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Physical Medicine and Rehabilitation Value in Bundled Payment for Total Joint Replacement and Cardiac Surgery: The Rusk Experience

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> "Change is the law of life. And those who look only to the past or the present are certain to miss the future."
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> —John F. Kennedy, June 26, 1963

Physiatry is at a crossroads. We may shortly find that we cannot rely on traditional care structures such as inpatient units, consultancies, and interventional procedures if we are to thrive in a world of value-based care. Pressures on costs, centralization of patient flow, outcomes reporting, and systemic consolidation will all necessitate a new approach. We need to define our role in changing models of payment and care delivery. There are significant threats to the viability of inpatient rehabilitation units and significant competition from other specialties for directing or providing care at skilled nursing facilities. As consolidation of health systems progresses and care is actively directed into discrete service lines, individual providers and specialties need to redefine their role and how they provide value in patient care. Providers will simply not be able to cherry pick only highly reimbursable procedures or even independently define their own paths for care. Physiatrists have a unique perspective on patient care, and our focus on function can translate into highly important outcomes for our patients. We also care for a diverse group of patients who often have little voice in the larger debates on health care access and expenditures, necessitating our role as advocates and leaders in care processes.

Bundled care represents one of the dominant mechanisms of payment to which we must adapt. These payment structures are fluid and defined by the systems involved in the bundle. Fixed payments (eg, per insuree) are divided among the provider team members, and those involved must add value to the episode of care. The implication is that physiatrists will no longer be able to serve as stand-alone consultants or as the conduit to filling inpatient units with patients from other providers or hospitals. Rather, we will need to function as part of an organized system of care that meets the needs of all stakeholders, including the patients, other providers, and administrators. As physiatrists, we need to demonstrate improvement in outcomes while controlling costs if we are to maintain a role in a bundle and avoid being clinically and monetarily marginalized. Because these payment structures, as they relate to procedures, are often focused on expensive and well-defined interventional care, such as a hip replacement or coronary artery bypass surgery, physiatry does not really "own" the patient population undergoing such procedures, much less do we actually perform the procedure that is central to that bundle. This means that our involvement, and hence compensation, is not only not guaranteed, it may well be deemed unnecessary if we cannot show the utility of our care.

In this setting, physiatrists have to find a way to adapt the delivery of physical medicine and rehabilitation care to meet the needs of the stakeholders in the bundle. If our care can add value, we will be integral components of the care teams. To that end, our focus should be on how we can meet the needs of our teams rather than what we cannot do in such restricted health care environments. How do we go about this? We need to be articulate, flexible, show foresight, and be at the table. Flanagan et al provide us with an example at New York University (NYU) of how this can be done.

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Introduction

Health care is experiencing the greatest changes and challenges since the initiation of Medicare and Medicaid more than a generation ago. Increasing costs and large numbers of uninsured Americans, combined with concerns of maintaining and improving quality services, ultimately led to the passage of the Affordable Care Act, which was signed into law by President Obama in 2010. The aims of Affordable Care Act were to expand health care coverage to millions of uninsured Americans, improve the quality of health care, and to decrease health care expenditures. The law also created the authority to test new payment and service delivery models. In response, the Innovation Center created the Bundled Payments for Care Improvement (BPCI) Initiative [1]. It comprised 4 broadly defined models of care that linked payment for all the services beneficiaries received for a defined episode of care for a specific condition or procedure, such as a total joint replacement.

Organizations that were permitted to participate in one of the models entered into a payment agreement with the Centers for Medicare and Medicaid Services that included financial and performance accountability for the episode of care selected. One significant aspect of these arrangements was that participants accepted financial risk, including the costs of acute and postacute care services. Participation in this initiative by any health care system would impact the postacute care continuum, necessarily including the degree of involvement of physical medicine and rehabilitation (PM&R). Given PM&R's traditional role in the postacute care continuum for a substantial portion of conditions considered for BPCI inclusion, several formidable challenges to physiatrist's impact on quality care, functional outcomes, and involvement in health care reform arose. In that regard, innovative implies continued availability of rehabilitation services in both acute and postacute settings to ensure that PM&R maintains its value to quality health care and optimized functional outcomes while lowering overall costs.

Under a traditional fee-for-service payment system, providers are paid for discrete components of care for a given condition or episode, which frequently are delivered in a fragmented manner with little financial risk borne by the providers. Concern from payers and others is that incentives associated with fee-for-service encourages volume rather than quality care, potentially leading to escalating costs [2], inconsistent outcomes, and poor coordination of care among providers. BPCI was intended to counter this by driving providers to institute improved communication and coordination during the episode, resulting in better outcomes and more efficient use of resources.

Within the BPCI payment model, cost savings, if achieved, would be shared between the health system and Centers for Medicare and Medicaid Services, whereas expenditures that exceeded the targeted price for the bundle would be borne by the health system alone. Participation in BPCI was generally financially positive for hospital systems. Analysis of mean episode cost savings achieved by hospitals participating in a 90-day BCPI for joint replacements was $1166 greater than nonparticipating hospitals [3]. However, this was largely achieved by reducing use of institutional postacute care settings. Therefore, risks to PM&R in a bundle payment paradigm are the perceived high cost of care provided in both inpatient rehabilitation facilities (IRFs) and subacute rehabilitation institutions (SARs) and the role physiatrists play in these setting, the necessity of which would be under greater scrutiny.

The NYU-Langone Rusk Experience

PM&R provides high-quality care, improves outcomes and, when provided in a multitude of settings including acute care hospitals, has been shown to simultaneously decrease hospital costs [4,5]. Given the financial pressure to reduce the use of IRF and SAR level of care in bundled payment models, rehabilitation services, including those provided by physiatrists, need to shift to other settings in the continuum to ensure patients achieve optimal functional outcomes and assure the relevance of physiatry inclusion. NYU—Langone Medical Center initiated a BPCI under Model 2 for Medicare beneficiaries undergoing cardiac surgery and total joint arthroplasty in late 2013. Model 2 was inclusive of the time period 72 hours before admission, the acute inpatient hospital stay, and all postacute care—related services up to 90 days after hospitalization.

Before NYU-Langone Medical Center engaged in the BPCI, past care models used throughout the medical center and the various postacute care venues in which patients received their care were assessed. Similar to studies examining costs associated with bundle initiatives [3,6], analysis revealed that both IRF and SAR care accounted for a significant portion of expenditures. Furthermore, hospital readmission rates for postcardiac surgery patients receiving care at SAR facilities were greater than those admitted to IRFs (unpublished data). Given both the quality and financial implications in the BPCI combined with evidence that PM&R improves both these metrics [4,5], the medical center acknowledged the potential risk for poorer outcomes if patients were discharged to the community without sufficient PM&R interventions, which could result in greater readmission rates and costs. Therefore, they included the Department of Rehabilitation Medicine (Rusk Rehabilitation) in the planning for the bundle. The planning process examined options to provide meaningful rehabilitation services to patients undergoing the selected surgical procedures while simultaneously reducing the previous heavy reliance on IRF- and SAR-level care. Efforts to meet this challenge included participation of key Rusk