LONG-TERM CARE HOSPITAL
ROUNDTABLE

LTCH ROUNDTABLE • DECEMBER 2022

Patients Face Reduced Access to Long-Term Care Hospitals Due to Closures and Bed Reductions

AUTHORS

Lane Koenig, PhD
Julia Sheriff
Elizabeth Hamlett
KNG Health Consulting, LLC

COLLABORATIVE EFFORT BETWEEN NALTH AND SELECT MEDICAL

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.

CONTACT

lane.koenig@knghealth.com
www.knghealth.com

KEY FINDINGS

- From 2012 to 2021, the number of long-term care hospitals (LTCHs) and LTCH beds decreased by 22% and 24%, respectively, while the U.S. population aged 65 years old or older grew by 29% during this same period.
- Closures have been more frequent since the implementation of the site-neutral payment policy, with 95 closures (or 75% of all closures since 2012) occurring between 2016 and 2021.
- Seventy-eight percent (78%) of Medicare beneficiaries resided in a hospital referral region with at least one LTCH at the end of 2020, down from 80% at the end of 2016.
- The annual closure rate for LTCHs slowed during the COVID-19 public health emergency (PHE) but is likely to accelerate once the PHE regulatory waivers end.

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 the COVID-19 public health emergency (PHE), LTCHs emerged as critical healthcare providers in their communities and continue to treat some of the most vulnerable patient populations.[1]

LTCHs are facing financial pressures, primarily from reduced Medicare payment rates and growth in Medicare Advantage (MA), a program where Medicare beneficiaries receive their benefits through private insurers. Congress temporarily restored payment cuts to LTCHs during the COVID-19 PHE through waivers of existing regulatory and payment requirements, but these cuts will be reinstated once the PHE ends. In addition, MA enrollees make up nearly 44% of all Medicare beneficiaries and are expected to comprise more than half of all Medicare beneficiaries by 2030.[2] Prior research has shown that MA enrollees are less than half as likely to receive LTCH care compared to Medicare Fee-for-Service (FFS) beneficiaries.[3] MA plans can reduce access to LTCHs through prior authorization denials.

In this brief, we examine changes in the availability of LTCH care between 2012 and 2021.

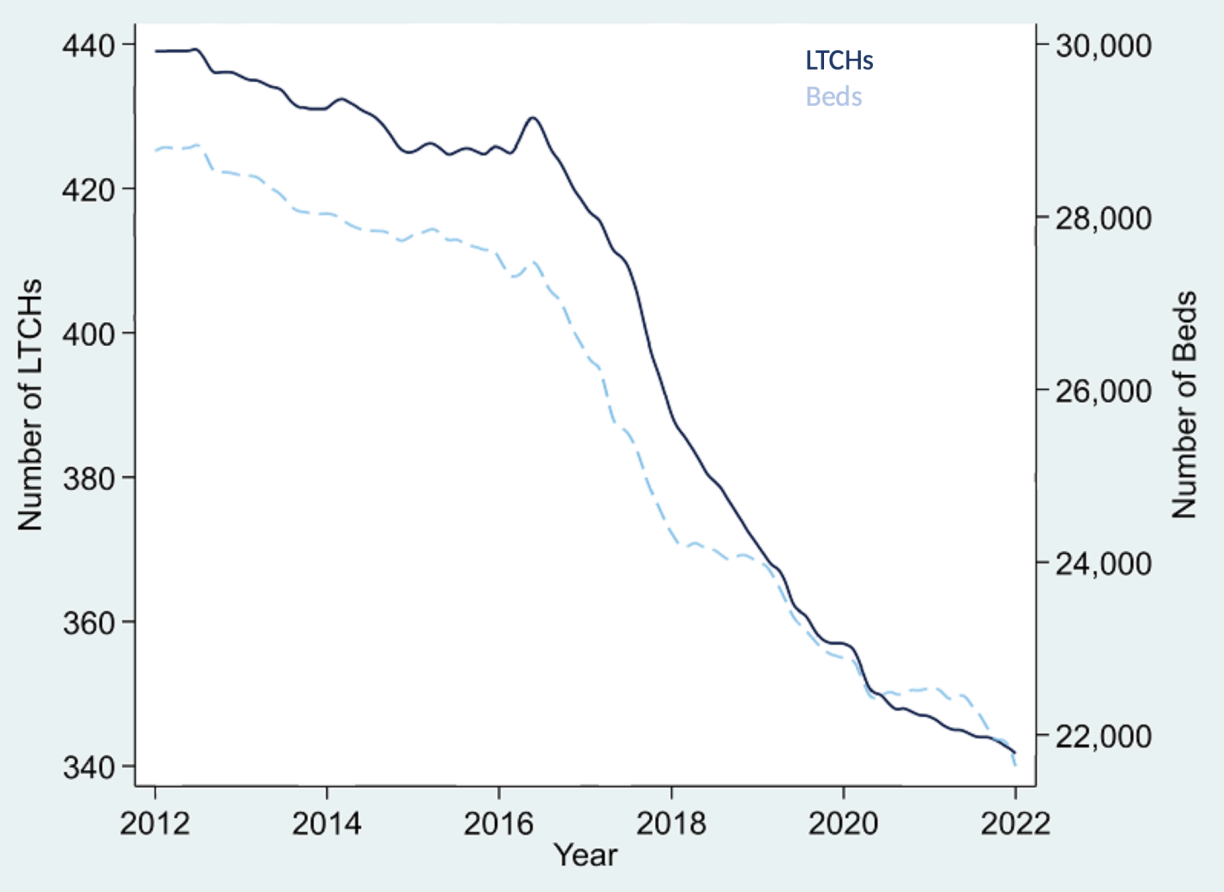
[1] https://repository.library.georgetown.edu/bitstream/handle/10822/1062183/KoenigUnuigbe_Aug2021_1062183.pdf?sequence=2&isAllowed=y
[2] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data
[3] https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/public/researchbriefs&whitepapers/2021/200226.1_nalth_policy_p03.pdf

FINDINGS

There were 439 LTCHs in operation in calendar year (CY) 2012. By the end of CY 2021, 342 LTCHs were still in operation for a net reduction of 97 facilities or 22% of all LTCHs **(Figure 1)**. Over the same period, the number of staffed LTCH beds decreased by 7,039, a 24% reduction. While LTCHs do not operate in all markets because some areas may be too small and do not have enough chronically critically ill and medically complex patients, the large majority of beneficiaries have access to LTCH services within their hospital referral region. However, this percentage is in decline. The share of Medicare beneficiaries with access to an LTCH within their hospital referral region was 78% in 2020, down from 80% in 2016. The reduction in access to LTCH care occurred during a period of significant growth in the number of U.S. residents 65 years old or over (a core group accessing LTCH care), which grew from 43.1 million to 55.8 million between 2012 and 2021, according to the U.S. Census Bureau.

Since 2012, 126 LTCHs have closed and 29 opened. Most of the reductions occurred between 2016 and 2021, with an average of 9.4 LTCHs closures for every opening over this period. Almost 50 LTCHs closed in 2017 and 2018 alone, during the initial phase-in years for the Medicare payment cuts, while 15 closed in 2019, 11 closed in 2020, and five closed in 2021. The slowdown in LTCH closures may be due to the COVID-19 PHE and associated waivers. These specialty hospitals cared for a relatively large share of COVID-19 patients given the small number of LTCHs in the U.S. During the COVID-19 PHE, LTCHs provided a relief valve for crowded hospital intensive care units and other units.

Figure 1: Operational LTCHs and Beds from CY 2012 through CY 2021

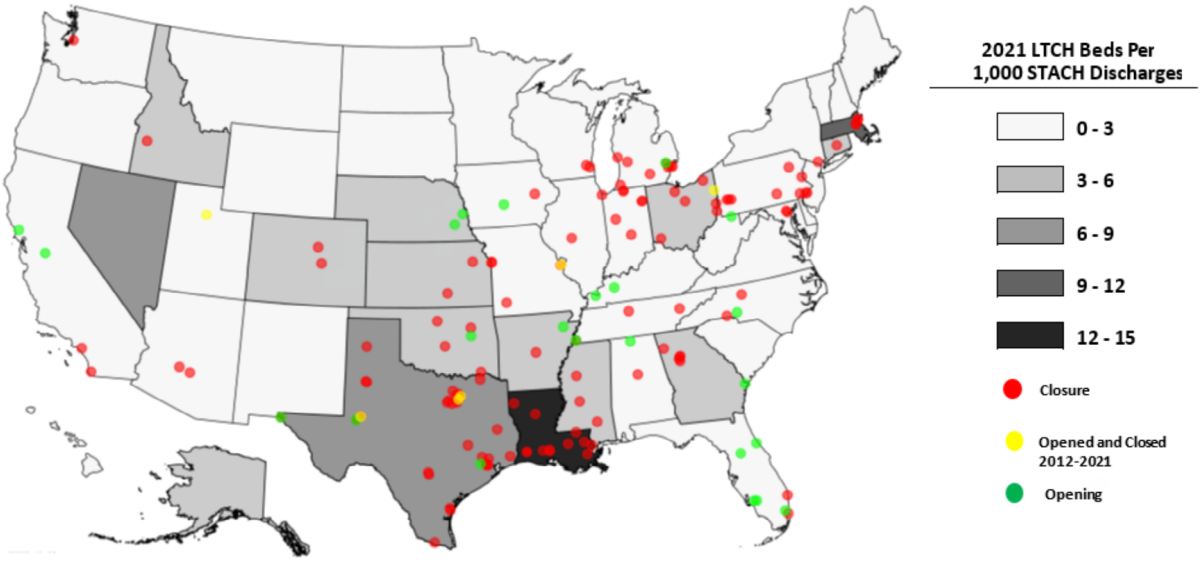


Source: KNG Health Consulting analysis of June 2022 Provider of Services File, June 2022 & October 2019 Provider Specific Files, and 2012-2022Q1 Standard Analytic File

In Figure 2, we show a map of the U.S. indicating where openings and closures occurred between 2012 and 2021, as well as the number of LTCH beds per 1,000 Medicare Fee-for-Service (FFS) discharges from a short-term acute care hospital (STACH) in 2021. Of the 23 states that experienced a decrease in the number of LTCHs over the period, eight of those states had openings, which minimally offset the decrease in LTCHs. In 2012, approximately 50% of all LTCHs were located in seven states: Texas, Louisiana, Ohio, Pennsylvania, California, Florida, and Michigan. Many of these states experienced the most closures, with Texas, Louisiana, Pennsylvania, and Michigan all experiencing reductions between 30% and 42% **(Figure 2).** Florida saw a small net increase in the numbers of LTCHs, while California experienced no net change. Four states had no LTCHs in 2021, and 88% of states had less than five LTCH beds per 1,000 Medicare FFS STACH discharges.

Patient access to LTCHs has fallen significantly since 2012 due to closures and bed reductions. Once the PHE ends, LTCHs will be subject to reimbursement cuts that will result in payments covering less than half of the cost of caring for select patient types.[4] As a result, industry observers expect significant additional closures and bed reductions. Further contraction of the sector may cause patients in some regions to have limited access to the types of specialized care offered in these hospitals, including ventilator weaning.

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



Source: KNG Health Consulting analysis of June 2022 Provider of Services File, June 2022 & October 2019 Provider Specific Files, and 2012-2022 Q1 Standard Analytic File
Note: STACH = Short Term Acute Care Hospital

METHODOLOGY

We used the June 2022 Provider of Services (POS) File, June 2022 Provider Specific File (PSF), and Medicare claims to complete the study. The POS file is publicly available and includes data on facility characteristics and geographic information for all hospitals treating Medicare patients. These data were used to identify facility openings and closures. The PSF provides data on staffed LTCH beds. We used the 100% Inpatient Standard Analytic Files from 2012 to 2022Q1 to examine acute care discharge patterns and verify LTCH opening and closure information. These files include discharge-level information for all Medicare fee-for-service stays at STACHs and LTCHs.

[4] The American Hospital Association. Re: Concerns regarding Payment for LTCH PPS Site-neutral Cases and the LTCH 25% Rule. Accessed on October 28, 2022, at https://www.aha.org/system/files/2018-03/180325-fy-2019-ltch-p-rule.pdf