on providers.

Policies associated with the dual-rate payment system have reduced the number of cases eligible for standard LTCH payment, resulting in lower volumes and a concentration of more complex, higher-cost patients. At the same time, changes in patient flow—particularly patients remaining longer in acute-care settings—have further reduced access to LTCH services for individuals who would historically have been transferred.

These trends have contributed to declining LTCH capacity and growing pressure across the care continuum. As fewer LTCH beds are available, acute-care hospitals must increasingly manage high-acuity patients for longer periods, often in settings not designed for extended recovery.

We encourage CMS to continue evaluating the broader impact of these policies on patient access, provider sustainability, and care delivery across settings.

IMPACT OF EPISODE-BASED PAYMENT MODELS

AzHHA is concerned about the growing impact of episode-based payment models, including the Transforming Episode Accountability Model (TEAM) and the proposed expansion of the Comprehensive Care for Joint Replacement Model (CJR-X), on LTCHs and patient access to post-acute care.

Under TEAM, participating hospitals are financially accountable for the total cost of care across an episode, including post-acute services. In practice, that creates strong incentives to reduce post-acute spending. While that may improve efficiency in some cases, it also risks discouraging appropriate referrals to LTCHs—particularly given the higher costs associated with caring for medically complex patients. This is not a theoretical concern for Arizona. We already have LTCHs located in a TEAM market, and these incentives will directly influence referral patterns and access to LTCH care.

The proposed nationwide expansion of the CJR model (CJR-X) raises similar concerns. As these models continue to expand, there is a real risk that care is shifted toward lower-cost post-acute settings without fully accounting for patient complexity. For patients who truly require LTCH-level care, that shift may not be clinically appropriate and could limit access to the right setting at the right time.

We support the goal of improving care coordination and efficiency across the continuum. At the same time, these models need to recognize the distinct role LTCHs play in treating highly complex patients. We encourage CMS to closely monitor how these policies affect post-acute utilization and patient access and to ensure that payment incentives do not unintentionally steer patients away from medically necessary LTCH care.

LTCH QUALITY REPORTING PROGRAM — DATA SUBMISSION TIMELINE

AzHHA is concerned with CMS's proposal to shorten the LTCH Quality Reporting Program (QRP) data submission timeline from 4.5 months to 45 days.

While we support efforts to improve the timeliness of quality data, this change would be challenging to operationalize. Data validation, aggregation, and submission processes involve multiple systems and staff, and a compressed timeline increases the risk of reporting errors and incomplete data.

Finalizing clinical documentation and QRP data often extends beyond the patient stay, and compressing this timeframe does not reflect operational realities in LTCHs. If finalized, CMS should take a more measured approach. At a minimum, we recommend a longer submission window—no less than 100 days—to better balance timeliness with accuracy and allow providers to maintain focus on patient care operations.

We appreciate the opportunity to comment on the FY 2027 LTCH PPS Proposed Rule and look forward to continued engagement with CMS on these important issues. If you have any questions or would like to discuss these comments further, please do not hesitate to contact us.

Sincerely,

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