Governor's Planning Council
on Developmental Disabilities
Minnesota State Planning Agency
300 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155

BASE LEVEL REVIEW

ANCILLARY SERVICES IN LONG-TERM CARE FACILITIES

AGENCY: DEPARTMENT OF HUMAN SERVICES

PROGRAM ACTIVITY: INCOME MAINTENANCE

BUDGET ACTIVITY: HEALTH CARE PROGRAMS

MANAGEMENT ACTIVITY: MEDICAL ASSISTANCE

A. PROGRAM DESCRIPTION

For the purposes of this review, "Ancillary Services" are defined as the following rehabilitative and therapeutic services: physical therapy, speech therapy, and audiology. These services are designated as optional services for purposes of state participation in the Medicaid Program, and have been adopted as a covered service under Minnesota's program since its inception. (See 42 CFR 440.110, Minnesota Statute 256B.02, subdivision 8, Minnesota Rules, parts 9500.1070, subparts 12-15,)

In State Fiscal Year 1986, the Medical Assistance (MA) Program paid $20,615,858 directly to long-term care facilities for therapy services billed to the program on a fee for service basis. The F.Y. 1986 payments represent a 25.1% increase over funds paid in F.Y. 1984 for the same services. During the same time period, the growth in MA payments for mandatory services, optional services, and all services combined increased 5.6%, 15.9%, and 10.4% respectively. Correspondingly, the growth in MA payments for skilled nursing home care, from F.Y. 1984 to F.Y. 1986 was 7.5%.

In addition, in F.Y. 1986 the MA program also paid for therapy through the per diems of some long-term care facilities, and through invoices submitted by other vendors of medical care who have provided services and have elected to bill the program directly, e.g., rehabilitation agencies and independent practitioners. Billing for therapy by the latter vendors of medical care is permitted by Minnesota Statutes 256B.433, and payments to these vendors as well as per diem payments are not included in the $20 million figure noted in paragraph 2.

B. POLICY OBJECTIVES

Ancillarly Services were adopted as a covered service in the Minnesota Medicaid Program to provide essential rehabilitative services to MA recipients. In addition to ancillary services which may be provided by a long-term care facility, services to the general MA population may also be provided by inpatient and outpatient hospitals, home health agencies, rehabilitation agencies, and independent practitioners. Of the latter groups, only rehabilitation agencies and independent practitioners may provide services In the long-term care setting. Inpatient and outpatient ancillary services must be provided in the hospital setting if they are billed to the Medical Assistance Program.

In all service settings, a physician order is required as a condition of reimbursement. The requirement for a physicians order is intended to address the medical necessity of ongoing ancillary services and to place the physician in a case manager role. The efficacy of the medical model in controlling growth and service utilization is questionable.

Rehabilitative and therapeutic services are critical services in long range efforts to reduce institutional costs. Appropriate services can hasten deinstitutionalization from long-terra care settings, shorten lengths of stay in inpatient hospital settings, and enable continued independent living in community settings. The potential for saving institutional dollars is clear. The potential for over-provision, abuse, and excessively high profits is also.

C. ANALYSIS

1. Statistics

The following data provides an overview of ancillary services in the Medicaid program. The information is quantitative in its scope and is not intended as a measure of the programs effectiveness in achieving optimum rehabilitative potential. Note that statistics for rehablli- tation agencies and independent practitioners are not specific to long-term care services and may include services for other popula- tions. While a high percentage of these services are probably for the aged population, only the data from "long term care facilities" is specific to the population in question.

a. Average number of active providers of ancillary services by provider type for calendar year 1985 (PWBS 7240, OD 4077).

(1) Long Term Care Facilities	220
Rehabilitation Agencies	19
Independent Physical Therapist	39
Independent Speech Therapist	25
Independent Audiologists	12

(1) This figure represents only facilities that bill for ancillary services on a fee for service basis.

b. Total number of recipients receiving receiving ancillary services by provider type and total dollars paid for State F.Y. 1986 (PWBS 3101, OD 00239).

Long Term Care Facilities	11,222	20,615,848
Rehabilitation Agencies	3,781	4,836,914
Independent Physical Therapists	798	352,594
Independent Speech Therapists	567	185,227
Independent Audiologists	1,283	63,665

Statistics compiled by the Department's Long-Term Care Division, In preparation for the 1986 legislative session, allude to the profit- ability of therapy in the long-term care setting. Cost report data from 70 nursing homes, that bill therapy on a fee for service basis, was analyzed to assess profitability. Allocated therapy related costs (direct and indirect) were subtracted from revenue received by the individual homes for therapy services to determine the excess revenue received by the individual homes for therapy services to determine the excess revenue associated with ancillary services.

The average excess revenue, or profit, for these facilities was 27.4% of the revenue received. Of the 70 homes sampled, 22 (31%) realized a profit of 30% or more from payments received.

Tremendous financial incentives exist in the long-term care segment of ancillary services under the Medical Assistance Program. Current statutory construction contributes to continuation of those incen- tives.

Examples of statutory insufficiency are: lack of a bilateral prohibi- tion of fee splitting between facility and therapy provider, a statu- tory prohibition on recovery of founds from a facility if services were not medically necessary, failure to centralize the responsibility and liability for therapy on the long-term care facility.

Some advances In administering the therapy segment of the MA program can be accomplished in rule; the following will identify rule and legislative action which alone or in combination can facilitate administration of the program.

2. Rule Action

   a. Rule language can identify and define restorative therapy, main- tenance therapy, and rehabilitative nursing. Clarifying the distinction between therapy and nursing would identify services which are covered by the nursing component of the per diem.

   b. Additional rule language could attempt to reduce the financial incentive associated with overutilization of therapy. Rule language could require the nursing homes to offset therapy profit In the cost report if the nursing home bills on a separate fee schedule. This would be consistent with the "therapy-at-cost" concept practiced in at least 30 other state programs which only cover therapy In the facilities per diem. Offsetting fee for service profits, rather than per diem payments, allows the facil- ity to receive payment for those needing therapy without causing non-therapy patients to subsidize those receiving therapy.

3. Legislative Action

a. Minnesota Statute, section 256B.064, subdivision la provides that no sanction or monetary recovery can be imposed against a nursing home for unnecessary therapy, if that therapy is ordered by a physician. This language assumes that the physician is fully cognizant of the client's therapy needs, and has initiated an order for therapy. The reality of therapy orders is that the physician is not always medically involved with the client and signs an order provided by the therapist. Given the financial incentives in therapy under the current rules and laws, some therapy that is ordered is not medically necessary, but cannot be recovered by the department.

b. Minnesota Statutes, section 256B.433 permits the nursing home or other vendors to bill for therapy. Proposed rule language could reduce the financial incentives if facilities are billing as discussed in Rule Action; however, if other vendors are allowed to bill without restriction, financial incentives remain, and the potential for "dummy§ corporations, established by the facili- ties, is heightened.

Statutory changes could centralize the responsibility for therapy on the facility and, in conjunction with rule language, reduce the financial incentive for therapy. The advantage of this action is that it does not cause a reduction in services to patients and does not force therapy back into per diems causing subsidizations of therapy costs by patients not receiving therapy.

c. Current statutory provisions prohibit vendors of therapy, who bill the MA program, from splitting their fees with the long-term care facility except as required to provide for rent or purchase support services. However, statute does not provide that the rent or purchase of service is at cost and excessive fees are sometimes required as a condition of contracting with the facility.

At the present time, no statutory language exists to curtail fee splitting if the transaction works in reverse and the facility submits the request for payment. The facility may require a straight 40-60 or 30-70 split as a condition of awarding the contracts.

d. Potential Medical Assistance liability for ancillary services in long-term care could be lessened by creation of a direct statu- tory link to Medicare. Adopting Medicare guidelines for therapy services would obligate Medical Assistance to the coinsurance and deductible for Medicare eligible clients.

e. In conjunction with rule action number 2, regarding provision of therapy at cost, statute could reflect the intent to provide therapy without a profit incentive. Enabling legislation could be structured for either a fee for service or per diem reimburse- ment system.