LONG-TERM CARE HOSPITAL ROUNDTABLE

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Medicare Advantage Use of Long-Term Care Hospitals Increased During the COVID-19 Public Health Emergency, but Utilization Remained Less than Half of Traditional Medicare

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The LTCH Roundtable is a collaborative effort between the National Association of Long-Term Hospitals (NALTH) and Select Medical. NALTH is the only trade association dedicated exclusively to advocacy for Long-Term Care Hospitals (LTCHs) and their critically ill patients.

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KEY FINDINGS

- Long-term care hospitals (LTCHs) are specialized providers for select critically ill and medical complex patients who require extended hospital-level care. In 2021, use of LTCHs by Medicare beneficiaries remained low, with approximately 1.0% of Traditional Medicare (TM) and 0.4% of Medicare Advantage (MA) patients discharged from a short-term acute care hospital being admitted to an LTCH.
- Between 2018 and 2021, the rate of LTCH use in MA was, on average, 61% lower than in TM. While the gap has narrowed, the differential use of LTCHs by MA and TM beneficiaries remains significant (65% lower in 2018 vs. 57% lower in 2021).
- Although the use of LTCHs in MA increased by 21% during the COVID-19 public health emergency, the change is likely temporary with these specialty hospitals serving as overflow settings for crowded intensive care units. Even so, MA use of LTCHs remained less than half that of TM during COVID-19.
- As MA enrollment continues to grow, Medicare beneficiaries can be expected to experience limited access to LTCH care due to restrictive prior-authorization practices and narrow provider networks. Reduced access to LTCH care will disproportionately impact Medicare beneficiaries of color.

INTRODUCTION

Long-term care hospitals are acute care hospitals that provide specialized programs of care for high acuity patients who require an extended inpatient hospital stay. These facilities are designed to care for severely ill patients who, though clinically stable, still require complex treatment. Amid COVID-19, LTCHs emerged as critical healthcare providers in their communities and continue to treat some of the most vulnerable patient populations.[1]

LTCHs are facing challenges in caring for Medicare beneficiaries due to the growth in Medicare Advantage, a program where Medicare beneficiaries receive their benefits through private insurers. MA enrollees made up nearly 48% of all Medicare beneficiaries in 2022 and are expected to account for the majority of Medicare enrollees in the next couple of years.[2]

The growth exhibited in MA can, in part, be attributed to the increased enrollment of Black and Hispanic beneficiaries, and Medicare-Medicaid beneficiaries (or dual eligibles).[3] As of 2019, beneficiaries of color comprised 31.5% of the MA beneficiary population, compared to 20.8% for Traditional Medicare (TM). Between 2013 and 2019, the number of full or partial dual-eligible beneficiaries enrolled in MA increased from 2.4 million to 5.4 million.[4]

Prior research has shown that MA enrollees are less than half as likely to receive LTCH care compared to TM beneficiaries.[5] MA plans can reduce access to LTCHs through prior authorization denials. These restrictive tactics are widespread in MA plans, with 4 in 5 MA beneficiaries enrolled in plans that require authorization for Medicare-covered services.[6] In a recent report, the Office of Inspector General at the U.S. Department of Health and Human Services raised concerns regarding MA plans use of prior authorization to deny access to medically necessary care, including post-acute care like LTCHs.[7]

In this brief, we document disparities in the use of LTCH services in MA and TM between 2018 and 2021. We measure LTCH utilization in MA and TM as LTCH discharges per 1,000 short-term acute care hospital (STACH) discharges.

FINDINGS

Between fiscal year (FY) 2018 and FY 2021, the rate of LTCH use in MA was 61% lower, on average, than in TM (4.2 vs. 10.6) **(Figure 1)**. Over time, the gap between MA and TM LTCH utilization has narrowed, with the rate difference of 7.7 (3.9 vs. 11.6) in Q4 2017 decreasing to 6.0 (3.9 vs. 9.9) in Q4 2021. This decrease in the gap between MA and TM LTCH utilization can be attributed to falling LTCH use in the TM population and increased use in MA. Notably, MA plans use of LTCHs spiked from 3.8 in Q2 2020 to 6.2 in Q3 2020, a 63% increase, during the COVID-19 PHE **(Figure 1)**. During the same period, a similar yet smaller spike is observed among the TM beneficiary population, with TM LTCH discharges per 1,000 STACH discharges increasing from 10.2 in Q2 2020 to 11.5 in Q3 2020. A second, smaller spike occurred in Q2 2021 in both MA and TM due to the winter 2021 COVID-19 surge, a result of the Omicron variant. On average, MA plans use of LTCHs increased by 21%, between the pre-COVID-19 period (October 1, 2017 to March 31, 2020) and the COVID-19 period (April 1, 2020 to September 30, 2021) included in our data. The increased rate of LTCH use is corroborated by previous literature assessing LTCHs' emergent role as a critical provider throughout the COVID-19 PHE.

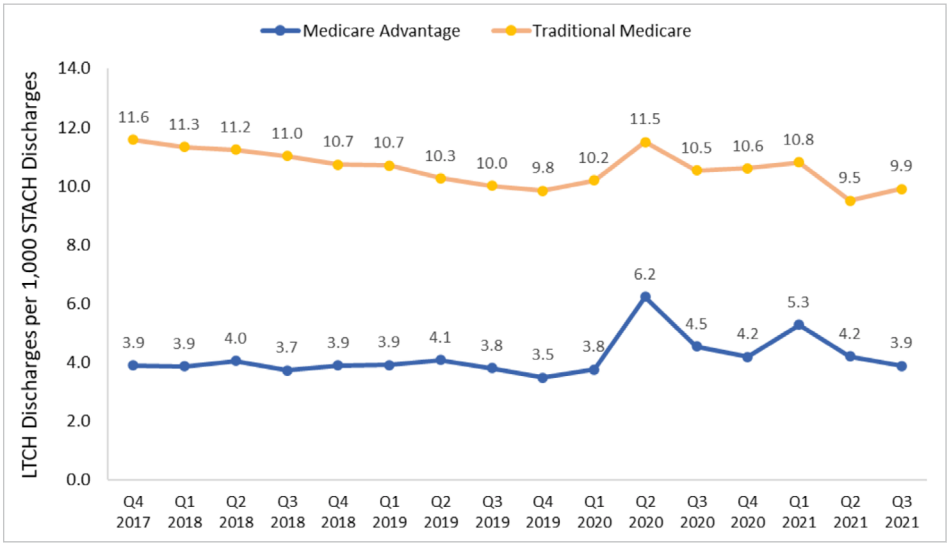


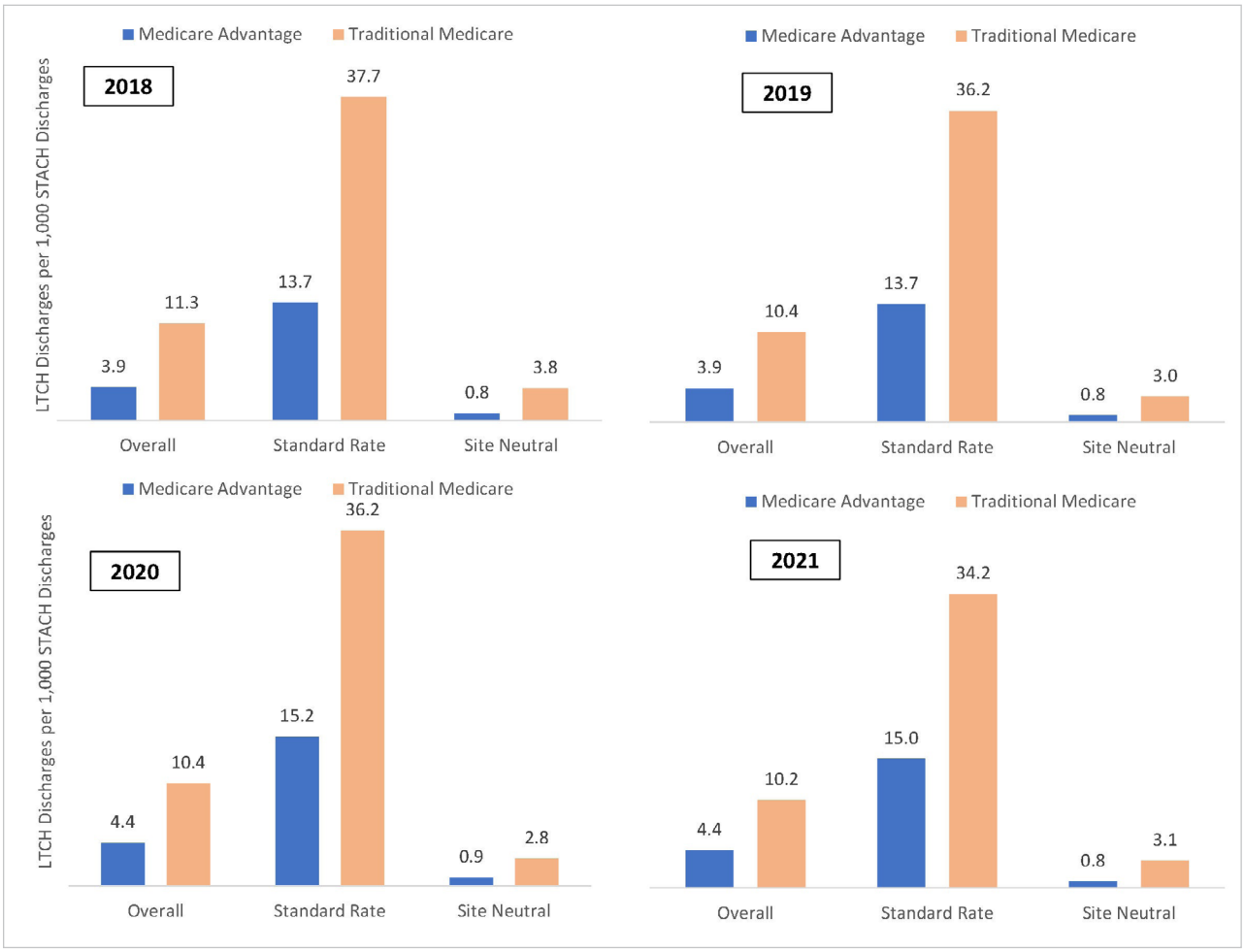
Figure 1 Nationwide LTCH Discharges per 1,000 STACH Discharges from FY 2018 through FY 2021

Source: KNG Health Consulting analysis of 2018, 2019, and 2021 Hospital MedPAR file

LTCH use rates vary greatly between Medicare beneficiaries who have spent 3 or more days in the intensive care unit (ICU) (standard-rate cases under the Medicare LTCH prospective payment system) and those who have not (site-neutral cases) **(Figure 2)**. For standard-rate cases, MA LTCH use rates ranged from 13.7 (2018) to 15.0 (2021), while site-neutral cases stayed below 1 LTCH discharge per 1,000 STACH discharges over the entire period. We observed a sharp increase in MA LTCH use among standard-rate cases in 2020 and 2021, suggesting that the increase in MA plans use of LTCHs during the COVID-19 PHE was almost entirely due to the increased use of LTCHs for standard-rate cases. For TM, the pattern is different, with observed reductions in both rate of LTCH use among standard-rate and site-neutral cases between 2018 and 2021.

Rates of LTCH use were higher for beneficiaries of color than White Medicare beneficiaries in both MA and TM. Over the entire four-year period, LTCH use rates in MA were 5.4 for beneficiaries of color and 3.8 for White beneficiaries, while the corresponding use rates in TM were 15.5 and 9.4. The lower use of LTCHs in MA relative to TM were greater for beneficiaries of color (65% reduction) than for White beneficiaries (60%).

Figure 2 Geographic Distribution of LTCH Closures and Openings (2012 – 2021)



Source: KNG Health Consulting analysis of final 2018, 2019, 2021 Hospital MedPAR and proposed 2020 MedPAR files.

Note: Standard Rate = Cases that spent 3 or more days in an intensive care unit (ICU) at a short-term acute care hospital prior to LTCH admission; Site Neutral = Cases that spent fewer than 3 days in an ICU prior to LTCH admission.

METHODOLOGY

We used the national Medicare Provider Analytics Review (MedPAR) files from 2018 to 2021 to complete the study. The MedPAR file is publicly available and provides claims data for patients discharged from a STACH or LTCH, whether the claim was MA or TM, and whether a patient spent time in the ICU. We utilized the claims data to create a rate comparing LTCH and STACH discharges. In addition, to assess the impact of the COVID-19 PHE we split the MedPAR data by fiscal year quarters.

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