

## **Climate Too Chilly for LTACH Moratorium**

**by**

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The old saying is that nothing succeeds like success. In the health care industry, however, that saying might be changed to nothing attracts the attention of legislators and regulators like success. Such was the case with physician-owned specialty hospitals whose popularity led to Congress placing an 18-month moratorium on new development in the Medicare Prescription Drug and Modernization Act, which became effective on December 8, 2003. Now the growth in the number of long term acute care hospitals (LTACHs) has prompted Representative Pete Stark (D-CA) to propose a temporary moratorium on their development. There is every reason to believe, however, that the similarities end there. The current political climate does not favor the imposition of a moratorium on LTACHs, as it did in the physician-owned hospital situation, and, in the case of LTACHs, the substantive arguments against a moratorium are very compelling.

Representative Stark's action was apparently in response to a report issued by the Medicare Payment Advisory Commission ("MedPAC"),<sup>1</sup> According to his press release, Representative Stark's concern seems to be focused on three factors:

1. According to the MedPAC report, in the past decade, the number of long term acute care hospitals ("LTACHs") in the United States has grown from 109 to 300 and Medicare expenditures directed to LTACHs have increased from \$398 million in 1993 to an anticipated \$2.3 billion in 2005;
2. The growth in LTACHs, according to Representative Stark, "is being fueled by large, for-profit companies that are reporting significant revenue increases and robust profit margins;" and
3. The suggestion in the MedPAC report that LTACHs are being used as a "substitute" for less costly skilled nursing facilities ("SNFs").

As the name of his bill suggests, Representative Stark proposes to address these concerns by placing a moratorium on new LTACH development. Rather than placing a set date on the end of the moratorium, the bill would actually leave it up to the Secretary of Health and Human Services to determine when to lift the ban. Formally, Representative Stark's bill would place a temporary moratorium on the development of new LTACHs until the Secretary of Health and Human Services makes three determinations:

1. There is a clinical need for a growth in the number of beds in long-term care hospitals;

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<sup>1</sup> Variation and Innovation in Medicare, June 2003.

2. An appropriate reimbursement system and rate is in place for Medicare payment for LTACHs; and
3. There is a clinical admission policy for LTACHs that minimizes the admission of patients into LTACHs that can appropriately be treated in less costly settings.

The moratorium would end when the Secretary makes these findings and presents them to Congress one month in advance of the end of the moratorium. LTACHs “in operation or under development (as determined by the Secretary)” on the date that the act becomes effective would not be subject to the moratorium.

As we shall see, there are substantial reasons to question both Representative Stark’s concerns and the need for the findings mandated by his bill. Given the current political climate, however, there appears to be little chance that the bill will make it through Congress.

At first blush, one might expect that Congress would embrace a moratorium on a “fashionable” provider venue like the LTACH, as it did in the case of physician-owned specialty hospitals. However, there are major differences in the constituencies between those that supported the moratorium on specialty hospitals and any constituency that would support a moratorium on LTACHs. The anti-physician-owned bill was widely supported by community hospitals, community hospital systems, hospital associations and their lobbyists who were concerned about the potential competition from the specialty hospitals. This, however, is the same group that is benefiting or will benefit from the presence of LTACHs in their systems. Not only are they unlikely to support Representative Stark’s new bill, but it would hardly be surprising if they oppose it.

### **LTACH Growth and the For-Profits**

According to Representative Stark, one of the major reasons for concern is the three-fold growth in the number of LTACHs in the last decade. While that may look like a lot of growth in the abstract, one needs to consider that there are approximately 5,000 acute care hospitals in the United States. 300 LTACHs represents only 6 percent of that figure. Thus, it is at least as reasonable to assume that the growth in LTACHs is being fueled by unmet patient need as much as it is by positive profit-margins. This small percentage also speaks to Representative Stark’s argument that the same types of patients are being placed in LTACHs as were formerly being placed in skilled nursing facilities. Studies have shown that these patients are, in fact, remaining in the acute care hospital without reimbursement to the provider. LTACH case managers and physicians have been carefully adhering to medical necessity criteria to ensure that only medically appropriate patients are being admitted to LTACHs.

As far as profit-margins are concerned, Representative Stark's focus on the major presence of for-profit corporations in LTACH development ignores the fact that the way the federal government has structured the system virtually guarantees more opportunity for the for-profit corporations than it does for the non-profit hospital or healthcare system. In order to be certified as an LTACH, the current regulations require the hospital to undergo a 6-month data collection period during which the hospital establishes that its Medicare patients have an aggregate length of stay of at least 25 days. During this 6-month period, the hospital is paid only at the Acute Care Prospective System rate. Thus, patients that are occupying the hospital's beds for three weeks or more are being reimbursed for only 3 to 5 days of that period. As a result, the typical LTACH experiences losses of \$1.5 million to \$2 million during that six-month period before it starts to see a positive influence on its finances.

This situation provides the for-profit companies with a tremendous advantage, since they can turn to all the traditional forms of financing, including the investment banking community, in order to clear this hurdle. The only options for non-profit hospitals and healthcare systems, on the other hand, are to issue bonds or to seek out equity partners. Thus, as long as the 6-month "penalty period" remains in place, the major for-profit presence in LTACHs will continue, but not so much because of profits as because of the availability of financing.

### **"Appropriate Reimbursement" and Admissions**

Representative Stark's statements that LTACHs lack appropriate reimbursement mechanisms and admission criteria ignore the careful thought that CMS put into the development of the prospective payment system for LTACHs ("LTC-PPS"). The LTC-PPS was put in place by CMS in 2002 only after careful study of its experiences in cost-based reimbursement of LTACHs under TEFRA. The reimbursement amounts assigned to each LTC-DRG were designed to match the acuity level of the DRG with the anticipated length of stay. As it has gained experience with the LTC-PPS, CMS has carefully adjusted reimbursement levels. This was done in the 2003 update to the LTC-PPS and again in the proposed update that CMS issued in January of this year. It is difficult to imagine that, as Congress considers Representative Stark's bill, it will not arrive at the conclusion that an appropriate reimbursement mechanism is already in place. In their own words, when increasing the LTACH market basket by 2.9 percent, CMS stated in its introduction to the proposed update, LTACHs "are designed to assure appropriate payment for services to the medically complex patients treated in these facilities, while providing incentives to hospitals to provide more efficient care of Medicare beneficiaries."

As for admission criteria, Representative Stark's proposal ignores the fact that unlike other post-acute care facilities, an LTACH is an acute care hospital exactly like all other "general" acute care hospitals. A physician referring a patient to an LTACH must certify the medical necessity for an acute level of care including 7.5

– 9.0 direct nursing hours and daily physician visits for that patient just as the physician must do for the general hospital. This overriding medical necessity criterion, of course, remains in place throughout the patient’s stay in the LTACH. In other words, just as in all other hospitals, the criteria for admission to an LTACH is medical necessity.

### **Opportunity Presented by the “Under Development” Exemption**

Even if Representative Stark’s proposal were to become law, the bill itself presents an opportunity for hospitals and hospital systems seeking to add LTACHs to their continuum of care to avoid its application. The bill, by its terms, would exempt from the moratorium any LTACH “under development” on the date that it becomes effective. The bill leaves it to the Secretary of DHHS to define what “under development” means. It can be expected that DHHS will utilize the definition of “under development” found in the physician-owned hospital moratorium, which contains a similar exemption. That exemption requires CMS to consider:

- “(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and
- “(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such a date.”

Given the pace of the legislative process, any hospital or hospital system seeking to develop an LTACH that completes the initial regulatory filing process and commissions architectural plans for the LTACH within the next 12 months should be able to come within the “under development” exemption.

### **Conclusion**

Considering the current political climate and the broad-based constituency that would support continued LTACH development, it is unlikely that Representative Stark’s proposal will become law. Sound arguments support the conclusion that no such moratorium is necessary. However, even if the bill were enacted, the bill’s “under development” exemption gives providers an excellent opportunity to avoid the moratorium’s effects if they act promptly.

About the Author:

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