Case Management in an Era of Healthcare Reform

What We Know

› Healthcare reform in the United States was initiated by the Patient Protection and Affordable Care Act (PPACA), which was passed by Congress and signed into law by the President on March 23, 2010; the Supreme Court upheld the healthcare law on June 28, 2012\(^1\).\(^2\)\(^3\)

› Reduction in readmissions to hospitals is an identified target area for healthcare reform\(^4\)

› Healthcare services are transitioning from a focus on quantity to a focus on quality\(^4\).\(^5\)
  • Developing changes in the healthcare system are related to readmissions, reimbursement, pay for performance, outcomes, and contracted reviewer agencies

› Case managers provide transition planning and education for patients and their family members/other caregivers and function as liaisons between patients and healthcare providers. Future roles will continue to be established during healthcare reform, and there will be increased opportunities in skilled nursing facilities, long-term acute care hospitals, home care agencies, and hospices. Case managers are recognized as key players in maintaining compliance with reimbursement requirements\(^1\)

› In response to the PPACA, there is an increased interest in implementing Accountable Care Organization (ACO) models of health care to increase quality of care and contain costs. ACO models will require making structural, operational, and cultural changes in healthcare systems. The impetus to change the healthcare culture, outcome measurements, and processes will require collaboration among the following:\(^8\)
  • Physicians, staff nurses, and nurse leaders
  • The Centers for Medicare & Medicaid Services (CMS)
  • Third-party payers
  • Health administration leaders

– Case managers are recognized as important providers for the utilization of predictive modeling (PM) tools and being involved in developmental efforts to identify patients who are at high risk for readmission and maximize reimbursement under an ACO model\(^8\)

- Case managers will require extensive education for the advanced practice role and for performing the readmission screening surveys that are anticipated to emerge during healthcare reform

› The CMS is expunging its past operation as a passive payer and is moving toward becoming an active purchaser of value-based healthcare products and services; other third-party payers are expected to follow suit. Quality health care is recognized as a composite of patient outcomes, patient safety, and other patient experiences and is related to reimbursement. Value-based purchasing scores based on the Hospital Value-Based Purchasing Program that are translated into payment for the 2013 fiscal year have been set by CMS as follows:\(^2\).\(^3\).\(^4\).\(^5\)

  • 70% is applied to the processes of care (e.g., core measures, which are evidence-based clinical measures established by The Joint Commission for quality of care [e.g., care for patients who are diagnosed with heart failure or pneumonia])
  • 30% is applied to certain dimensions of patient satisfaction (e.g., nurse and doctor communication, pain management, overall patient satisfaction rating)
Hospitals that are graded lower than peer hospitals on quality outcome indicators will not receive full payment from the CMS; in some cases, hospitals will be requested to return funds to the CMS. Quality outcome indicators will be used to hold hospitals to certain clinical standards and determine reimbursement. The impact of this on the business and financial health of hospitals is related to the following:

- Reductions in payment
- National coverage determinations (NCDs)
  - A nationwide determination of whether or not Medicare will pay for an item or a service
    - Case management departments will need to maintain current information regarding items and services that are listed on the Medicare determination list
- Local coverage determinations (LCDs)
  - Local determinations of payment for an item or service will be made by a fiscal intermediary or a carrier under Medicare Part A or Part B
- Readmissions
  - Readmissions are considered by the CMS to be an outcome measure; reimbursement calculations for individual hospitals are made based on national readmission rates for specific diagnoses and are intended to improve health care for beneficiaries and control unnecessary spending of healthcare dollars
    - Case-mix differences based on the clinical status of each patient are risk adjusted for readmissions
    - Case managers will be expected to properly assess patients regarding the need for postacute services, discharge education, and follow-up to prevent readmissions
  - Case managers will need to access all in-hospital patients every day to verify that discharge planning goals are met
- Core measures
  - Case managers are not directly accountable for meeting core measures; the core measures responsibility will fall under identifying compliance gaps
- Healthcare-associated conditions (also known as conditions that were not present on admission)
  - As of October 1, 2008, hospitals do not receive additional reimbursement for cases in which one or more of the selected conditions was not present on admission
  - Case managers are responsible for identifying documentation deficits regarding conditions that were assessed to be present on admission but were not properly documented; this task is especially important for case managers in emergency departments
- Meaningful use (i.e., set of standards for managing the use of electronic health records and allowing eligible providers and hospitals to earn incentive payments by meeting specific criteria)
  - Meaningful use standards are defined by the CMS under the realm of Medicare and Medicaid Incentive Programs
  - All eligible healthcare providers, hospitals, and critical access hospitals (CAHs) must utilize certified electronic health record (EHR) technology
  - Case management departments do not have direct responsibilities related to meaningful use but should be included in meetings about the use and integration of EHR technology; case managers should receive proper training regarding documentation on using EHR technology
- Hospital Care Quality Information from the Consumer Perspective (HCAHPS) scores
  - The HCAHPS is a survey of 18 questions on care and patient rating items that encompasses significant patient-focused issues such as communication with doctors and nurses, responsiveness of hospital staff, pain management, communication about medication, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment

One of the fastest growing opportunities for case managers is working as a contractor (also known as an independent) with payers, group medical practices, and employers or working directly with patients and family members; contractor case managers are not employed by a hospital. Independent case managers are assisting patients and families with navigation through the complex healthcare system. Case managers explain a diagnosis and educate patients and families on locating primary care providers, making informed treatment choices, managing the medication regimen, preventing complications, and containing healthcare costs. Large corporations are recognizing the importance of having case managers for the promotion of wellness and management of chronic diseases in their employees. Incorporating case managers in the new and evolving healthcare system will optimize care for patients who require complex care with improved utilization of healthcare resources. Investigators suggest implementing integrated case management as a
cost-effective solution for the care of patients while improving outcomes for providers, hospitals and clinics, ACOs, health insurance plans, the U.S. health system, and society(1)

**What We Can Do**

- Become knowledgeable about case management in the era of healthcare reform and evolving changes in the healthcare system; share this information with your colleagues
- Collaborate to develop your facility’s case management program to meet the needs of every patient and to maintain compliance with healthcare reform quality outcome indicators
- Collaborate to identify and implement validated and reliable screening tools for patients who are at risk for readmission in your patient population
- Assist in identifying and implementing case management-specific software for your facility’s EHR system and promote proper training
- Keep current with the NCDs; for more information, refer to https://www.cms.gov/medicare-coverage-database/indexes/nca-open-and-closed-index.aspx
- Keep current with the LCDs for your specific area; for more information, refer to https://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html
- Remain current with the changing healthcare laws and PPACA at https://www.hhs.gov/healthcare/about-the-aca/index.html

**Coding Matrix**

References are rated using the following codes, listed in order of strength:

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M</td>
<td>Published meta-analysis</td>
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<tr>
<td>SR</td>
<td>Published systematic or integrative literature review</td>
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<tr>
<td>RCT</td>
<td>Published research (randomized controlled trial)</td>
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<tr>
<td>R</td>
<td>Published research (not randomized controlled trial)</td>
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<td>C</td>
<td>Case histories, case studies</td>
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<td>G</td>
<td>Published guidelines</td>
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<td>RV</td>
<td>Published review of the literature</td>
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<td>RU</td>
<td>Published research utilization report</td>
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<td>QI</td>
<td>Published quality improvement report</td>
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<td>PGR</td>
<td>Published government report</td>
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<td>PP</td>
<td>Policies, procedures, protocols</td>
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<td>X</td>
<td>Practice exemplars, stories, opinions</td>
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<td>GI</td>
<td>General or background information/texts/reports</td>
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<td>Unpublished research, reviews, poster presentations or other such materials</td>
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<tr>
<td>CP</td>
<td>Conference proceedings, abstracts, presentation</td>
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**References**

1. As healthcare reform evolves, CM opportunities are increasing. (2011). *Case Management Advisor*, 22(12), 133-144. (GI)