The Case Management Transformation Initiative (CMTI) powered by Marsh is a Hospital Council of Northern and Central California (Hospital Council) fee-for-service program developed by Hospital Council and Marsh Risk Consulting’s Clinical Healthcare Consulting Practice. CMTI is an interactive, nine-month, results-oriented transformation program that will provide your hospital with the tools to transform your current case management function into a comprehensive, physician-centric, outcome-based program.
CMTI ENABLES HOSPITALS TO:

- Improve value-based purchasing scores
- Improve pay-for-performance reimbursement models
- Mitigate compliance and Recovery Audit Contractors (RAC) exposures
- Improve patient outcomes
- Reduce costs of care
- Enhance net revenue
- Reduce preventable readmissions
- Improve hand-off communications among providers
- Improve those processes that translate into publicly-reported quality and cost performance metrics
- Improve patient and physician satisfaction

WHAT IS INCLUDED IN THE CMTI PROGRAM?

- Each CMTI program is restricted to 20 hospitals. Live, monthly, collaborative learning sessions are included for participating hospital teams. Learning sessions will be tailored to address specific case management issues and concerns among participants. This learning environment encourages rapid adoption and improvement in practices, processes, and outcomes.

- Participating hospitals create four-member CMTI teams consisting of the director of case management, director of performance improvement, CMO/physician advisor, and a nursing representative. Other representatives may be encouraged to attend specific sessions.

- Monthly interactive educational web conferences will be provided to further the program goals and education, answer questions, provide direction, and maintain momentum.

- A case management program gap analysis and an assessment for each participating hospital will be conducted.

- Three full days of on-site, goal-focused consulting will be given to each participating hospital.

- Metrics and dashboards will be created for each participating hospital to measure progress and success.

- Post-test and skills assessments will be used to measure hospital teams’ progress.

- Attendees at the kick-off and at each in-person meeting will earn Continuing Education hours (BRN Credit and ACHE Category, Type II Credit).
WHAT WILL CMTI COST?

The cost per participating hospital is $39,000, which represents a significant discount. Typical fees for a similar individual consulting program are $60,000–$100,000.

WHAT IS THE RETURN ON INVESTMENT OPPORTUNITY?

The return on investment (ROI) for each organization will vary and is based on reduced length of stays, costs, and readmissions; improved quality and HCAHPS scores; and mitigated RAC and MIC risks. Examples of potential ROI opportunities, both economic and operational, include:

• **CMS Pay-for-Performance and Value-Based Purchasing Initiatives (VBP)**
  Potential impact: Up to two percent of each Medicare patient discharge revenue at risk for each hospital according to the phase in schedule.

• **Length of Stay (LOS)/Cost per Case Reduction**
  Potential impact: $400,000 per year for a typical small- to medium-sized hospital for a one-day reduction in the length of stay (LOS) through case management (assumes cost of $400/day).

• **Reduced RAC Risks**
  Potential impact: $400,000–$500,000 per year (small-to medium-sized facility). By correcting the case management/documentation process and assuring appropriate placement based on medical record documentation, an average small-to-medium facility can reduce its risk for RAC take-backs.

• **CC/MCC Capture Increase**
  Potential impact: $100,000–$200,000 per year for most hospitals of 100–250 beds. By incorporating a concurrent documentation improvement component into the case manager’s function and providing training and education related to documentation improvement, the query process shifts from post-discharge to prior-to-discharge, which has a positive impact on the number of days in accounts receivable and can significantly improve reimbursement.

“[Even during] the early days of our involvement in this program, already the data has revealed that our ALOS is decreasing. Further, our communication internally between the executive committee, medical staff and risk management, quality and patient safety personnel is much improved.”

BARTON MEMORIAL HOSPITAL
• **Patient Satisfaction (part of VBP score)**
  Potential impact: Improved VBP scores. From admission to discharge, the case manager is ideally placed to help enhance patient satisfaction. Increasing the quality and effectiveness of case management can help improve the satisfaction scores, an important metric in determining the VBP.

• **Physician Satisfaction**
  Potential impact: Physician satisfaction with case management services is one metric typical to the case management department scorecard. The value in high physician satisfaction stresses the need for a partnership between physicians and case managers to improve the physician’s rounding experience.

• **Readmissions**
  Potential impact: CMTI introduces the concept of longitudinal case management with post-discharge follow up, as opposed to episodic case management that ends at discharge.

  The 2011 CMTI results include enhanced revenue and cost savings that ranged from $50,000 to more than $1 million annualized. While the financial impact was significant and important, participants also realized the following successes and improvements:

  • Re-established current Conditions of Participation (CoPs) to avoid fines and penalties for non compliance with regulations
  • Improved knowledge base of how RAC operates and education of RAC take-backs
  • Improved patient and physician satisfaction
  • Improved communication with physicians, nursing staff, and patients
  • Implementation of an ED Case Management program to address and reduce the “frequent flyers” that take needed resources from the Emergency Department

  “While I was concerned about joining the Hospital Council CMTI because we had not budgeted for it in the current cycle, I knew it was something that would have real value for our hospital. After only a few months in the program, I can already see that my decision has been validated! This is an excellent program that gives us the tools to navigate the changing health care landscape.”

  EMANUEL MEDICAL CENTER
WHY IS CMTI NECESSARY?

The traditional case management model will not support the demands of today’s evolving health care environment. For every health care dollar spent, both public and private payers are attempting to measure, monitor, and improve quality and patient safety. This increased scrutiny is forcing hospitals to focus more closely on case management. Additional drivers for improved case management:

- It is predicted that 75 percent of hospitals will incur revenue losses under health care reform and reimbursement changes.

- There is increased transparency on readmission rates, mortality, patient satisfaction, and quality data scores available to payers and the public. As a consequence, hospitals face an average VBP revenue risk of $250,415 for 2012, and $1.88 million over five years.

- This potential revenue loss includes possible reductions in Medicare reimbursement of up to two percent for inappropriate readmissions.

- RACs, MICs, and other review entities deny payment for care that is not clearly documented for medical necessity and appropriateness. During the RAC demonstration project alone, more than $1.03 billion in Medicare payments to hospitals was recouped largely due to improper documentation, coding, and simple errors.

- In the future, it is likely that hospitals will be provider-led organizations that will not only manage the full continuum of care, but also assume accountability for the overall costs and quality of care for a defined population over time. Therefore, case management programs must effectively manage appropriateness of care, utilization of services, reimbursement, length of stay, and denials.

(Statistics cited here derived from Value-Based Purchasing Impact Study. Sponsored by Data Advantage LLC, 2009.)
HOW DO YOU MEASURE IMPROVEMENT THROUGH CMTI?

CMTI participants will be provided with detailed case management and financial key performance indicators (KPIs) at five intervals. These include a review of the last two years to establish baseline performance, plus data uploads every quarter for three consecutive quarters to measure and report rapid-cycle progress, and an additional update one year after the completion of the initiative.

The data downloaded from hospitals will be incorporated into Marsh’s secure web portal that provides access to financial, operational, and case management KPIs trended over several quarters, including average length of stay (ALOS), costs or charges by Medicare Severity Diagnosis Related Group (MSDRG), diagnosis, attending physician, and surgeon. All data on the uniform bill (UB04) are captured and can be aggregated and sorted by:

- MS-DRG
- Primary diagnosis
- Principal procedure
- Physician
- Admission, procedure, or discharge date
- Zip code
- Financial class
- Payer
- Patient type
- Length of stay
- Disposition destination

“I just wanted to thank you for all that you are doing to help us get into a Case Management PROCESS. Not only do I keep on learning with every session, feeling more equipped as each day goes by, but the session with the CEO and the CFO was very successful... Thank you for sharing your expertise and being so willing to get us through some hurdles. We all appreciate it. Already, we have learned so much and you guys are doing a fantastic job equipping us.”

TEHACHAPI HOSPITAL
For registration and participation information, contact:

JENNA FISCHER
Vice President of Quality Improvement and Patient Safety
JFischer@hospitalcouncil.net
925 746 5106
www.hospitalcouncil.net

Marsh is one of the Marsh & McLennan Companies, together with Guy Carpenter, Mercer, and Oliver Wyman.

This document is not intended to be taken as advice regarding any individual situation and should not be relied upon as such. The information contained herein is based on sources we believe reliable, but we make no representation or warranty as to its accuracy. Marsh shall have no obligation to update this publication and shall have no liability to you or any other party arising out of this publication or any matter contained herein.

Any statements concerning actuarial, tax, accounting, or legal matters are based solely on our experience as insurance brokers and risk consultants and are not to be relied upon as actuarial, accounting, tax, or legal advice, for which you should consult your own professional advisors.

Any modeling, analytics, or projections are subject to inherent uncertainty, and the Marsh Analysis could be materially affected if any underlying assumptions, conditions, information, or factors are inaccurate or incomplete or should change.

Marsh makes no representation or warranty concerning the application of policy wordings or the financial condition or solvency of insurers or re-insurers. Marsh makes no assurances regarding the availability, cost, or terms of insurance coverage. 

Copyright © 2012 Marsh Inc.
All rights reserved.
Compliance MA12-11666
3638