Health Policy Newsletter

Volume 17 Number 3 **September, 2004** **Article 4**

The Health Policy Debate Regarding Long-term Care Hospitals

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD*

*University of the Sciences in Philadelphia

Suggested Citation:
Stefanacci RG. The health policy debate regarding long-term care hospitals. Health Policy Newsletter 2004; 17(3): Article 4. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol17/iss3/4.

The Health Policy Debate Regarding Long-term Care Hospitals

In what has been referred to as a transformation of health care delivery in South Philadelphia, Thomas Jefferson University Hospital's (TJUH) Methodist Hospital Division acquired the acute care operations of TJUH's and Mercy Health System's St. Agnes Medical Center. St. Agnes will now be home to a joint Methodist/St. Agnes long-term care hospital (LTCH). Given the significant role that the long-term care hospital will play in this new continuum of care system in South Philadelphia and the careful attention that LTCHs are receiving on Capitol Hill, the issue of health policy surrounding LTCHs is timely.

To begin the discussion of LTCHs, some background information is essential. An LTCH must meet many of the requirements of an acute care hospital facility and have an average patient stay of longer than 25 days to be eligible for Medicare payments. Currently, there are no clinical patient criteria under Medicare for entrance into an LTCH except the anticipated 25-plus day length of stay. LTCH patients are generally medically complex, having conditions that include ventilator dependency, multiple medical system failures, complicated infectious conditions, wound care and post-surgical recuperation. If the average length of stay falls below 25 days, the facility is considered an acute care facility, where reimbursement levels are generally lower because they are based on much shorter lengths of stay. This system provides incentives for acute care facilities to transfer patients to other facilities such as LTCHs, where an additional charge is paid and lengths of stay are expected to be at least 25 days.

LTCHs are one of four types of post-acute care settings that are reimbursed under the Medicare program. The other postacute care venues are skilled nursing facilities, rehabilitation facilities and home health care services. Since 1993, while the growth of other post-acute care venues has been moderate or down, there has been over a 275 percent increase in the number of LTCHs. A principle reason for their growth is the rise in the "hospital within a hospital" model. Here systems are financially rewarded for shortening their acute length of stay by transferring their patients to LTCHs. As a result of this growth, Centers for Medicare and Medicaid Services (CMS) expenditures for LTCHs grew from $398 million in 1993 to $2.8 billion this year. This is also reflected in the profit margins for these facilities, which average around 20 percent, while acute care hospital and skilled nursing facilities have experienced three to five percent and one to two percent profit margins respectively.[1]

The concern from a health policy perspective, raised by Congress, is whether LTCHs are worth the resources being spent on them. Fisher and colleagues helped validate a long held, but seldom proven, belief that more resources do not equate to better outcomes.[2] In fact, they were able to show that in areas of the country where greater health care resources are utilized outcomes were poorer.

This view underlies the concern over LTCHs, illustrated in a recent Joint Economic Committee brief that examined the base cost per episode in Medicare post-acute settings. The brief demonstrated that LTCHs had a base cost per episode of care of $35,700 compared with $4,000 for home health care services, $8,300 for skilled nursing facilities (SNFs), and $12,500 for inpatient rehabilitation facilities.[3] While the analysis of the Joint Economic Committee did not necessarily compare similar patients, a recent Medicare Payment Advisory Commission (MedPAC) study suggested that SNFs and LTCHs may be clinical substitutes for each other despite a four to fivefold cost differential. MedPAC also

demonstrated that use of LTCH care grows four-fold if a facility is in a community, meaning we utilize the resources that are available, sometimes despite the lack of true need.[4]

In the end, sound health policy needs to be developed that assures that patients are cared for in the most efficient and effective system for the best outcomes. MedPAC has supported CMS's objective to ensure that long-term care hospitals serve Medicare beneficiaries who need acute long-term care and cannot be treated by acute care hospitals. One specific recommendation has been that review by the quality improvement organizations to monitor appropriateness of patients for LTCHs be implemented. It is clear that simply having an entry criteria based on length of stay does not assure that the most appropriate patients are cared for in LTCHs. Health policy needs to be developed to assure appropriate admission criteria and payments needed for efficient use of our limited health care resources.

References

1. Liu K, Baseggio C, Wissoker D, Maxwell S, Haley J, Long S. Long-term care hospitals under Medicare: facility-level characteristics. *Health Care Financing Review* 2001;23:1-18.

2. Fisher ES, Wennenberg DE, Stukel TA, et al. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Annals of Internal Medicine* 2003;138:273-287.

3. Joint Economic Committee. Long-term care hospitals: more facilities, more expenditures, more questions (Economic Policy Brief). Washington, DC. February 2004.

4. Medicare Payment Advisory Commission. Medicare payment policy. (Report to Congress). Washington, DC. June 2004.

About the Author

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is the Founding Executive Director of the Health Policy Institute at the University of the Sciences in Philadelphia. Please address questions and comments to r.stefan@usip.edu.