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 in 2010; the U.S. Supreme Court upheld the PPACA in 2012

• The PPACA was designed to be a comprehensive health insurance reform system that offered all U.S. citizens access to affordable health insurance options. Primary goals of the PPACA included
  – New consumer protections (see below)
  – Improving quality and lowering costs (see below)
  – Increasing access to affordable care in part by expanding Medicaid coverage
  – Extending coverage to early retirees and individuals with pre-existing conditions
  – Eliminating annual and lifetime limits on insurance coverage
  – Online comparison of health insurance options
  – Holding insurance companies accountable in part by
    – Limiting premium increases and administrative costs/profits
    – Strengthens Medicare Advantage plans that provide high quality care

› Significant changes were required to affect the goals of the PPACA, some of which are reviewed in this topic, while others continue to evolve. The focus of this topic is how those changes relate to case management and how case managers are well-positioned to support patients and families as they navigate through these benefits

› New consumer protections included, in part:
  – Online information about insurance coverage
  – Prohibitions against discrimination due to pre-existing conditions or gender
  – Establishing consumer assistance programs in states that receive federal grants
  – Prohibitions from lifetimes bans on essential benefits

› Improving quality and lowering costs
  – Case management has emerged as an important tool, not only to reduce healthcare costs, but also to improve the quality of care by
    – Promoting coordination of resources
    – Supporting patients through transitional care interventions
    – Facilitating access to resources and services
    – Promoting continuity of care
  – Healthcare services transitioned from a focus on quantity to a focus on quality—instead of payment for as many services as could be billed, the emphasis became on payment for appropriately billed services. Other aspects in the healthcare reform include reducing readmission rates, reimbursement, pay for performance and outcomes, and utilization of contracted reviewer agencies
  – Quality outcome indicators are used to hold hospitals to established clinical standards and determine reimbursement. Some of the impact on the business and financial health of hospitals is related to the following:
    – Reductions in payment if quality indicators are not met
Core performance measures, established by The Joint Commission, which are evidence-based national standards of care and treatment for common conditions proven to reduce complications and lead to better outcomes. These are defined so that measures of comparable care can be examined across institutions to identify gaps in compliance. Case managers are required to be aware of core performance measures but are not held responsible for meeting these standards.

Healthcare-acquired infections (HAIs) or hospital-associated conditions, also known as nosocomial infections or conditions that were not present on admission. As of October 1, 2008, hospitals do not receive reimbursement for HAIs.

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 critical for case managers in emergency departments because in most cases the condition must be documented within 24 hours of admission to avoid an HAI designation.

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 the level of noise in the hospital environment.

- Hospitals that are graded lower than peer hospitals on quality outcome indicators do not receive full payment from the Centers for Medicare & Medicaid Services (CMS); in some cases, hospitals will be required to reimburse the CMS for payments already received.

- Financial penalties and incentives are intended to incentivize hospitals to reduce readmissions by improving care coordination and efficiency and outcome.

- 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 healthcare 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:

  - 70% is applied to the processes of care (e.g., core measures)
  - 30% is applied to certain dimensions of patient satisfaction (e.g., nurse and doctor communication, pain management, overall patient satisfaction rating)—see HCAHPS scores discussed above

- 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 acute care in-hospital patients daily to verify discharge planning goals are met regarding the need for post-acute services, discharge education, and follow-up to prevent readmissions. This will require extensive education for the advanced practice role and for performing the readmission screening surveys that are anticipated to emerge during healthcare reform.

- Case managers are recognized as critical utilizers of predictive modeling tools as well as being involved in developmental efforts to identify patients who are at high risk for readmissions.

- Accountable Care Organization (ACO) models of health care are gaining popularity in response to the PPACA. ACOs, which are networks of doctors and hospitals that share financial and medical responsibility to increase quality of care and contain costs. The ACO model is that coordinated care can reduce costs. Case managers have come to play a vital role in the success of more than 900 ACOs as of 2017. The impetus to change the healthcare culture, outcome measurements, and processes will require collaboration and coordination among

  - physicians, staff nurses, and nurse leaders
  - the Centers for Medicare & Medicaid Services (CMS)
  - third-party payers
  - health administration leaders

- Public Health and Promoting Interoperability Programs (PHPIP), formerly known as Electronic Health Records Meaningful Use is a term referring to a set of standards for managing certified electronic health record (EHR) technology in a manner that promotes exchange of information to improve care coordination and quality of care. It incentivizes eligible providers and hospitals to earn payments by meeting specific criteria.

- PHPIP standards are defined by the CMS under the realm of Medicare and Medicaid Incentive Programs.
– All CMS-eligible healthcare providers, hospitals, and critical access hospitals (CAHs) must utilize certified EHR technology
– Case management departments do not have direct responsibilities related to PHHIP standards but should be included in meetings about the use and integration of EHR technology; case managers should receive training regarding EHR technology

› Implications and opportunities for case managers related to healthcare reform in the U.S. (1,7,8,11,12)

• Case Management Roles. The value of case management is well documented: it effectively reduces emergency department visits and hospital readmission, and shortens the length of stay of high risk and vulnerable patients with chronic conditions and those with high rate of utilization of healthcare services by developing articulated and comprehensive plans of care, and monitoring and evaluating their implementation. (15,18) Case management programs have been and are anticipated to continue to be a centerpiece of the strategy to expanding Medicaid programs. Nursing case management in an era of healthcare reform expands on these roles and future roles will continue to evolve during healthcare reform. There will be increased opportunities in skilled nursing facilities, long-term acute care hospitals, home care agencies, and hospices (1,9,18)

– Resource utilization. Incorporating case managers in the new and growing 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 (13)

– Transition planning and Liaison. Case managers provide transition planning and education for patients and their family members/other caregivers and function as liaisons between patients and healthcare providers (2,8,13,18)

– Compliance managers. Case managers are recognized as key players in maintaining compliance with reimbursement requirements (2,8,13,18)

• One of the fastest growing employment opportunities for case managers is working as an independent contractor (also known as an independent case manager) with payers, group medical practices, and employers or working directly with patients and family members; independent contractor case managers are not employed by a hospital (8)
– Independent case managers assist patients and families as they navigate 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 benefits of utilizing case managers for supporting wellness programs and managing employees with chronic diseases (8)
– Case management effectively reduces emergency department visits and hospital readmissions, and shortens the length of stay of patients with chronic conditions with high rate of utilization of healthcare services (15,18)

• Barriers for case management practice include a lack of knowledge about the scope of practice, limited adoption of standards of practice and guidelines, insufficient awareness of cost-effectiveness of case managers, and insufficient knowledge about the role and competencies of case managers (2,2)

**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
› 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:

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

## References


