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New Definition

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Care Management in the Era of Bundled Payment for Care Initiatives

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Introduction

Care management's place in healthcare has never been more vital than now. There are a high degree of government and payer initiatives aimed at reducing healthcare spending and cost, and improving quality and efficiency. Based upon the nature of core functions performed by care management professionals, they are poised to be instrumental in effecting the outcomes of these initiatives within a variety of healthcare settings and in the community. Given the incremental shifting from an acute care case rate reimbursement system to a bundled payment for care system, care management programs can assist their organizations in being at the forefront of these changes. It is the skill in keeping pace with regulatory and payer changes, and knowledge of utilization review regulations, payer requirements, and community resources for example, that empower these professionals to identify strategies that affect patient outcomes and organizational bottom lines.

More than a decade ago, *The Triple Aim*, promulgated by the Institute for Healthcare Improvement (IHI),¹ served as a significant catalyst for a new approach to optimize healthcare system performance. The tenets are a framework for:

1. improving patient experience of care, quality and satisfaction;
2. improving the health of populations; and
3. reducing the per capita cost of healthcare.

Trends in rapidly escalating healthcare spending and future projections were in part an impetus for change. According to a recent summary of National Health Expenditure projections 2015-2025 by the CMS Office of the Actuary,² health spending is currently at 17.5 percent. It is expected to reach 20.1 percent by 2025 and grow at an average rate of 5.8 percent per year. This growth would be 1.3 percent faster than the Gross National Product (GNP) rate per year. Many factors influence these projections including variability from anticipated expansion of healthcare coverage under The Affordable Care Act, and an aging population who affect Medicare and Medicaid spending. Care management practice considers many factors related to age, illness and utilization of services for the right need, at the right time, and in the right setting. This special set of skills, knowledge and practice will be essential during the evolution in newer value and care based reimbursement models.

Bundled payments for care

Traditionally acute care hospitals are paid by Medicare and some commercial insurers at a set rate under the prospective payment system for a corresponding illness or surgery coded as a diagnosis related group or DRG. The Inpatient Prospective Payment System (IPPS) Rule defines updates to DRG's and specific requirements, targets, timelines and phases for all initiatives, rules and changes each new fiscal year (FY) beginning October 1.³

The Centers for Medicare and Medicaid Services (CMS) have become more rigorous in developing measures for healthcare quality, cost, efficiency and satisfaction. Public reporting of hospital outcomes for value based care has driven hospitals to comply and receive performance based incentive payments for targeted clinical and process outcomes, patient satisfaction, and lower mortality and readmission rates. Significant research concerning poor patient outcomes due to fragmented care and the lack of coordinated care also prompted CMS for a more aggressive call to action. Further research also demonstrated that bundled payments can align incentives for providers of care and foster better coordination of care across all specialties and settings. A bundled payment (paid retrospectively) is a single payment to providers or healthcare facilities, or jointly to both, for all services to treat a given condition or provide a given treatment.⁴ When CMS announced the pilot for Bundled Payments for Care Initiative (BPCI) in 2013, it was designed to focus on a more inclusive approach of care delivery across the care continuum while adding financial incentives for those who reach CMS targets.

Three aims, better *health*, better *care*, and lower *costs* through improvement for all Americans led CMS to four new innovative payment model options that organizations could enter into. These models were designed to build in financial and performance accountability for episodes of care, and effect higher quality and improved coordinated care for lower cost to Medicare.⁵ Examples of the models by the CMS Innovation Center are outlined below.

Bundled Payment Models				
	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients, all DRGs	Selected DRGs +post-acute period	Post acute only for selected DRGs	Selected DRGs
Services included in the bundle	All part A DRG-based payments	Part A and B services during the initial inpatient stay , post-acute period and readmissions	Part A and B services during the post-acute period and readmissions	All Part A and B services (hospital, physician) and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

Source: CMS Innovation Center Webinar: Episode Definitions: What you need to know for the Bundled Payments for Care Initiative. January 5, 2012

Depending on the model a participating organization opted for, they could select DRG's from a sample with a high volume of episodes (i.e. Major Joint Replacement, Simple Pneumonia, Heart Failure and Shock, Syncope and Collapse). Several of these diagnoses have been on CMS' radar for over a decade through their mandated quality reporting so it was a natural progression to include these diagnoses in the new payment model.

The shift from a DRG based payment to a bundled payment methodology adds increased accountability for providers across the continuum of care. Under bundled payments models that focus on improving processes for care coordination and transitions of care, it is essential to develop innovative ways to provide patient education, foster patient engagement, and build community

relationships across the care continuum. Here care management and social work professionals have solid skills to support these efforts.

Evidence based research and health policy experts alike have shown that there are common root causes for system breakdowns that lead to ineffective coordination of care and poor care transitions. The landmark work *Crossing the Quality Chasm*, published in 2001 by the Institute of Medicine (IOM), found many factors influencing poor transitions in care from one setting or provider to another. Decentralized systems and layers of processes and hand-offs confuse patients and families and are wasteful.⁶ Research in care transition models is dominated by Dr. Eric Coleman, Professor of Medicine and Head, Division of Health Care Policy and Research at University of Colorado. However, the Agency for Healthcare Research and Quality (AHRQ), the National Transitions of Care Coalition (NTOCC), and The Joint Commission (TJC) also have studies in this area.

The *Care Transitions Program* developed by Dr. Coleman is widely applied across the country and is associated with significant decreases in re-hospitalization rates. The principles of his work center on:

- maintenance of a personal health record;
- primary care physician follow-up;
- alertness to red flags; and
- use of a “transition coach” to focus on patient self-identification of goals and developing self-management skills.⁷

The work of the transition coach, usually a nurse or social worker, starts in the hospital. In this regard, dedicated roles within care management can be trained and perform well in this capacity. According to AHRQ, “*care coordination involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care.*” Here a care management role in assessing the full scope of patient needs is pivotal. Core functions performed by the care manager and social work professional as they work with nurses, physicians and the entire healthcare team are built upon communication, coordination and effecting safe transitions.

The NTOCC, founded by the Case Management Society of America, was formed in 2006 to define solutions that address gaps that impact safety and quality of care for transitioning patients.⁸ Research, tools and resources available on their website, include *Your Rights During Transitions of Care: A Guide for Health Care Consumers and Family Caregivers*. Care management professionals who are involved in care coordination or transition planning serve as patient advocates and can help ensure patient rights are upheld.

The Joint Commission's initiative is to “define methods for achieving improvement in the effectiveness of the transitions of patients between healthcare organizations, which provide for the continuation of safe, quality care for patients in all settings.” Their work emphasizes the need for a more effective approach to continuing patient care, identifying root causes of ineffective transitions of care including communication breakdowns, patient education breakdowns and accountability breakdowns.⁹ Other work, such as the Hand-off Communication Project, was generated

through the Center for Transforming Healthcare and also provides tools and a validated measurement system to help drive process change.

Initiatives in care management are well documented with new roles to address care transitions such as care coordinator, transitional care nurse or social worker, transitional case manager and navigator. These have been created with the goal of improving care coordination, patient transition from one level of care to the next, reducing breakdowns in communication and handoffs, as well as readmissions to emergency care or acute care settings. One approach, which supports the objectives of the BPCI movement, was designed to clinically integrate care management across the continuum by integrating components of transitional care management and comprehensive care coordination. Transitional Care Managers function in the hospital and emergency department (ED) to intervene and establish services for home health, post-acute facilities, caregiver assistance or other resource needs.¹⁰ Another facility initiated care redesign changes for the orthopedic total hip and knee population and developed a case management navigator role to serve as patient partner, educator and advocate through the continuum.¹¹

Implications for care management programs and professionals

Given hospital challenges in today's healthcare environment, the transition from a "case" management to "care" management process is dynamic and necessary to function if a BPCI model and population are selected in your organization. Functions, roles and responsibilities will vary among care management programs and settings but the ability to grow and adapt to change within the healthcare system is vital. Care managers, social workers and adjunct staff within care management programs are presented with many issues to consider in their work. . These include clinical, social, socioeconomic and legal; payer source; regulatory and contract requirements among others. Clinical, professional and technical knowledge, solid critical thinking, communication and decision making skills, resourcefulness and good provider relations are important for these roles to be successful in bundled payment system.

As bundled payment models are adopted, organizations may consider utilizing professionals who primarily practice the key functions of care coordination and planning for safe transitions of

care. Given this, there is no better time than the present for care management leaders to evaluate their program.

Consideration should be given to the following:

- What are goals, roles and functions of the program and is it on par with the organization's current strategic plan and goals?
- Is the hospital participating in any of the BPCI models, and if so do managers and department staff understand how it relates to their work on an operational level?
- What data is available for readmissions and related value-based outcome/process measures? Is data specific to Medicare patients?
- Have roles and accountabilities been identified within the organization to support defined populations in the BPCI model? What education is required?
- Have processes for hand off communication and transition planning been examined for opportunities and improvement?
- Have post-acute transition relationships and data been reviewed for patterns and trends that may be in conflict with the goals of BPCI model(s) selected?
- Is care management involved with providers and clinical team for care coordination within the respective disease population and BPCI model?

Conclusion — The future is closer than we think...

The surge for ongoing healthcare reform and change will continue to move at a record pace. CMS plans to continue rolling out phases of the BPCI models to additional disease and surgical groups which can eventually erode the case rate prospective payment system as we know it. Non-government payers will pay close attention to these trends and continue to develop new strategies for cutting cost and limiting the care they will pay for adding more burden on providers and consumers of care. Additionally, population health management initiatives will continue with a steady momentum. As you evaluate these trends and the areas affected within your organization, recognize that the practice of care management transcends the entire continuum of care and can positively influence care coordination, safe transitions and positive outcomes. Learning to work within a bundled payment model is one more hurdle to overcome. Be confident with the ability to improve patient health outcomes, reduce cost of care, and add value to your organization's success.

Endnotes

- 1 Institute for Healthcare Improvement: The Triple Aim. www.IHI.org.
- 2 www.cms.gov/Research-Statistics-Data-and-Systems/NationalHealthExpenditureData/projections 2015-2025; July 14, 2016.
- 3 Federal Register/Vol. 81, No.162/Monday August 22, 2016/Rules and Regulations.
- 4 The Payment Reform Landscape: Bundled Payment. Health Affairs Blog. Suzanne Delbanco, July 2, 2014.
- 5 CMS Bundled Payments for Care Improvement Initiative Fact Sheet. January 30, 2014.
- 6 Health Policy Briefs: Improving Care Transitions. HealthAffairs.org. September 13, 2012.
- 7 Transitional Care Can Reduce Hospital Readmissions. www.medscape.com/AmNursToday. 2015;10(4).
- 8 Improving Transitions of Care—National Transitions of Care Coalition. Issue Briefs September, 2010. www.NTOCC.org.
- 9 The Joint Commission: Hot Topics in Healthcare: Transitions of Care.
- 10 Innovations in Clinically Integrated Care Management Across the Continuum of Care. ACMA; Collaborative Case Management Issue 58 2016.
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