Joint Economic Committee Democrats

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Long Term Care Hospitals: More Facilities, More Expenditures, More Questions

Long Term Care Hospitals (LTCHs) have undergone recent rapid growth, consume an increasing amount of Medicare expenditures, report high profitability, and appear to admit many patients who may be served equally well in a less costly treatment venue. These findings call for the close monitoring of this industry and for possible corrective interventions by the Centers for Medicare and Medicaid Services (CMS) and/or Congress.

Background

LTCHs are one of four types of post-acute care settings that are reimbursed under the Medicare program. The other post-acute care venues are skilled nursing homes (SNFs), inpatient rehabilitation facilities and home health care services.

A LTCH must meet the requirements of an acute hospital facility and have an average patient stay of longer than 25 days to be eligible for Medicare payments. This length-of-stay criteria is calculated using only Medicare admissions. There are no clinical patient criteria under Medicare for entrance into a LTCH except the anticipated 25-plus day length of stay. Patients in LTCHs are generally medically complex and have conditions that include ventilator dependency, multiple medical system failures, complicated infectious conditions, wound care and post-surgical recuperation.

Currently, only 1 percent of Medicare beneficiaries discharged from acute hospitals are transferred to LTCHs. These facilities are the most expensive on average of all the post- acute alternatives. **Table 1** displays data from the CMS website on the approximate base cost per episode for each of the post-acute settings. These costs can be adjusted upward based on the severity of the patient's clinical diagnosis.

Table 1

Base Cost per Episode in Medicare Post-Acute Settings

Setting	Cost
Home Health Care Services	$4,000
Skilled Nursing Facility (SNF)	$8,300
Inpatient Rehabilitation Facility	$12,500
Long-Term Care Hospital (LTCH)	$35,700

LTCHs were initially reimbursed on the basis of an average cost per patient discharged. CMS, following a mandate from the Balanced Budget Refinement Act of 1999, developed a prospective payment system (PPS) that began implementation in 2002. Under this system, facilities are reimbursed a specified rate based on patient diagnosis; length of stay is not a factor unless it falls significantly below the anticipated 25-day period. LTCH payments are currently in the midst of a five-year transition to this PPS. However, companies can elect to switch more quickly to full

PPS reimbursement. Wall Street analysts' reports indicate that for-profit providers are choosing to convert to the PPS much faster than required due to its increased profitability. This profitability is produced by the ability of the facilities to significantly decrease length of stay while receiving the same prospective payment that is based on a longer length-of-stay. For example, Kindred, a major for-profit provider in the industry, reduced its Medicare length of stay in its LTCHs from 34.8 days to 31.6 days (or 9.2 percent) over just the past year.

Recent Rapid Growth in Long-Term Care Hospitals

According to the June 2003 Medicare Payment Advisory Commission (MedPAC) Report to Congress, there has been substantial growth in the number of these facilities over the past decade. Since 1993, the number of LTCHs has increased from 109 to 300 facilities—an increase of over 275 percent. Whereas early LTCHs tended to be large freestanding government or not-for-profit facilities, the newer facilities tend to be smaller, for-profit and located as a separate entity within a larger acute hospital – the so-called "hospital within hospital" model.

Annual Medicare LTCH spending has jumped from $398 million in 1993 to $1.9 billion in 2001 – an increase of over 475 percent.

The hospital within hospital model is very attractive to traditional acute care hospital settings, which Medicare also reimburses with a set rate based on diagnosis. These facilities are financially rewarded for short lengths-of-stays and are penalized for longer lengths-of-stays. LTCH units located in the same physical plant as the acute care hospital offer a readily accessible placement for longer stay patients and a profitable conversion alternative for under-productive hospital space. MedPAC reports that acute care hospitals that were primary referrers to LTCHs have substantially higher aggregate Medicare inpatient margins than the aggregate margins for all acute hospitals.

Corresponding with the increase in the number of facilities is a rapid increase in Medicare spending on LTCHs. Annual Medicare LTCH spending has jumped from $398 million in 1993 to $1.9 billion in 2001 – an increase of over 475 percent. CMS estimates that expenditures for LTCHs will reach $2.3 billion annually by 2005 and $2.96 billion by 2009.

For-Profit Sector Growth and High Profitability in Long Term Care Hospitals

Two large for-profit companies, Kindred Healthcare (formerly Vencor) and Select Medical, account for much of the recent rapid growth in these facilities. According to Securities and Exchange Commission (SEC) filings, Kindred has increased the number of their LTCHs by almost 17 percent to 77 facilities in the past year. Similarly, Select Medical showed an increase from 57 to 66 LTCH facilities over the past year—an increase of almost 16 percent. These new facilities are almost exclusively of the hospital within hospital model and both companies report intentions to continue this high rate of expansion.

Earnings from the LTCH divisions of both these companies show significant increases. Recent SEC filings indicate that 9-month earnings increased 19.5 percent for the same period in the prior year for Kindred. Select Medical reported a remarkable 91 percent increase. Both companies are reporting robust margins of around 20 percent from their LTCH business. This compares to profit margins this year of 3-5 percent and 1-2 percent for publicly traded acute hospital and SNF companies respectively. Wall Street recognition of these increased earnings and the industry's positive

earnings outlook is likely related to the 300 percent increase that has been posted this year in the stocks of these publicly-traded companies.

Skilled Nursing Facilities and Long Term Care Hospitals as Substitutes

Recent MedPAC data suggest that SNFs and LTCHs may be clinical substitutes for each other despite a 4 to 5-fold cost differential to Medicare—$8,000 vs. $35,700 respectively. There may be substantial overlap between the types of patients being treated in each venue. For example, the likelihood of admission into either a SNF or LTCH increases with clinical complexity, but the likelihood of a SNF admission decreases with the physical proximity of an LTCH facility. In market areas that did not have a LTCH facility, 61 percent to 90 percent of patients across diagnoses with the highest clinical severity are admitted into SNFs. This potential for LTCHs to substitute for less costly SNF care is exacerbated by the fact that there are currently no clinical patient admission criteria for LTCH's except for the anticipated 25-plus day length of stay.

SNFs and LTCHs may be clinical substitutes for each other despite a 4 to 5-fold cost differential.

More research is needed to determine which specific clinical conditions are best served in LTCHs based on outcome data and/or which clinical services are only available in an LTCH setting.

Conclusions

This review of the LTCH segment of the Medicare provider network raises several important public policy questions:

1. Is there evidence of <u>clinical need</u> to support the rapid growth in LTCH facilities — particularly the hospital within hospital LTCH facilities? Do LTCHs have better outcomes for specific conditions or offer services that are not available in other settings? The possibility that this rapid growth is being fueled primarily by the high profitability of these facilities should be investigated. Furthermore, is this a case of what the respected Dartmouth health care analyst Dr. John Wennberg calls supply sensitive services where the growing number of suppliers are creating excessive demand rather than a real clinical need driving this expansion?

2. Is the current Medicare payment system inappropriate or is the reimbursement amount excessive for LTCH services?

3. Are LTCHs and SNFs clinical substitutes? Are there clinical criteria that can be developed to determine which patients require LTCHs vs. SNFs? If these venues can effectively treat some of the same patients, why should Medicare be paying a significant premium for one setting over the other for the treatment of these similar patients?

In the interim, it may be appropriate for Congress, which is responsible for the oversight of Medicare expenditures, to enact legislation temporarily placing a moratorium on the future growth of this provider segment until these questions are answered. Both MedPAC and the Health and Human Services' Office of the Inspector General are already investigating aspects of these issues. LTCHs, SNFs, patient advocacy groups and other relevant sources can offer additional data. Using the data obtained during this moratorium, CMS and the Congress can make an informed decision on what interventions are necessary within the LTCH industry to both ensure beneficiaries are receiving the treatment they require and that Medicare funds are being prudently spent.

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