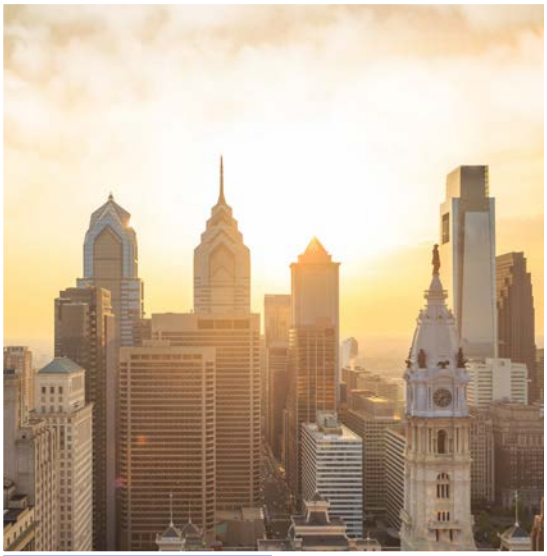
Pennsylvania's Long Term Care Hospitals (LTCHs)

Beyond the ICU

The role of these hospitals in the healthcare continuum and the regulatory threat to their existence



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Key Findings

- The 12 long-term acute care hospitals (LTCHs) in Pennsylvania provided over 130,000 days of inpatient care to critically ill and medically complex patients in 2022. Patients cared for at Pennsylvania's LTCHs had an average length of stay (ALOS) of almost 29 days. By comparison, the ALOS at general hospitals is approximately six days, reflecting differences in severity of illness.

- LTCHs are specialty hospitals that can provide intensive care unit (ICU)-level care and offer focused and specialized care to patients on ventilators, those with multiple organ system failure, and those with severe skin wounds. ICU beds are a limited resource and have too often been in short supply, particularly during the COVID-19 pandemic. The care provided by Pennsylvania LTCHs frees up this valuable resource at general hospitals.

- LTCHs, including those in Pennsylvania, have faced a challenging environment due to low Medicare reimbursement for their most costly patients and an increasing number of prior authorization denials by Medicare Advantage plans. As a result, the number of LTCHs in Pennsylvania has fallen by more than a third since 2016.

- Medicare established the LTCH high-cost outlier (HCO) policy to improve payment adequacy and to help prevent providers from avoiding or underserving the sickest and costliest patients in Medicare. The HCO policy provides additional payments for the costliest of cases. However, recent regulatory changes in how Medicare pays for HCO cases have become the latest challenge facing Pennsylvania LTCHs.

- To be eligible for outlier payments under Medicare, an LTCH must incur a certain amount of financial loss (fixed-loss amount). Medicare pays an LTCH 80 cents for each additional dollar of cost past that fixed-loss amount. If finalized through the regulatory process, the fixed-loss amount will increase to more than $90,000 in fiscal year (FY) 2025, up from roughly $27,000 in 2021.

- Without changes to the pending HCO policy, Pennsylvania LTCHs will be negatively impacted by reductions in outlier payments under Medicare, potentially reducing patient access to care and increasing hospital readmissions. These effects would disproportionately impact the care of some of the most vulnerable and sickest of all Medicare beneficiaries.

Introduction

The Commonwealth of Pennsylvania is home to 12 long-term acute care hospitals (LTCHs). These hospitals specialize in treating the most medically complex patients who require extended hospitalization. LTCHs must meet the same certification requirements as short-term acute care hospitals (STACHs), although they are considered post-acute care providers because almost all LTCH admissions follow a stay in a STACH.[1] In addition, LTCHs are required to have an average length of stay for select Medicare beneficiaries of over 25 days. By comparison, the average length of stay of Medicare beneficiaries at a STACH is around six days, reflecting the difference in average patient complexity between these hospitals.

SINCE 2016, A THIRD OF PENNSYLVANIA'S LTCHS HAVE CLOSED DUE TO AN INCREASINGLY CHALLENGING ENVIRONMENT

LTCHs contribute to the functioning of Pennsylvania's healthcare system in two ways. First, LTCHs free up STACH resources. Research has shown that capacity constraints at STACHs can have negative impacts on quality of care and patient outcomes.[2,3] LTCH admission has been estimated to reduce STACH length of stay and days in an intensive care unit (ICU) by an average of seven and two days, respectively, and 15 and six days for patients on prolonged mechanical ventilation (96+ hours on a ventilator).[4]

Second, LTCHs provide an environment where the most complex patients can receive an extended hospital stay at facilities that specialize in treating these types of patients. During these extended stays, LTCHs use a multidisciplinary approach to care, clinically specialized staff, and care programs designed to treat specific clinical conditions, like respiratory failure and severe wounds.

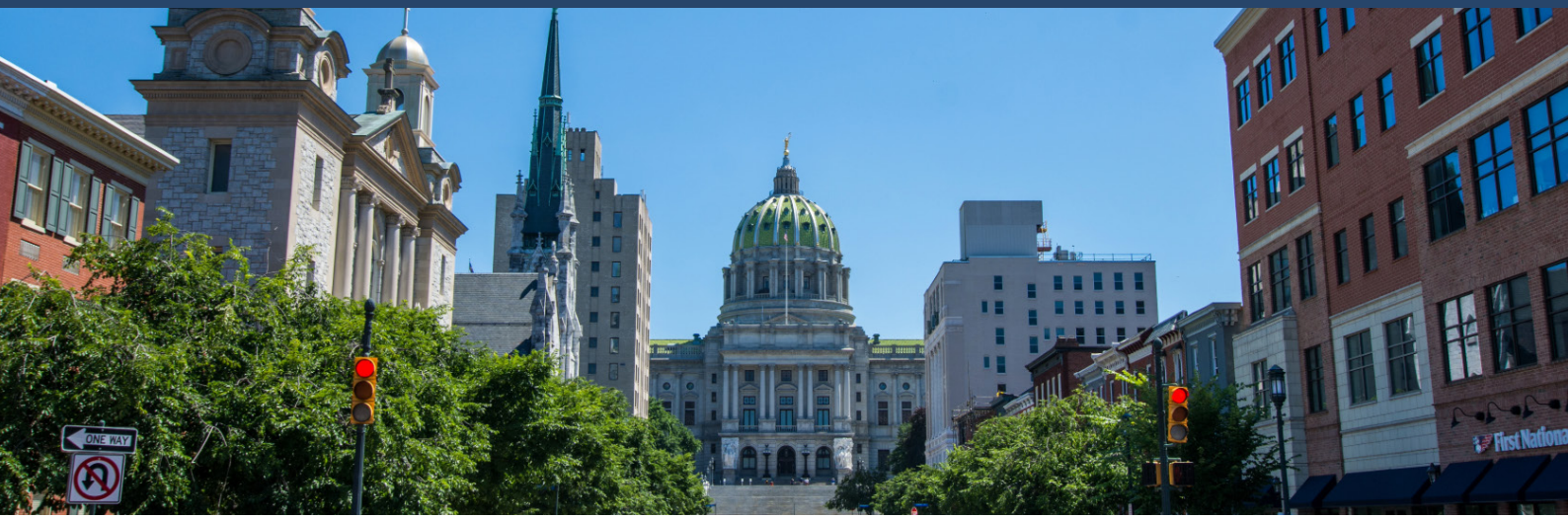
[1] STACHs are general acute care hospitals. Some patients at STACHs have long stays. However, we use the short-stay descriptor for ease of presentation in differentiating these hospitals from LTCHs.

[2] Eriksson CO, Stoner RC, Eden KB, Newgard CD, Guise JM. The association between hospital capacity strain and inpatient outcomes in highly developed countries: A systematic review. J Gen Intern Med. 2017 Jun;32(6):686-696.

[3] Gabler NB, Ratcliffe SJ, Wagner J, Asch DA, Rubenfeld GD, Angus DC, Halpern SD. Mortality among patients admitted to strained intensive care units. Am J Resp Crit Care. 2013;188(7):800-806.

[4] Koenig, L, Steele-Adjognon M, Cintina I. Long Term Acute Care Hospitals Reduce Length of Stay and Days in an Intensive Care Unit for Critically Ill and Medical Complex Patients: Final Report. January 2024. Accessed on April 14, 2024 at https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/LTCH_roundtabley_01162024.pdf

Introduction [cont'd]



Since 2016, a third of Pennsylvania's LTCHs have closed due to an increasingly challenging environment. In that year, the Centers for Medicare & Medicaid Services (CMS) began phasing in a dual payment system established by Congress. The dual payment system encourages LTCHs to focus on patients meeting certain criteria (i.e., those that previously spent three or more days in a STACH ICU or patients on prolonged mechanical ventilation) by significantly reducing reimbursement rates for all other patients. As a result, LTCHs have reduced admissions of patients not meeting the specified patient criteria, and average patient acuity and costs have increased. At the same time, the share of Medicare beneficiaries enrolled in Medicare Advantage has grown from 33 to 51 percent.[5] Medicare Advantage plans use prior authorization to limit the use of LTCHs by their enrollees and, as a result, rates of STACH discharges to LTCHs are 60 percent lower among Medicare Advantage beneficiaries compared to their Traditional Medicare counterparts.[6]

More recently, LTCHs are facing lower reimbursements for very high-cost cases. Under the Medicare LTCH prospective payment system (PPS), these specialty hospitals are eligible for additional "high-cost outlier" (HCO) payments for cases with extremely high costs. An LTCH case is only eligible for HCO payment once an LTCH case's costs exceed the applicable base payment by a specific amount, called the fixed-loss amount (FLA). The FLA is the minimum losses the LTCH must incur before qualifying for any HCO payments. After meeting this threshold, the HCO policy pays 80 cents on the dollar for any additional costs incurred beyond the FLA. In 2024, the FLA is almost $60,000. Between 2021 and 2023, the FLA has more than doubled.

This study aims to assess the role of LTCHs in Pennsylvania, their contributions to the state and residents, and explores the financial implications of the HCO policy on these specialty hospitals.

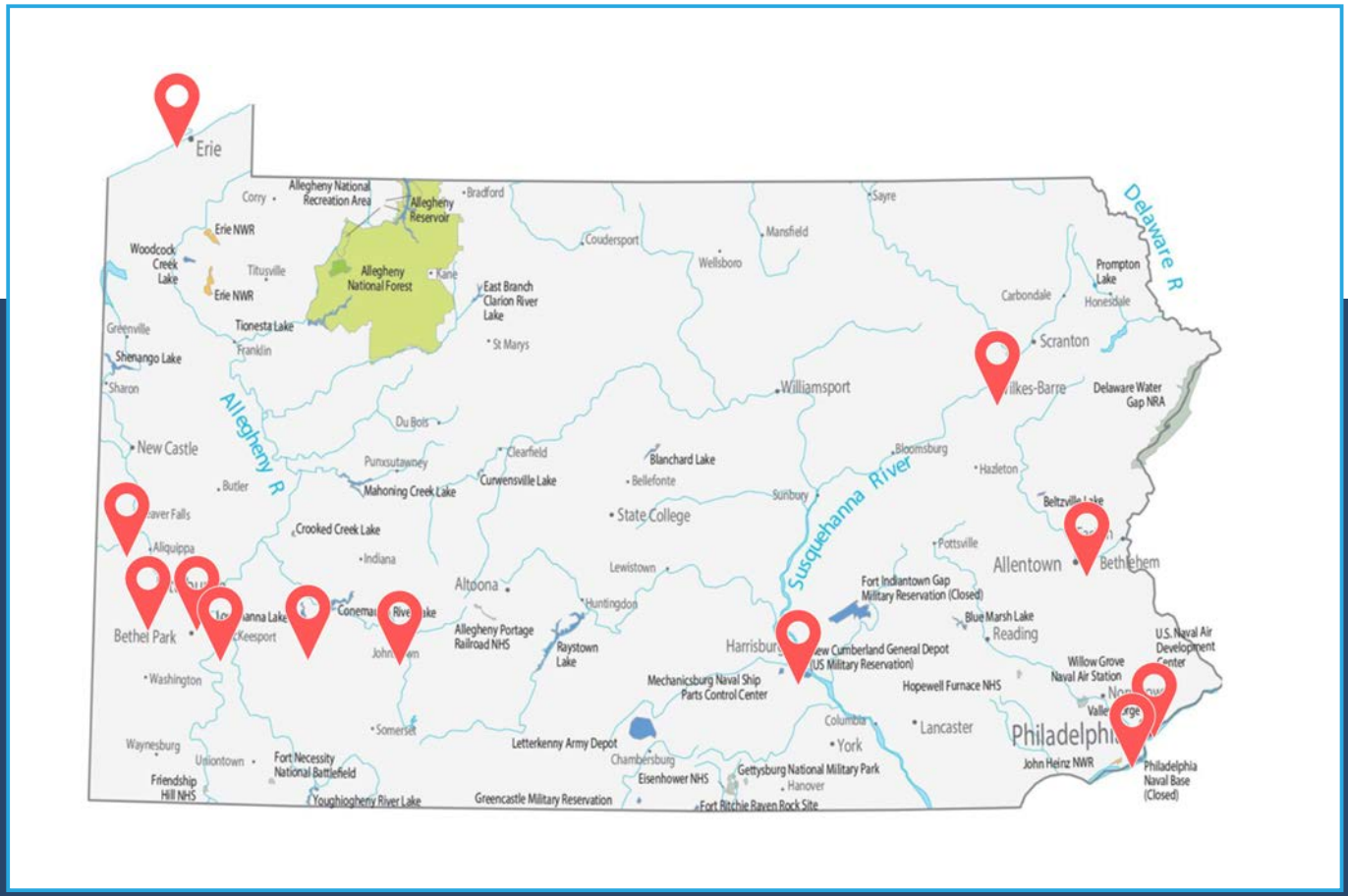
[5] Ochieng N, et al. Medicare Advantage in 2023: Enrollment Update and Key Trends. August 2023. Kaiser Family Foundation. Accessed on April 14, 2024 at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/
[6] https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/itch_roundtable/ltch-ma-final.pdf

Pennsylvania's LTCHs: Patient Care and Economic Contributions to the State

Trends in Number of LTCHs and Patients Treated

There are currently 12 LTCHs in Pennsylvania. These hospitals are scattered throughout the state but tend to be located in or around major cities **(Figure 1)**. In fiscal year (FY) 2022, these LTCHs served more than 4,500 patients who required over 130,000 inpatient days, with patients staying for an average of 28.5 days. Medicare beneficiaries accounted for 44 and 41 percent of total discharges and inpatient days, respectively. While Medicare represents a large share of Pennsylvania's LTCHs' payer mix, the share has decreased over the last few years (2018 shares: 66% Medicare discharges and 63% Medicare days).

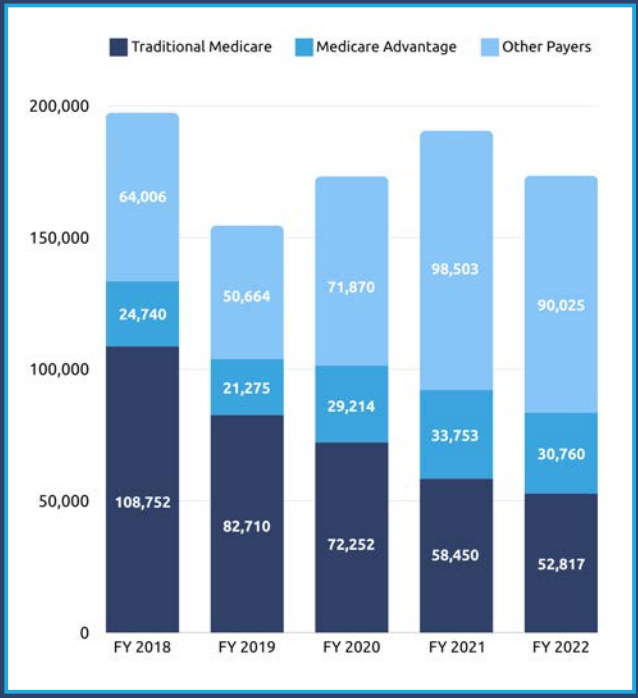
Figure 1. Map of Current Pennsylvania LTCHs



The number of hospitals and patients treated at Pennsylvania LTCHs has also fallen over the last several years. In the FY 2014 claims data, CMS reported 21 Pennsylvania LTCHs in operation with 1,241 beds.[7] For FY 2022, only 13 Pennsylvania LTCHs, with 641 beds, had a Medicare claim in the data.[8] Between 2018 and 2022, Pennsylvania LTCHs experienced a 37 percent decrease in Medicare inpatient days and a 12 percent decrease in all inpatient days **(Figure 2)**.

The contraction of the LTCH sector in Pennsylvania follows nationwide trends.[9] The decreased utilization of LTCH services among Medicare beneficiaries can be explained by the full implementation of the LTCH dual payment system and significant growth in the Medicare Advantage program, under which plans often restrict the use of LTCHs through denials of prior authorization requests.

Figure 2. PA LTCH Inpatient Days from 2018 to 2022



Source: KNG Health analysis of FY 2018 to FY2022 cost reports.

Economic Contributions of Pennsylvania's LTCHs

Based on analysis of FY 2022 Cost Report data, Pennsylvania LTCHs employed almost 2,000 Pennsylvanians with total salaries over $87 million. In addition, these LTCHs paid approximately $4.5 million in taxes to local, state, and federal government.

Following national trends, Pennsylvania LTCHs experienced net financial losses for Medicare in FY 2022. The negative value in 2022 follows two years of positive Medicare margins for Pennsylvania LTCHs and LTCHs nationally.

The small positive margins in 2020 and 2021 were primarily due to a temporary pause of the dual payment system during the COVID-19 public health emergency and suspension of the sequestration. Over the last couple of years, rising costs and staffing shortages have significantly impacted LTCHs. Preliminary estimates of LTCH Medicare margins from 2023 cost reports indicate that the negative trend in Medicare margins was likely experienced by LTCHs in 2023.

[7] Value obtained from the 2016 LTCH PPS Impact File.
[8] Value obtained from the 2024 LTCH PPS Impact File.
[9] Koenig L. et al. Total Patient Care Spending for Long Term Acute Care Hospitals Fell Significantly Between 2015 and 2020, Driven by Medicare Spending Reductions. September 2022. Report prepared for the LTCH RoundTable. Accessed on April 16, 2024 at https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/itch_roundtable/221004_-_LTCH_Roundtable_-_F.pdf

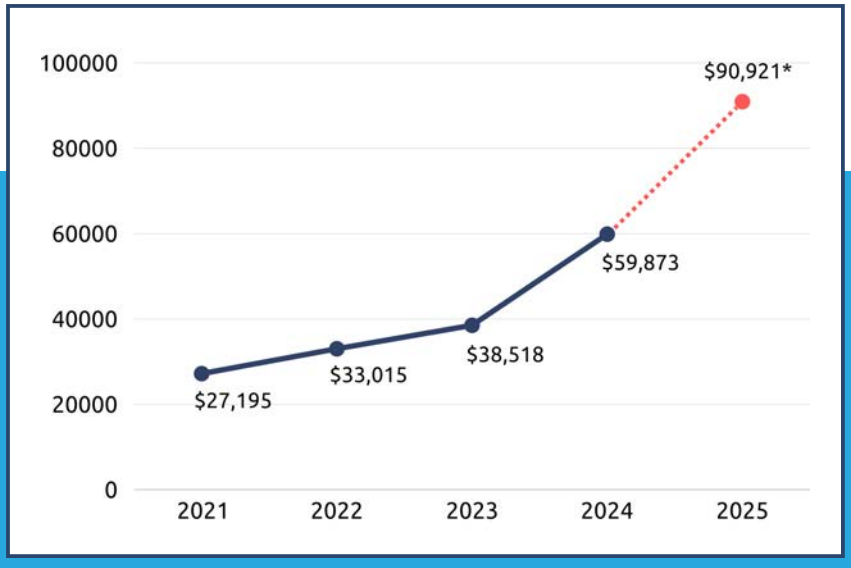
Understanding the High-Cost Outlier Policy and Importance to PA LTCHs

Established under the LTCH PPS, the HCO policy provides additional payments to LTCHs for cases with exceptionally high costs of care. The HCO policy aims to improve payment adequacy under the LTCH PPS and to prevent providers from underserving the costliest patients. To be eligible for outlier payments, an LTCH must incur losses on a case (costs in excess of base payments) of a minimum amount, known as the FLA. Under the LTCH HCO policy, CMS will reimburse an LTCH for 80 percent of costs incurred in excess of the sum of the base applicable PPS payment and the FLA.

CMS sets the FLA each year as part of its annual LTCH PPS rulemaking process. It prospectively forecasts the FLA so that outlier payments are expected to equal 7.975 percent of payments for cases paid under the LTCH PPS. As a result, the HCO threshold changes each year and is dependent on historical claims data and a variety of forward-looking assumptions.

Between 2021 and 2024, the FLA has more than doubled **(Figure 3)**, increasing from $27,195 to $59,873. In other words, currently an LTCH must lose about $60,000 on a case before Medicare provides additional payments to offset losses. In the FY2025 Hospital Inpatient Prospective Payment System (IPPS) and LTCH PPS Proposed Rule, CMS has proposed an FLA for standard rate cases of $90,921, a 52% increase from the 2024 FLA.

Figure 3. Fixed-Loss Threshold between FY2021-FY2025*



Source: FY2021-2025 Medicare Rulemaking.
*Value from FY2025 Proposed Rule.

Because of the rising FLA, the consequences of having high-cost cases can be financially impactful. Many LTCHs are relatively small, discharging, on average, 154 Traditional Medicare beneficiaries in 2022. Despite the increasing FLA, the share of discharges that qualify for outliers in Pennsylvania LTCHs has increased from 9 to 12 percent between 2018 and 2022 **(Figure 4)**. The share of outlier cases varied greatly across providers, ranging from 2 to 40 percent of cases in 2022. HCO cases have consistently represented a disproportionately large share of both payments and costs for Pennsylvania LTCHs, accounting for roughly a quarter of total Traditional Medicare payments and a third of costs.

Figure 4. Share of Cases, Payments and Costs from High-Cost Outlier Cases in PA LTCHs

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Share of Outlier Cases	9%	11%	13%	14%	12%
Share of Payments	19%	22%	24%	26%	24%
Share of Costs	27%	30%	31%	34%	32%

Source: KNG Health analysis of 2017-2022 Standard Analytic Inpatient file.

We demonstrate the effects of the higher, proposed FLA for FY 2025 relative to prior years (2021, 2023) through the presentation of a specific example **(Figure 5)**. We consider a hypothetical case with an LTCH cost of $90,000 in FY 2021. We inflate the costs to FY 2023 and FY 2025 using CMS cost inflation adjustment applied to develop the FLA in those years. We then estimate outlier payments and LTCH losses on the case at the FLA in place in 2021 and 2023 and the proposed FLA for 2025.

Between 2021 and 2023, the financial loss experienced by the LTCH increases by roughly 38 percent, increasing from $31,442 to $43,379. Under the proposed FY 2025 FLA, the same case would no longer qualify as an HCO, precluding the LTCH from receiving additional payment. As a result, the financial loss on this case increases 83% compared to FY 2023 (from $43,379 to $79,321).

Figure 5. Total and High-Cost Outlier Payments

Estimated Cost of Care			
	FY 2021	FY 2023	FY 2025 PR
Estimated Cost of Care	$90,000	$106,933	$126,120
HCO Threshold Calculation			
LTC-DRG Payment + Fixed-Loss Amount			
	FY 2021	FY 2023	FY 2025 PR
LTC-MS-DRG Payment	$41,568	$44,111	$46,800
Fixed Loss Amount	$27,195	$38,518	$90,921
HCO Threshold	**$68,763**	**$82,629**	**$137,721**
HCO Payment			
80% x (Estimated Cost of Case - HCO Threshold)			
	FY 2021	FY 2023	FY 2025 PR
Qualify for HCO Payment	**Yes**	**Yes**	**No**
Estimated Cost of Care	$90,000	$106,933	$126,120
HCO Threshold	$68,763	$82,629	$137,721
Differences	**$21,237**	**$24,304**	**($11,600)**
	x 80%	x 80%	x 80%
HCO Payment	**$16,990**	**$19,443**	**$0.00**
Final Payments and Losses			
Medicare Covered Charges x Overall Hospital CCR			
	FY 2021	FY 2023	FY 2025 PR
Final Medicare Payment	$58,558	$63,554	$46,800
Cost of Care	$90,000	$106,933	$126,120
Total Loss on Case	($31,442)	($43,379)	($79,321)

Note: PR=Proposed Rule
Source: KNG Health Analysis of FY2021 and FY2025 IPPS/LTCH PPS Rules

Comparison of High-Cost Outliers to Other Cases

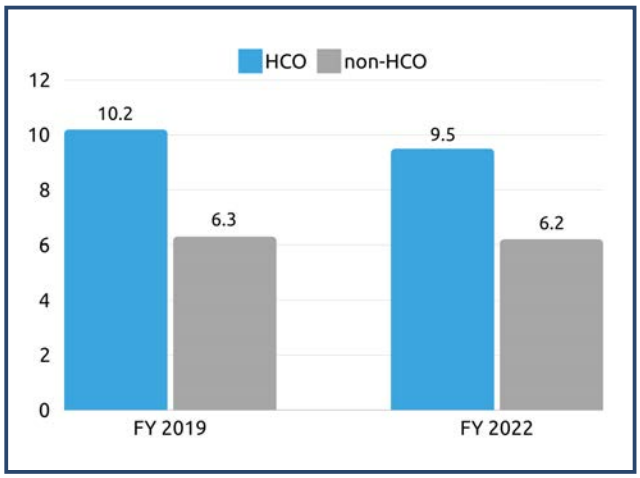
Patients that receive HCO payments in Pennsylvania's LTCHs exhibit distinct clinical and financial characteristics compared to non-high-cost patients. Within both the STACH and LTCH settings, HCO patients are significantly more medically complex and costlier than their non-high-cost counterparts.

Clinical Characteristics

To assess patient complexity, we calculated the number of complications or comorbidities (CC) and major complications or comorbidities (MCC) a patient had based on their LTCH claim. CMS uses CCs and MCCs as part of its grouper to assign patients to payment groups, or Medicare-Severity Diagnosis-Related Groups (DRGs).

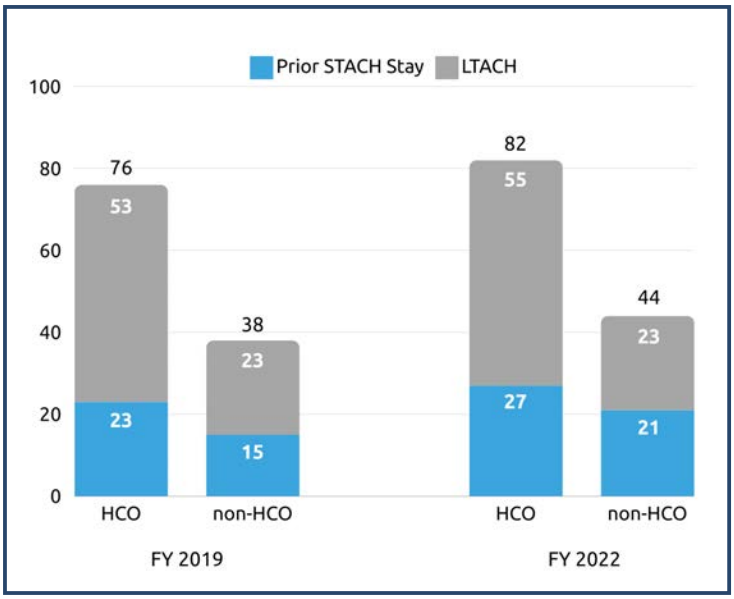
DRGs with a CC or MCC have higher payments because comorbidities and complications correlate with higher costs of care. We found that HCO patients at LTCHs exhibited more elevated rates of CCs and MCCs than non-HCO patients, indicating more complex healthcare needs and greater resource utilization **(Figure 6)**.

Figure 6. Average Number of Comorbidities and Complications at PA LTCH*



Source: KNG Health Consulting analysis of 2019 & 2022 Standard Analytic Files.
Notes: HCO=High-Cost Outlier; FY=Fiscal Year
*This was calculated by summing the complication or comorbidity and major complication or comorbidity counts

Figure 7. Average Length of Stay

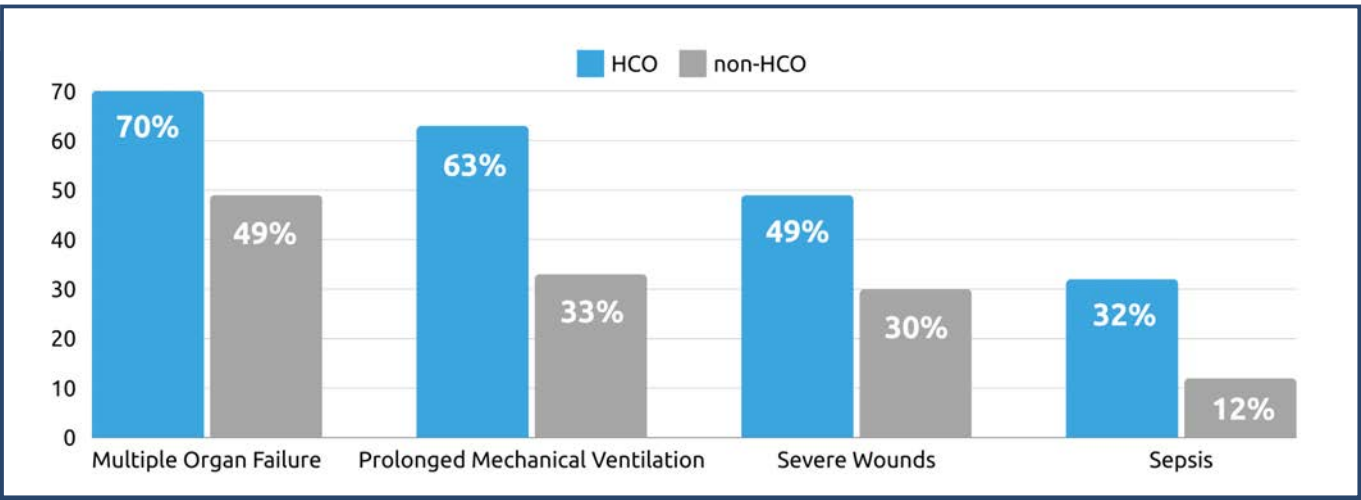


LTCH HCO patients also experienced prolonged hospital stays during their LTCH stay and during the STACH stay immediately preceding admission to the LTCH **(Figure 7)**. During prior STACH stays, LTCH HCO patients spent more time, on average, in the ICU than other patients. In addition, in FY 2022, HCO patients averaged 22 days in the STACH ICU, while their less costly counterparts averaged 18 days (not shown in Figure 7).

Source: KNG Health Consulting analysis of 2019 & 2022 Standard Analytic Files.
Notes: HCO=High-Cost Outlier; LTCH=Long-Term Acute Care Hospital; STACH=Short-Term Acute Care Hospital

LTCHs specialize in the treatment of conditions like multiple organ failure, prolonged mechanical ventilation, severe wounds, and sepsis. The share of HCO patients with those conditions is significantly higher than for non-HCO patients **(Figure 8)**.

Figure 8. Clinical Characteristics by HCO Status



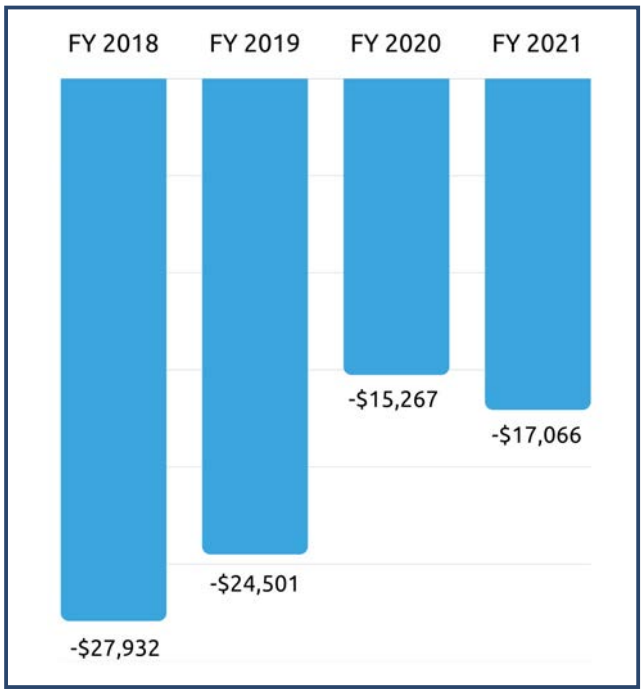
Source: KNG Health Consulting analysis of 2022 Standard Analytic Files.
Notes: LTCH=Long-Term Acute Care Hospital; MOF=Multiple Organ Failure; PMV=Prolonged Mechanical Ventilation; HCO=High-Cost Outlier; FY=Fiscal Year

Financial Characteristics

HCO patients consistently have lower payment-to-cost ratios (PCRs) than those for non-HCO LTCH patients, indicating a higher degree of financial strain on LTCH facilities that provide care to these individuals. A PCR less than 1.0 indicates that the LTCH experiences a financial loss on a patient. Between 2018 and 2022, the PCR for HCO patients was less than one, while the PCR for non-HCO patients was greater than one. In 2022, for example, the PCR was 0.73 for HCO patients at LTCHs, indicating that, on average, LTCHs received 73 cents for each dollar of cost for these patients. Additionally, the PCR for all LTCH cases in Pennsylvania decreased from 1.07 in 2019 to 0.97 in 2022, reflecting increasing financial strain over time. The average costs per discharge for HCO patients were substantially greater, reflecting the elevated expenses associated with managing their healthcare needs. As explained above, the losses incurred due to treating HCO patients are only partially covered by HCO payments **(Figure 9)**.

Should the proposed FY2025 FLA go into effect, the PCR for LTCHs that treat the sickest and most costly patients will continue to decrease.

Figure 9. Average Net Loss on HCO Cases



Source: KNG Health Consulting analysis of 2022 Standard Analytic Files.
Average net loss accounts for HCO payments.
Notes: HCO=High-Cost Outlier; FY=Fiscal Year

Discussion

This study examines the role of LTCHs in the Commonwealth of Pennsylvania and the challenges faced by these specialty hospitals. In 2012, 12 LTCHs in Pennsylvania provided over 130,000 days of inpatient care, helping to free up ICU beds at general hospitals by providing focused and specialized care to patients on ventilators, those with multiple organ system failure, and severe skin wounds. However, the number of LTCHs in Pennsylvania has fallen by more than a third since 2016.

Proposed changes to Medicare's high-cost outlier policy have the potential to negatively impact Pennsylvania LTCHs' ability to continue to care for the sickest and most vulnerable Medicare beneficiaries residing in Pennsylvania. Without changes to the policy, Pennsylvania LTCHs will face material reductions in outlier payments.

If the proposed FY2025 HCO policy is not revisited, it may have consequences for Pennsylvania's LTCHs and their patients, including:

Reducing Access to Care

The financial strain incurred by LTCHs due to lower PCRs for HCO patients may compromise the availability and quality of care provided to all patients. This could result in reduced access to essential medical services for those few, but very sick, Medicare beneficiaries in need of LTCH care.

Increasing Hospital Readmissions

Inadequate resources and capacity constraints stemming from the HCO policy may contribute to premature patient discharge or inadequate rehabilitation, leading to heightened rates of hospital readmissions. Such readmissions not only impose additional burdens on patients but also strain healthcare resources and incur avoidable costs.

Recommendations

Between substantial increases in labor costs and the financial pressure associated with treating fewer and sicker patients, Pennsylvania LTCHs are facing significant challenges. Given the rapid increase and high proposed level for the HCO FLA, policymakers should re-examine the methodology used by CMS to pay for such cases, and work to find long-term solutions that mitigate the risk LTCHs face when treating the sickest and most costly Medicare patients.