# Hospital Case Management

*The essential guide to hospital-based care planning*

# Reimbursement changes are on the way

Medicare will pay for value, and volume

In a few years, hospital reimbursement is going to be a whole new ballgame as the Centers for Medicare and Medicaid Services (CMS) rolls out a plethora of changes in the way hospitals are paid, mandated by the Patient Protection and Accountable Care Act.

Hospitals will have a lot at stake as the new payment programs are rolled out, says Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates, a healthcare consulting firm in Atlanta. “It’s going to be hard to stay on top of all the processes and performance measures on which they are going to be rated,” Malcolm warns. “Case managers need to start looking at ways to get ahead of the game and to develop initiatives to improve quality and efficiency.”

Beginning with discharges on or after o ct. 1, 2012, the Hospital Value-Based Purchasing program will use a complicated formula to reward or penalize hospitals for how well they perform. Michael Taylor, MD, vice president of operations at Executive Health Resources, a Newton Square, PA, healthcare consulting firm points out that the Value-Based Purchasing program is designed to be revenue neutral, which means it will be more of a penalty program than an incentive program. Hospitals that perform well on quality measures compared to other hospitals and/or improve their performance on the measures will receive value-based incentive payments. Reimbursement will be reduced for those who do not perform well. (For more details on value-based purchasing and a list of quality measures, see p. 166.)

Also beginning in fiscal 2013, CMS will begin penalizing hospitals if they are in the top tier of hospitals with 30-day readmissions for heart failure, pneumonia, and acute myocardial infarction (AMI).

Eventually, hospitals that are in the top 25% of hospitals with 30-day readmissions for the three diagnoses will be penalized as much as 3% of all discharges. Beginning with discharges on or after Oct. 1, 2012, hospitals in the top tier will be penalized by 1% of their total discharges. The figure goes up to 2% in fiscal 2014 and 3% in fiscal 2015.

CMS has announced its intention to add outcomes and efficiency measures to value-based purchasing and to add diagnoses to the readmission reduction program in the future. In addition, CMS has announced a Medicare spending-per-beneficiary performance measure that will be used in the Inpatient Quality Reporting program and for the value-based purchasing program. The spending-per-beneficiary performance measure will be implemented in fiscal 2014 and for the first year, it will be determined by data from hospital discharges cover hospital discharges from May 15, 2012, through Feb. 14, 2013. CMS will calculate the Medicare Part A and B spending per beneficiary beginning three days prior to an admission through 30 days after the patient is discharged from the hospital.

Susan Wallace, MEd, RHIA, CCS, CCDS, director of inpatient compliance for Administrative Consultant Services, a healthcare consulting firm based in Shawnee, OK, explains that during the first year, data from the Medicare spending-per-beneficiary initiative will be used for Inpatient Quality Reporting and posted on the Hospital Compare Web site (http://www.hospitalcompare.hhs.gov). In subsequent years, the data will become part of value-based purchasing, and hospital performance on that measure will make up 20% of the value-based purchasing scores, Wallace adds.

CMS acknowledges that physician management, beneficiary compliance with post-discharge instructions, and availability of community resources might contribute to Medicare spending after discharge, says Deborah Hale, CCS, president of Administrative Consultant Services, Shawnee, OK. "But CMS has stated that hospitals have a significant influence on Medicare spending if they provide appropriate, high-quality care before and during a hospital stay and do a good job of discharge planning, care coordination, and transitioning patients to the next level of care," Hale says. "Medicare spending-per-beneficiary means that hospitals will have a lot more at stake than just finding a place for a patient to go after discharge.

Case managers will need to become involved in decisions about the post-hospital setting and make sure the providers to whom they discharge patients provide cost-effective and high quality care, Hale adds.

## Tracking patients after discharge

Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts in Dallas, suggests that case management directors start tracking where patients are going after discharge and where patients are coming from when they are readmitted if they aren't already doing so. "It falls back to the case management leadership to know the results of care their patients receive at the next level of care," she says. "If patients who are referred to a certain home care agency or a skilled nursing facility are frequently readmitted, you know there is a problem there."

Taylor says, "Hospitals need to pay close attention to improving quality by making sure they do the right thing in the right way at the right time." For example, reducing infection rates involves using the proper techniques, the right equipment, and the right cleaning methods, but it also means moving patients through the hospital efficiently so the chances of infection are reduced, he says.

However, moving patients through the continuum must be balanced against readmission reduction efforts, Taylor says. "Hospitals have to find a way to provide high-value, cost-effective care while improving care transitions between inpatient and post-acute levels of care," he says.

There is concern in the provider industry that the CMS has not yet found a formula that makes the new reimbursement initiatives fair to hospitals across the board, Taylor adds.

"In the meantime, it's clear that hospitals need to focus on reducing all readmissions and give specific attention to reducing readmissions for patients with heart failure, pneumonia, and AMI," he says. "At the same time, they should pay close attention to the measures CMS designates for value-based purchasing and institute programs to optimize the value they are providing with regard to those measures."

### SOURCES

For more information, contact:


- **Beverly Cunningham**, RN, MS, Vice President, Clinical Performance Improvement, Medical City Dallas (TX) Hospital. E-mail: Beverly.Cunningham@hcahealthcare.com.
- **Deborah Hale**, CCS, CCDS, President and Chief Executive Officer, Administrative Consultant Services, Dallas. E-mail: dhale@acsteam.net.
- **Joanna Malcolm**, RN, CCM, BSN, Senior Consultant, Pershing, Yoakley & Associates, Atlanta. E-mail: JMalcolm@pyapc.com.

• **Michael Taylor**, MD, Vice President of o perations at Executive Health Resources, Newton Square, PA.
E-mail: mtaylor@ehrdocs.com.
• **Susan Wallace**, MEd, RHIA, CCS, CCDS, Director of Inpatient Compliance for Administrative Consultant Services, Shawnee, o K. E-mail: swallace@acsteam.net. ■