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The Hidden Costs of Therapy Management Models

Skilled Nursing Facility (SNF) Providers continue to weather reimbursement changes, increased regulatory scrutiny and face ongoing staffing challenges. These Providers are searching for innovative solutions to improve outcomes in the most cost-effective ways. The objective of this whitepaper is to assess the relative operational, clinical and financial differences between adopting a Management Agreement Model (Advisor) contrasted with an outsourced Full-Service Contract Rehabilitation Model (Partner). This paper should answer questions Providers might have about the most cost-effective approach to providing the highest quality rehabilitation program in their communities.

Operational Considerations

A substantive difference between an Advisor and a Partner centers around accountability.

Accountability in a SNF therapy department is centered around financial, regulatory, program and operational responsibility that yields best-in-class therapy outcomes

There is a unique set of obstacles created by a Management Agreement Model exclusive to the Advisor, which impacts the operations and compliance of the program. The Advisor is unable to truly hold clinicians to high performance standards when there is no direct supervision or ability to enforce those standards. The ability to correct and replace therapy staff is limited for the Advisor due to the fragile relationship between the therapist, the Advisor and their employer (the Client). With the ongoing fear that criticism from therapists may jeopardize their contract, the Advisor's objectivity and effectiveness remain compromised. It is unrealistic to expect the Advisor to achieve consistent financial, clinical and operational accountability while providing only limited interactions such as monthly performance reviews and periodic in-service training. Ultimately, there is an inherent conflict of interest and lack of accountability in the Management Agreement Model because the Advisor does not directly manage the clinicians and risks losing their contractual arrangement out of fear of offending the clinicians – who are employees of the SNF.

Furthermore, because the Advisor has no skin in the game with respect to shared financial risk and service quality indemnification, there are longer-term hidden costs and unforeseen quality concerns that Providers should understand before engaging in a Management Agreement Model.

Financial Considerations

Management Agreement Model Advisors are quick to initially get a SNF Providers' attention by asserting that a Full-Service Contract Rehabilitation Model is more expensive and erodes most of the therapy profits. They attempt to demonstrate cost savings recommending that the Provider hire

the therapists in-house and use the Advisor to manage the program for a monthly fee. They argue that the salary costs combined with the monthly management fee results in reduced costs for the community.

According to a recent study by Melissa (Sabo) Brown, an 18-year occupational therapist veteran and Chief Operating Officer with Gravity Healthcare Consulting1, SNF facilities will incur higher expenses contracting with the Advisor after it factors in all the relevant costs. These are explained below:

Inflated Wage Rates:
Gravity Consulting's research shows that both Management Agreement Models and In-House SNF models pay therapists and assistants from 60th to 90th+ percentile of the standard wages in any location1. The inflated wage rates that occur with a Management Agreement Model arise because the Advisor has little incentive to control or manage this expense since the skilled nursing facility pays the increased cost. In a management agreement the Advisor is tasked first and foremost with filling all open positions as quickly as possible, irrespective of the cost. As a result, Advisor-employed recruiters are more apt to pay therapists above-market wage rates and utilize expensive contract therapy to demonstrate they have successfully filled all open positions despite the inflated cost to the SNF. Advisors are not incentivized to invest in a sophisticated recruitment function and infrastructure because they generally recommend that Providers pay inflated therapist salaries to secure a therapist as quickly as possible. The initial additional labor expense or premium associated with a Management Agreement Model versus a Full-Service Contract Rehabilitation Model could be as high as $5K - $15K per facility per month plus the management fee which typically runs $7,000 to $15,000 per facility per month – a total monthly cost increase of $12,000 to $30,000 per month or $144,000 to $360,000 per facility annually.

Therapy Team Efficiency:
Therapists employed by the Provider for in-house or management agreement models often are utilized for various non-skilled activities (e.g., wheelchair maintenance, committees, etc.) inside a SNF. The Advisor has no incentive and no enforcement power to hold the therapy team to industry productivity standards, resulting in lost productivity and unmet resident needs. Advisors avoid managing productivity in order to keep therapists content. Decreased productivity and efficiency results in increased therapy expense to provide the same level of patient care, and significantly drives down overall revenue. Furthermore, the Advisor does not provide the daily oversight necessary to quickly flex staffing to meet fluctuations in skilled census and meet long-term care needs.

Undisclosed Overhead:
Finally, there are added overhead costs associated with in-house and management arrangements, such as corporate therapy management personnel, HR, recruiting, payroll, benefits, compliance, medical review (appeals), and other services not adequately covered by the Advisor. According to Gravity Healthcare Consulting, these incremental and usually undisclosed costs borne by the SNF Provider exceed $120,000 annually versus the all-in costs of a Full-Service Contract Rehabilitation Model[1].

Financial Considerations

	Contract Rehab Model	Management Agreement Model	In-House Model
Cost of Therapy Contract	$1,226,736	n/a	n/a
Cost of Management Agreement (per facility)	n/a	$120,000 ($10k/month/facility)	n/a
Additional Annualized Provider Staffing Costs	n/a	$1,228,293	$1,285,155
Total Costs	$1,226,736	$1,348,293 (increase of 9.9% of costs compared to contract rehab)	$1,285,155 (increase of 4.7% of costs compared to contract rehab)
Therapy Development Revenue	$2,317,252	$1,786,048 (decrease of 29.7% of revenue compared to contract rehab)	$1,607,443 (decrease of 44% of revenue compared to contract rehab)
Final Actual Therapy Department Margins	$1,090,516	$437,755 (60% reduction as compared to contract rehab)	$322,288 (71% reduction as compared to contract rehab)

Table 8: Final comprehensive costs, margins and revenue for 10 therapist department in 3 models. Data was taken from actual facilities from December 2019 to February 2020 (pre-COVID-19 in all facilities) and annualized to provide relevant PDPM comparison data.

A Full-Service Contract Therapy Partner assumes all these costs and manages them as a true Partner with a stake in the costs, revenues and outcomes of the therapy department. Both parties are aligned clinically and financially to put the resident first and to do right by each other. Any wage inflation or staff inefficiency is borne by the Full-Service Partner with no impact on the Provider. Full-Service Therapy Partners thoughtfully adjust staffing levels each day to ensure that care needs are met while expenses remain fixed for the Provider, all without compromising quality *(see Clinical Considerations section below).*

Over time the cost differential grows exponentially because of higher internal therapy wages, lower productivity and increased administrative burden. Management Agreements are an incredibly expensive model that do not produce improved clinical or financial outcomes.

In addition to the cost savings with a Full-Service Contract Rehabilitation Model versus a Management Agreement Model, Gravity Healthcare Consulting also noted an even bigger swing in Provider revenue or average per diems of $30+/day to the tune of over $500,000 annually1. The upside in revenue is made possible through greater accountability and clinical mentorship, achieving improved identification of resident's rehabilitation needs coupled with ensuring adequate capture of resident clinical acuity and characteristics, which drive accurate reimbursement under PDPM and beyond. Gravity's research showed Providers using Full-Service Contract Rehabilitation realized margins were more than double that of Providers with a Management Agreement.

Clinical Considerations

The second major and the most important differentiator between a Full-Service Contract Rehabilitation Model and a Management Agreement Model is quality patient outcomes through clinical support. Management contracts cannot offer the level of control and compliance with a robust clinical program that SNF Providers should demand from a third-party for two principal reasons:

1. Advisors do not employ the therapists and therefore, they do not have the authority necessary to enforce ethical clinical competence and compliance with protocols, policies, and procedures. The therapy team, in return, knows they do not really report to the outside Advisor and can disregard the guidance and supervision offered by them. As is the case with holding the therapy team to higher standards of efficiency and accountability, the Advisor's leverage and leadership drastically diminishes when faced with implementing elements such as care pathways or performance improvement plans. Consistent follow through is inhibited due to fear of complaints by the clinician to their employer. More concerning is the random delivery of care minutes and therapy intensity for patients with similar diagnostic characteristics due to the lack of control over clinical protocol enforcement according to the Gravity report1. The lack of consistency results from each individual therapist using their own independent judgment (or that of a peer) rather than a medically derived, evidence-based standardized pathway closely monitored and reviewed by on-site and off-site therapy leaders empowered to do so. The complete lack of standardization results in variable patient outcomes and opens the Provider up to increased scrutiny from outside audits.

2. The Advisor will not stand behind the Provider by indemnifying the SNF for claims unsuccessfully appealed, nor do they typically have the staff and resources necessary to successfully conduct this labor-intensive task. The Full-Service Contract Rehabilitation Partner indemnification generally extends to any fines rendered by outside auditors and agencies (e.g., MAC reviews, ZPICs, SMRCs, regulatory, etc.) stemming from audits or investigations that result from care delivery, documentation or other services inappropriately managed by the therapy team. Indemnification is made possible by the Full-Service Contract Rehabilitation Partner's confidence in their ability to engage with and hold their clinicians accountable through diligent and intense oversight which expands beyond the typical Advisor services of remote audits, monitoring or coaching.

Compliance Considerations with a Management Model

Compliance and program integrity are best maintained when clinicians are supervised by clinicians who are versed fully in federal and state regulations and *have the authority to hold their colleagues accountable* to those standards. Monthly program and documentation audits are important, but they do not replace the accountability created by daily onsite supervision. Best-in-class Full-Service Contract Rehabilitation Models establish clinical guiderails that manage individual discretion and eliminate large discrepancies in care provision.

Management Agreement Models provide consultative services for the clinical appeals process. Conversely, Full-Service Contract Rehabilitation Partners process claims on the Provider's behalf, from ADRs (Additional Documentation Requests) through the

Clinical Considerations	ALJs (Administration Law Judge reviews). More established Full-Service Partners employ RAC-CT certified reviewers who have the infrastructure to professionally process claims, protecting the SNF Provider's financial and reputational interests. Partners indemnify Providers for claims that do not meet the conditions of payment, this accountability ensures clinicians are held to the highest standard for quality documentation which support claims.	Advisors offer no indemnification because of their inability to enforce therapist accountability, and because it represents too much financial risk and exposure. They ultimately do not have the control they need to protect themselves against the consequences of poor execution. Alternatively, Partners accept full responsibility for staff accountability, program execution, shared quality and financial risk.
Treatment Management Under PDPM	PDPM eliminates therapy minutes as the primary determinant of payment and this change introduces uncertainty, challenges, and new potential risks for SNF Providers. News of therapy layoffs in the skilled nursing industry was common in the weeks following PDPM implementation and there were concerns that reduced quality may follow. While small reductions in therapy minutes were expected, large decreases are known to result in reduced functional gains[2].	Providers want a therapy Partner that can consistently demonstrate, document, and defend the level of care provided. Frequent clinical training, diagnosis-related care pathways and evidence-based treatment protocols ensure that patients with like conditions and deficits receive levels of care consistent with their documented needs and assure SNF Providers that therapy care is consistent, appropriate and defensible.
Therapy Considerations in Long-Term Population	In addition, therapists in an in-house or Management Agreement Model tend to inadequately manage long-term care needs, favoring less challenging treatments and residents. They also often spend too much time per treatment session with the Part A patient population, not correlated with the clinical profile of the resident, resulting in inflated or artificial productivity according to the Gravity assessment1. The Gravity consultants found that these programs provide fewer screens, treatments, and reduced therapy units per treatment day for long-term residents than Full-	Service Contract Rehabilitation Models. Without accountability to highly trained clinical leadership, therapists tend to spend more time evaluating and treating fewer patients. This results in increased incidence of falls and injuries, increased incidence of avoidable declines in ADLs with potential related survey tags, decreased CMI, and overall reduced resident and family satisfaction. Full-Service Contract Rehabilitation Models prioritize, better balance, and manage therapist productivity in a manner that is patient-centered rather than therapist oriented.

Conclusion

The absence of management authority to hold therapists accountable occurs when therapists are not employed by, and therefore do not answer to, a high quality Full-Service Rehabilitation Provider. This exposes the SNF to excessive individual therapist discretion that does not correlate with clinical indicators and variation in patient care treatment. The operational and financial risks are mitigated significantly through indemnification by the Full-Service Contract Rehabilitation Model.

A shared risk model with a national Full-Service Contract Rehabilitation Partner creates intense hands-on oversight with the authority necessary to optimize efficiency, reduce cost, provide evidence-based care with above average outcomes, and improve true SNF margins. Full-Service Contract Rehabilitation Models with outstanding Partners consistently outperform Management Agreement Models in all areas and result in the best resident outcomes and satisfaction.

References

1. Gravity Healthcare Consulting. “Rehabilitation Financial Analysis: Contract rehabilitation, Management Agreement & In-House Therapy Program Cost Comparison Comprehensive Report”, 2020
2. Jung, H. Y., Trivedi, A. N., Grabowski, D. C., & Mor, V. (2016, January). Does More Therapy in Skilled Nursing Facilities Lead to Better Outcomes in Patients with Hip Fracture? Retrieved June 2, 2020, from www.ncbi.nlm.nih.gov/pmc/articles/PMC4706596/