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CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

HEALTH REFORM

Healthcare Lingo: Let's Get on the Same Page

A health reform-inspired dictionary of top healthcare terms

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Since passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, a number of key terms have been making headlines. These terms are sometimes used interchangeably, sometimes properly and sometimes improperly. This article tries to broadly define the terms and clarify some of the distinctions so we can all speak the same language.

SYSTEMS OF CARE

PPACA has advanced several new types of systems of care to promote transparency, integration and accountability.

Accountable Care Organizations (ACOs) are regionally-based healthcare delivery systems in which a group of doctors, hospitals and other healthcare providers are integrated to deliver coordinated high-quality care to their patients. The ACO will be "accountable" for the overall cost and quality of care for their patients. The Center for Medicare and Medicaid Services (CMS) will use ACOs to promote shared saving and care coordination initiatives to help meet quality and cost goals. ACOs will be a vehicle for paying teams of healthcare providers to care for the "whole" patient, rather than requiring patients to pay for care one service at a time. ACOs will likely use case management and disease management interventions to coordinate care across the healthcare continuum. Although many of the ACOs will be created to support Medicare, they are also emerging in the private sector.

The Patient-Centered Medical Home (PCMH) is a team-based healthcare model in which the primary care physician, who has an ongoing relationship with the patient, provides comprehensive and continuous care coordination to meet the patient's care needs. The goal of the PCMH model is aligned with the ACO concept because they are both about improving accessibility, collaboration, record-keeping, patient safety and the overall quality of care, so many ACOs will rely on a PCMH care model. Fundamentally, the ACO is the infrastructure and the PCMH is the model for the delivery of care. PPACA has promoted the medical home model through a number of grant programs.

Collaborative Care Networks (CCNs) are community-based consortiums of healthcare providers established by PPACA with a unified governance structure. Like an ACO, their primary goal is to provide comprehensive coordinated and integrated healthcare services, in this case for low-income populations. HHS will help fund these network programs, which must include a hospital and a qualified health center. Among other services, CCNs must provide case and care management services.

Exchanges refer to the state-based insurance exchanges envisioned by PPACA as a way for individuals and small employers to more easily obtain healthcare coverage at rates similar to those enjoyed by large groups, which have the ability to negotiate favorable discounts. Assuming PPACA is fully implemented in 2014, these exchanges will serve as a central healthcare marketplace for millions of people.

The exchanges also will provide assistance to those who qualify for enrollment in state Medicaid programs (incomes below 138 percent of the federal poverty level), and be a conduit for offering federal subsidies to those who don't qualify for Medicaid and can't afford private health insurance. In addition, PPACA allows states to form a Small Business Health Options Program ("SHOP Exchange"), which is designed to help small employers coordinate and gain access to affordable health insurance for their employees.

CARE MANAGEMENT

PPACA has done a great deal to promote care management programs, but the nuances associated with various programs are often obfuscated. This is highlighted by the fact that many of the key terms were not actually defined in the PPACA legislation itself, but through the emerging regulations.

One good resource is the Case Management Model Act sponsored by the Case Management Society of America (CMSA). The Model Act defines the term case management as a "collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes...Related activities to case management include care coordina-

tion, complex condition management, population health management through wellness, disease and chronic care management, and promoting transitions of care services."

Here are several terms related to case management processes:

- **Care Coordination** ensures a patient's needs and care preferences are understood and shared between providers, the patients and their families. It also helps to streamline transitions in the care continuum. Many use the terms case management and care coordination interchangeably, but there are some nuances. Whereas case management often is used to describe the profession of case managers and programs that help coordinate care, care coordination is more often used to actively describe the process of how to promote a dynamic and integrated care paradigm for patients.
- **Chronic Disease Management,** which is referred to throughout PPACA, is actually specified as an "Essential Health Benefit" that must be covered. Chronic disease management programs are classified as quality initiatives under the medical loss ratio (MLR) guidelines (see below), so we should expect to see them continue to proliferate.
- **Transitions of Care** refers to the movement between providers and settings that a patient experiences during the care process. The importance of care transitions lies in the ability for hospitals to control readmissions by providing more effective transitions throughout the patient care process – from doctor, to hospital, to specialist, to home, for example. Many health plans are using "readmission management" to help assure appropriate care transitions.

KEY INSURANCE TERMS

PPACA reintroduces several key insurance reform concepts that have been around at the state level for several decades.

Essential Health Benefits are a set of healthcare service categories that must be covered by certain health plans beginning in 2014. While PPACA doesn't give an exact definition of what constitutes an essential benefit, it does identify the following broad categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care. HHS has elected to give states the ability to ultimately decide what services to include in the essential health benefits package.

The **Individual Mandate** portion of PPACA requires a person to purchase and maintain health insurance benefits. The individual mandate will take effect in 2014 if the Supreme Court does not strike it down. At press time, the Court was deliberating the constitutionality of the provision.

Medical Loss Ratios (MLR) is one of the most contentious provisions of PPACA. The MLR requirement forces insurance companies to allocate 80-85 percent of premium revenues to claims and efforts to improve the quality of healthcare services. If health plans charge too much for administrative costs, they must rebate some of the premiums back to the consumers. Many experts have expressed concerns about how the MLR will be calculated along with any rebates. Traditional utilization management functions are typically categorized as an administrative function of the MLR and therefore fall into the 15-20 percent bucket. In contrast, most case management programs that focus on coordinating care and chronic disease management programs fall under the larger bucket to improve the quality of care.

External Review occurs when an independent third party reviews a claim to determine if the insurer is obligated to pay. External review offers patients or their providers an opportunity to appeal an adverse medical necessity or benefit determination.

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