

# HOSPITAL CASE MANAGEMENT

*The essential guide to hospital-based care planning*

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## Reimbursement changes coming—CMs key to meet payer requirements

Work with quality, physicians on deficits

**W**hen it comes to ensuring that patients are receiving high-value, cost-effective care, case managers are where the rubber hits the road, says Michael Taylor, MD, vice president of operations at Executive Health Resources, a Newton Square, PA, healthcare consulting firm.

"As the Centers for Medicare and Medicaid Services [CMS] and commercial payers shift from paying for volume to paying for value, case managers are going to have a very important role in helping their hospitals achieve correct reimbursement for services that are compliant with regulatory requirements," Taylor says. "From now on, hospitals are not going to be compensated just for how many services they provide but for the outcomes of those services. They are going to be responsible for the outcomes of the care they provide as well," Taylor says.

The changes in reimbursement create incentives for hospitals to improve care; however, in many cases, the stick is bigger than the carrot, and many hospitals are going to lose, Taylor says. "The programs are not designed so that if everybody does a better job they will do well," he says. "Hospitals literally have to outperform other hospitals in order to benefit. It's likely that there will be more financial penalties in the future for hospitals that have high utilization and spending patterns across the continuum." (For a look at the initiatives and how they work, see related article on p. 171.)

## Change is on the way for hospital CMs

Hospital reimbursement as we know it is changing as the Centers for Medicare and Medicaid Services (CMS) rolls out new initiatives that base payments to hospitals on value as well as volume. In this issue of *Hospital Case Management*, we take a look at some of the changes that are coming down the pike and how they will affect case management. We'll give details on the value-based purchasing program, the initiative to reduce reimbursement for excess readmissions, and the new bundled-payment quality measure. We also offer tips for helping your hospital receive appropriate payment. It's all in this issue of *Hospital Case Management*!

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The Inpatient Prospective Payment System final rule for 2012 is one of the first times that CMS has been so clear about how quality is going to affect reimbursement, says Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts in Dallas. "There are a lot of changes coming down the pike,"

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### Editorial Questions

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## EXECUTIVE SUMMARY

Case managers can have a big impact their hospital's bottom line when the Centers for Medicare and Medicaid Services (CMS) begins rolling out initiatives that will reimburse hospitals for the value of the services they provide, in addition to volume.

- Start now to learn about the new reimbursement initiatives and work with quality staff and physicians to determine what issues need to be addressed.
- Take a proactive approach to discharges. Ensure patients understand their treatment plans and that there is a smooth transition to the next level of care.
- Hospitals with excess readmissions for heart failure, pneumonia, and acute myocardial infarction (AMI) will receive reduced reimbursement.
- Medicare will start tracking spending per-beneficiary for the entire episode of care, beginning three days before admission through 30 days after discharge.

Cunningham says. "It's important for case management leaders to understand that what case management does relates to the new reimbursement measures and how they affect the overall quality provided by the hospital. The bottom line is that these measures are simply doing the right thing for patients."

Taylor suggests that case management directors start by working with their hospital's internal quality department and engaging the physician staff as well. "There needs to be a combination of representatives from case management, quality, and the physician leadership who assess the different value-based purchasing measures and come up with a plan to address them," Taylor says.

Identify which patients are frequently readmitted and how much the hospital is spending on them, says Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates, a healthcare consulting firm in Atlanta. Look at how well they were ready for discharge, and determine where the deficits are in your educational process, she says.

Hospitals need to provide better education while patients are in the hospital and to start making follow-up calls after discharge to make sure the patients understand their treatment plan and are following the recommended regimen, Malcolm says. "Not only do hospitals have to make sure patients have a good discharge plan, that they understand their diagnosis, and what they should do when they get home; hospital case management must now extend into the patient's homes," she says.

Spend time with patients who are frequently admit-

ted and those who have newly diagnosed heart failure, Malcolm suggests. Make sure they understand their treatment plan, and find out if they have any questions. Build a relationship with your patients so they will learn to take care of themselves and stay out of the hospital, she says. "Often case managers don't follow up with patients to make sure they understand their treatment plan either because they don't have the time or they don't realize it is part of their job," Malcolm says.

## **A proactive approach to readmissions**

In some cases, reducing readmissions hinges on patient adherence, Malcolm points out.

"If a heart failure patient doesn't take the medication or eats and drinks more than allowed, they're going to come back to the hospital," she says.

"Unfortunately, hospitals are going to be penalized for patients' noncompliance."

Taylor predicts that in the future, hospitals might take more innovative approaches to reducing readmissions and optimizing post-acute care, such as increased use of telemedicine. "That hasn't happened yet largely because there has not been a clear financial incentive to do so," he says.

Case managers should work with the clinical nursing staff to develop check lists to make sure best practices and protocols are being followed, Taylor adds. For example, when a patient has joint replacement surgery, case managers could serve as an additional check to make sure that a physical therapist gets the patient out of bed and walking as soon as clinically appropriate. "It might not be obvious up front, but something as simple as early mobilization can sometimes affect the spending-per-beneficiary by possibly reducing the complications and the need for extensive outpatient therapy after discharge," Taylor says.

Look at how the hospital is performing now on CMS quality measures. Use physician and nurse resources to create a plan to address those issues. "Case management leadership should assess the department and create a plan to assess whatever deficits show up," Taylor says.

In case management departments in which utilization review staffs and care management staffs are different, both groups need to work together, he says. "All case managers need to work together, regardless of their assigned tasks. Value-based purchasing has both clinical and payment implications," Taylor says.

Malcolm cautions against giving case managers so many responsibilities they can't handle any of them adequately. Many times, jobs are assigned to the case managers because they're already in the record and

are talking with patients, she points out.

"Case management directors need to make sure that case managers have the time to take the extra steps that are going to be required with the new reimbursement initiatives," Malcolm says. "When you start putting too much on people, they start sinking. Hospitals are going to need to consider increasing the number of staff and decreasing the case management caseload to the lower limits of the benchmark in order to make sure the staff has time to ensure the hospital is being paid appropriately." ■