Editorial

SOME THOUGHTS ABOUT REHABILITATION AND CASE MANAGEMENT: AN INSURER’S VIEWPOINT

The past decade has witnessed an extraordinary growth in both the demand for medical rehabilitation services and the number and variety of facilities and services available. The perception of sometimes ill-defined therapeutic end points, coupled with somewhat open-ended reimbursement, produce actuarial malaise and clinical concerns, which will be explored elsewhere in this month’s issue of the Journal.

Demographics and technology have combined to create the explosive demand for rehabilitation service. Fifty percent of this care is delivered to individuals over the age of 65. Currently, 12% of the U.S. population is in this age category. By the year 2000, the elderly will comprise 13% of the population, or 35 million citizens, reflecting aging of the baby boomers and the gradual prolongation of our life span.

Many of the elderly have, or will have, major functional disabilities which impair their independence. Consequently, rehabilitation therapies will be directed increasingly toward degenerative, musculoskeletal, neurological, and cardiovascular conditions. In contrast, in under-65 subject populations, past traumatic and congenital conditions are more common. Altogether, more than 2 million people are expected to receive rehabilitation services this year.

In response to clinical need, and in no small measure to the expectation of profit, rehabilitation facilities, centers, and programs have proliferated. Consider these facts: The number of district units and beds in PPS-excluded facilities increased from 303 to 781 units (11,490 beds) during the past decade. Similarly, freestanding PPS-excluded rehabilitation facilities increased from 49 to 128, and their beds to over 7,000.

The trends are similar on the outpatient side. For example, between 1985-88 alone, the number of comprehensive outpatient rehabilitation facilities (CORFS) increased from 75 to 150. Also, the proportion of hospitals with organized outpatient rehabilitation departments increased from 27% to 46%.

The contemporary rehabilitation industry provides not only the full spectrum of traditional rehabilitation services, but now also offers on the whole new menus of high-touch, high-tech specialty programs. Today, many urban communities have multi-disciplinary, complex integrated services for such conditions as TBI, spinal cord injury, stroke, congenital and acquired pediatric problems, and occupational/industrial rehabilitation.

Discussions of the cost of medical rehabilitation are complicated by conflicting themes. On one hand, published figures from several sources suggest that every dollar invested in rehabilitation saves $10-$11, specifically in relation to the alternative of functional insufficiency and long-term care.

On the other hand, rehabilitation is often considered synonymous with interminable, labor-intensive treatment courses and phenomenally expensive catastrophic cases typified by traumatic brain injury. Treatment costs ranging from $200,000 to $500,000 have been reported for the rehabilitation phase of TBI therapy.

On a macro scale, the U.S. rehabilitation market is projected to grow 10%-19% per year, amounting to as much as $14 billion per year early in this decade. Approximately half of these figures represent hospital-associated payments.

To date, much of this activity has taken place in major metropolitan areas. Medical entrepreneurs believe that as many as 50 new geographic markets exist for hospital and outpatient rehabilitation in the U.S. In fact, the prevailing view in investment circles is that strong demand, and good reimbursement, make rehabilitation-related investments very favorable. This is indeed big business, and a profitable one! The implications for the health insurance industry are clear.

As the health insurance industry attempts to cope with yet another set of demands, a variety of solutions present themselves. I believe that optimal health insurance must include rehabilitation benefits. Exclusion of rehabilitation services, experience rating, and rigorous medical underwriting are not the appropriate answers to these demands.

Instead, I anticipate a quest for value in rehabilitation services. There will be an increasing focus on cost effectiveness, and on value as an expression of the cost/optimal outcome equation. Quantitating that value will be difficult.

In California, and presumably elsewhere, proprietary vendors of rehabilitation services aggressively market their facilities, system, and networks. Some appear to offer products that embody good managed care, and that appear to have proper emphasis on patient selection, provider selection, case management, and outcomes measurements.

Some are quite good, but in many cases their value is hard to assess. The “product” may consist of a cluster of brokered services. “Networks” may actually have demographically and geographically inappropriate numbers and distribution of care sites. Substantiation of outcomes and effectiveness may depend on data not yet available, and plausible methodologies may be presented as a surrogate for the data. Personally, I worry that care may be downloaded to a universe of unassessable practitioners after acute rehabilitation has been completed.

On the cost side, the discipline of placing providers at some financial risk is now being proposed by the vendors themselves. This will require careful observation. Medicare has not seen fit to do so for a variety of reasons. The potential for under-utilization would not be inconceivable in this high-stakes setting.

Yet another creditable solution involves the application of case management to rehabilitation. The ability of case management to control costs and optimize outcomes in high-cost and catastrophic settings is unquestioned. At Blue Cross of California, the ratio of expenses for cognitive level 3 (Allen Scale) patients...
with TBI in a limited benefit scenario averaged 54% of an unmanaged rehabilitation setting, and with rigorous case management, 38%. Similarly, for cognitive level 4 patients, the figures were 63% and 38%, respectively.

No doubt, sizable although more modest savings will accrue from case management in less complex and costly settings. Ultimately, there will be a level below which micromanagement issue will limit the value of case management. Also, the clinical integrity, motivation, and performance of the case managers will remain a concern. This will be especially true if they have a vendor relationship with the health insurer.

My plea is that each of these approaches be tempered by strong clinical input from all sectors of the rehabilitation provider community. This would include not only physicians, but legitimate professional therapists in all of the recognized disciplines. The insurance industry, and its medical directors, will need, and should seek, guidance to develop sound criteria for patient selection, utilization parameters, and outcome measurements and expectations. We need a clear vision of the potential, and the limits of, rehabilitation. The health insurance industry needs professional consultation to evaluate the increasingly cluttered world of rehabilitation entrepreneurs.

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