Case Management Models Supporting Healthcare Changes

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Speaker

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Learning Objectives

1. Describe how evolving healthcare policies and payment reforms impact the role and structure of case management.
2. Compare traditional case management models with contemporary models and identify their strengths and limitations.
3. Apply model selection principles to determine which case management design best supports organizational priorities, population needs, and financial sustainability.

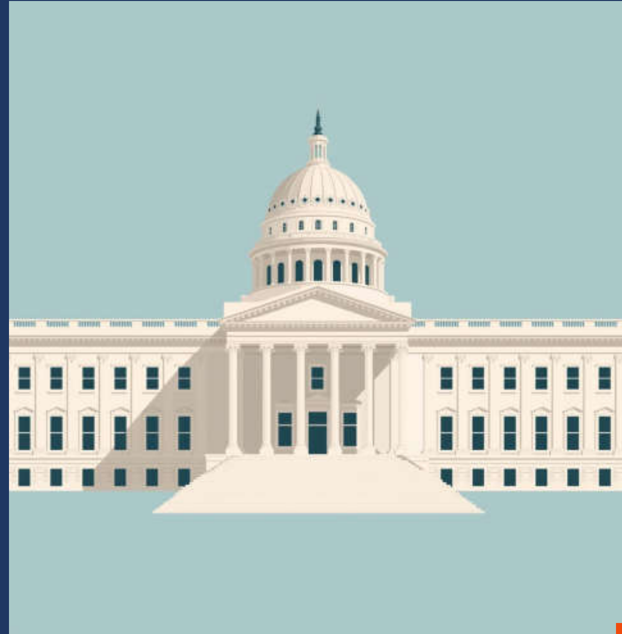
Why now

Maintaining our adaptability and relevance

- Healthcare systems are experiencing unprecedented regulatory, financial, and workforce disruption.
- Case management is no longer a support function providing services for discharge planning or care coordination tasks.
    - **It is a core operational strategy.**
- The models we use today directly influence patient outcomes, hospital capacity, and financial sustainability.

CMS Regulatory Shifts

- Removal of gender-affirming care services
- Research grants that specifically study marginalized groups and/or communities
- Removal of DEI research, grants, and departments in all federal programs.
- Removal of acute care facilities as a sanctuary location, allowing ICE presence in hospitals.
- Dismantling CMS's 'advancing health equity'
- $880 billion in cuts to the Medicaid program
- Increases to ACA subsidies which will either force individuals to elect a less-than-ideal health plan or risk going without coverage.



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FY 2026 Final IPPS & OPPS Ruling

CMS has removed

1. COVID-19 Vaccination Coverage Among Healthcare Personnel
2. Hospital Commitment to Health Equity
3. Screening for Social Drivers of Health
4. Screen Positive Rate for SDoH

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Physician Fee Schedule CY 26 Changes

- Community Health Integration (CHI) HCPCS Code G0019 is replacing the descriptor phrase of SDoH to **“Upstream Drivers”**
  - This means referrals are less restrictive and can include address needs such as “smoking, poor nutrition, low physical activity, substance misuse, or potential dietary, behavioral, medical, and environmental drivers”
- Removal of **Quality ID 487-** Screening for SDoH for MSSP populations
- Removal of the **health equity adjustment** for ACOs: This will be renamed as a benchmarking to a “**population adjustment**”
- **HCPCS code G0136** is not longer called the Administration of a standardized, evidence based- SDoH risk assessment
  - It has been replaced with **Administration of a standardized, evidence-based assessment of physical activity and nutrition,** 5-15 minutes, not more often then every 6 months.

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New efforts are focused on redefining outcome measures while lowering cost

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TEAM –Transforming Episode Accountability Model

Effective: January 1, 2026 – December 31, 2030

- Mandatory, episode-based payment model from CMS Innovation Center (CMMI)
- Holds hospitals financially accountable for total cost and quality of select surgical episodes
- Covers care from index admission through 30 days post-discharge
- Selected hospitals in designated Core-Based Statistical Areas (CBSAs) have mandatory participation requirements.
- **Included Surgical Episodes (5)**
  - Lower Extremity Joint Replacement (LEJR)
  - Surgical Hip/Femur Fracture Treatment
  - Spinal Fusion
  - Coronary Artery Bypass Graft (CABG)
  - Major Bowel Procedures

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TEAM Payment Methodology

- Hospitals bill fee-for-service during the year
- CMS performs **annual retrospective reconciliation** against risk-adjusted target prices
- **Shared savings or repayment** based on cost + quality performance
- **Risk Tracks**
  - **Track 1:** Upside-only (limited hospitals, early protection) – all hospitals will start in Track 1 this year.
  - **Track 2–3:** Increasing upside/downside risk with stop-loss limits

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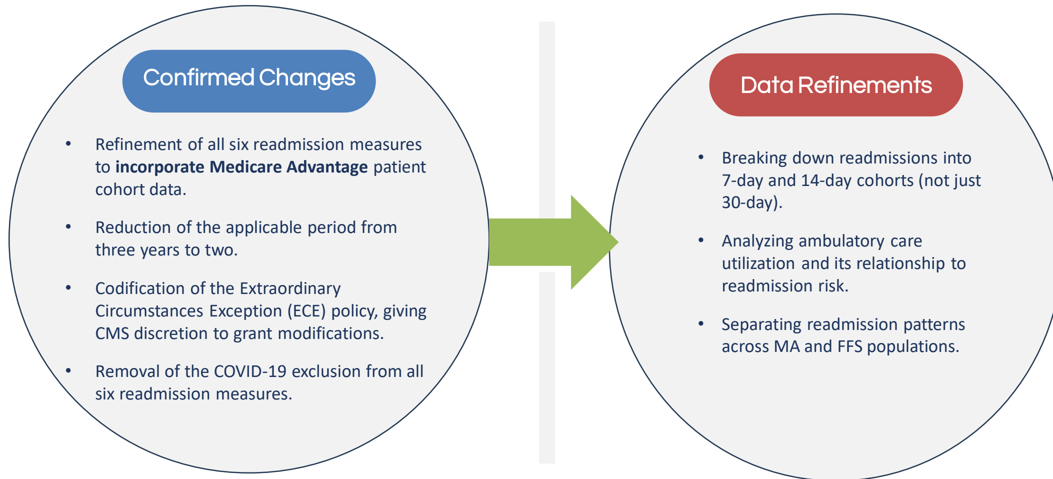
FY26 IPPS Readmission Expansion



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FY26 OPPS: Hospital Star Rating Adjustment

Stage 1

01 Implement a 4-star cap for hospitals in the lowest quartile of the Safety of Care measure.

Stage 2

02 Implement a 1-star reduction for hospitals in the lowest quartile of Safety of Care measure group performance beginning in Calendar Year 2027.

Safety of Care: **CLABSI, CAUTI, SSIs, MRSA events, C.diff, hip/knee replacement complications, serious complications.**

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Wellbeing Focus

The new interest discussed in CY 2026, which will likely officially be expected in CY 2027 is on the following areas:

- Outcomes instead of screening metrics
- A focus on overall health, emotional state, social connectedness, sense of purpose, and life satisfaction
- Potential Tools included a look at:
  - Nutrition- Efforts addressing malnutrition
  - Social Connectedness – Addressing social isolation
  - Physical Activity and Physical Capabilities
  - Skill building capabilities- patient self-management

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Impact on Healthcare

- **Loss of coverage:** The cuts are estimated to result in 11.8 to 16 million people losing their health coverage over the next decade.
- **Disruption of care:** Anticipate that many individuals will be going on and off their health insurance coverage.
  - **Lack of Preventative Care & Health Maintenance**
- **Risk to hospitals:**
  - The reimbursement cuts and increased number of uninsured individuals will place a significant financial strain on hospitals. This is in spite of the rural health funding that is being released.
  - Continued increase in hospital utilization with increased patient medical and social complexity all while outcomes are having a higher focus for delivery of care.

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Discharge Planning CoP Interpretive Guidelines

First major update since 2019-2020

Emphasis shifts from task completion to demonstrated patient centered process compliance.

- Early identification and proactive discharge planning.
- Meaningful patient and caregiver participation.
- Comprehensive evaluation of healthcare and non-healthcare needs.
- Continuous, dynamic assessment throughout the hospitalization.
- Documentation that proves the work occurred

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No Vacancy

- Emergency department boarding patients due to limited staffing and hospital unit capacity challenges
- Unsympathetic payer system
- Post-acute access delays and network constraints
- Increasing number of avoidable days tied to system-level barriers
- Case management is positioned as the problem-solver but is without authority or resources

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Transitions of the Case Management Model

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Traditional Models

Strengths

- Clear role definitions
- Familiar workflows
- Historically aligned with regulatory expectations
- Supports a nursing hierarchical structure
- Clinical staff were present in the hospitals and physically on the units

Inefficiencies in Present Day

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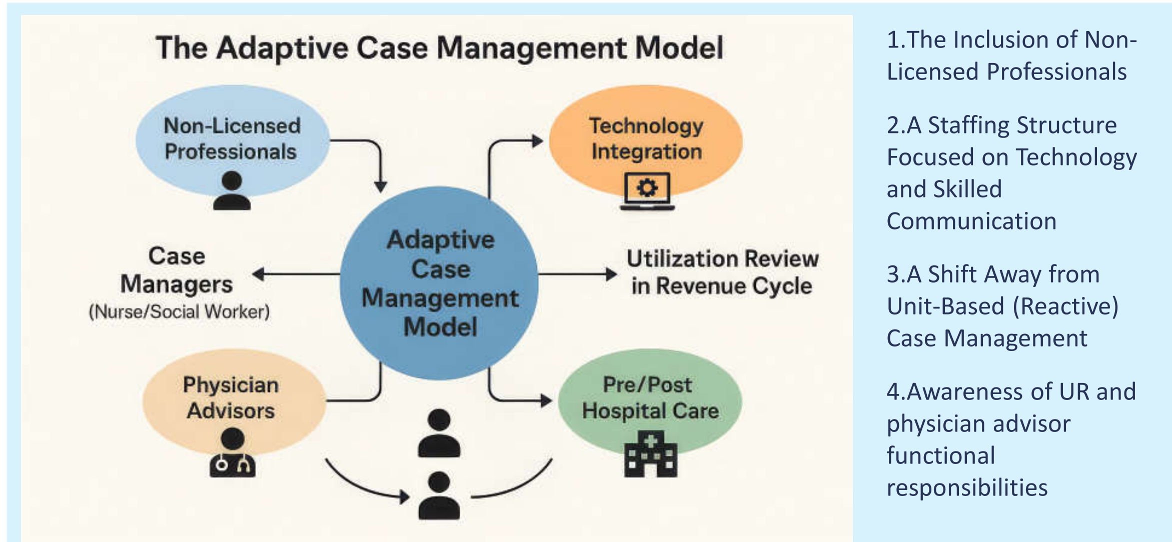
The Adaptive Model



1. The Inclusion of Non-Licensed Professionals
2. A Staffing Structure Focused on Technology and Skilled Communication
3. A Shift Away from Unit-Based (Reactive) Case Management
4. Awareness of UR and physician advisor functional responsibilities

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Technology & Skilled Communication

- Build teams that are technologically fluent and platform-aware
  - Does your onboarding time and training allow for technology support?
  - Are your leaders comfortable and up to date with your vendor tools and functionality?
    - Are they knowledge experts?
- Equip staff with tools that support real-time data access and documentation
- Align staffing with digital workflows, not just physical units
- Emphasis multiple modal communication techniques
  - Integrated techniques not overlapping or distracting models
- Prioritize skilled communication, both interprofessional and with patients
- Promote a culture of adaptability and continuous learning

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Plan Ahead & Staff the Doors

Plan Ahead

- Early ID of coverage risk/uninsured; engage Community Health Workers and Financial counseling on day 0.
- Surgical episodes: pre-hab, home-first planning
  - Remote initial assessments
- Single Case Agreements & Community partnerships – leverage direction back to the to community

Portals of Entry

- Effective ED staffing models average 1:40 patients to appropriate screen ED patients who are high utilizers, at risk of readmission and often SW roles with dedicated non-licensed workflows for arranging rides, follow ups, prescriptions, community resources
  - Focus is on priority 3s and establish schedules that align with peak hours for ED volumes and admission orders.
- “ED holding” is staffed as a unit
- Consider PACU support to avoid unnecessary admissions upstairs for discharge logistics.

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Utilization Management & Physician Advisors

Effective Utilization Management

- Not just OBS- IP management
- Medical necessity also includes – why is the patient here? Can they be discharged?
  - Progression of care management and collaboration
- Uninsured patients should be assumed as immediate denials that we are trying to overturn. No cases to ignore.
- Technology will continue to advance which means this team must start to adjust back into being an educator in the business of healthcare for CM and physicians.

Physician Advisor Support to CM, UM, & Medical Staff

Physician Advisors serve as a resource and recourse to the Case Management team and medical staff and are key to education and helping physicians understand the complexities to the regulatory environment.

- Physician advisors will lose their relevance if they are only hidden doing P2Ps and secondary reviews.
- Involvement is needed in education on documentation & medical necessity.
  - Progression of care
  - Complex care and transition management
  - Advocacy
  - Emergency room utilization
  - Denials management & prevention

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Case Management in 2026

1. Readmission strategies are not only transitional plans at discharge, but they are also outpatient strategies and ED partnerships.
   - Partner with the Emergency Department to consider how to avoid unnecessary admissions. *(Figuring it out once the patient is a head in a bed is the costliest option)*
2. Work with finance to capture all the dollars spent in a dedicate cost center for hospital provided charity care- the cost of discharging patients with/out means. $ tells a compelling story!
3. Adopt a mechanism for earlier interventions to address unfunded populations (complex population).
4. Staff creatively across hours: Hybrid models for weekends to increase needed staffing (1:60-80 pending the unit coverage). 2nd shift support to triage late discharges and continue patient movement.
5. Build independently workflows for non-licensed professionals with supported onboarding, training, and continual learning.
6. Don't do it alone, health system survival will require interdisciplinary collaboration and technology partnerships and stewardship.

Model Selection

Enterprise agile: Organized around a network of agile teams with end-to-end accountability; team leaders are held accountable for delivering agreed-upon outcomes.

- Role differentiation over license dependence
  - Competency alignment should first reflect needed function, not tradition
- Skill-based competency frameworks
  - Skilled communication (patient, family, physician, payer)
  - Regulatory fluency (CoPs, IPPS/OPPS, TEAM, MA requirements)
  - Technology proficiency (EHR workflows, care coordination platforms, dashboards)
  - Population-specific expertise (complex care, unfunded patients, behavioral health interfaces
- Leadership readiness

If leaders cannot articulate how case management impacts capacity, quality, and cost, the model will remain vulnerable, regardless of effort or intent.

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Measuring Impact

Operational Flow

- Avoidable days
- ED boarding hours
- Time-to-post-acute placement
- Length of stay variance by payer

Financial Performance

- TEAM episode cost performance
- Cost of care
- Denial prevention and overturn rates
- Charity care and unfunded care cost capture/ Hospital utilization improvements

Quality & Outcomes

- 7-day and 14-day readmissions (aligned with FY26 CMS refinements)
- Post-discharge follow-up completion

Workforce Sustainability

- Turnover and vacancy rates
- Onboarding and competencies
- Staff engagement

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No one-size fits all solution!

Hospital – Health System A

- CM program reports up through a strong CNO who understands value of CM program.
- They have a clear funnel of nursing and no ability to hire nurses into the CM program.
- They have a centralized team facilitating all post-acute authorizations
- They have created a unit dyad of CMA for every 2 CMs and a separate team who handle all regulatory requirements.
- SW, which is harder to higher, and covers additional BH requirements is more clinical a consultative.
- SW in the ED is 24/7.

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Hospital/Health System B

- CM reports with revenue cycle, with a robust and proactive UM team.
- The CM staff are either SW or RNs- there is no difference in these positions.
- This hospital struggles to find RNs or SWs for staffing, so they have opened flexibility of the roles and aligned pay to the role.
- BH has their own SWs who are heavily involved in ED and on medical units.
- CMAs are centralized and handle all the regulatory work as well as discharge logistics for follow up appts, transportation requests, and post-acute packet/referral management.
- CMs (SW/RN) also staffed in the ED for the medical portion – but only at peak hours (8-midnight).

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Change Management & Implementation Strategies

Start with purpose, not structure

- Frame change around system pain points: ED congestion, avoidable days, readmissions, and workforce burnout

Pilot before scaling

- Test adaptive workflows in targeted units or specific use cases (ED, uninsured, regulatory needs, complex care populations) before full deployment.

Redesign workflows before staffing

- Align roles with digital workflows and key decision points.
- Avoid physical units as the primary design decisions.

Invest in training and reinforcement

- Competency-based onboarding
- Ongoing education tied to regulatory changes
- Leader rounding focused on coaching, not auditing

Communicate early and often

- Clear articulation of "what changes" and "what stays"
- Defined escalation pathways
- Feedback loops with frontline staff

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Questions

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