



Understanding health care financing in 2022: A primer for CCM and CDMS certificant seeking to improve health outcomes under value-based care

The complex and evolving landscape of health care financing can seem daunting for people who work in the health care system—let alone clients. But by understanding the role of value-based care in health care financing, board-certified case managers (CCM) and disability management specialists (CDMS) can recognize their crucial role in helping clients to improve health outcomes.

Understanding the changing landscape of health care payments is not only critical for CCM and CDMS certifiants to help clients navigate the health care system, but also to support clients in the development of care plans to improve health and productivity, enabling a successful return to work, to play, and to living.

As payment systems shift to gradually incentivize quality of care and health outcomes over volume of services, CCM and CDMS certifiants increasingly play a key role in their success.

Key Terms Defined

- **Fee for service care**¹ – A method of payment in which doctors and other health care providers are paid for each individual unit of service.
- **Managed care**² – A system of health care delivery that aims to provide a generalized structure and focus when managing the use, access, cost, quality, and effectiveness of health care services.
- **Health maintenance organization (HMO)**¹ – A type of health insurance that usually limits coverage to care from providers who work for or contract with the HMO. Generally do not cover out-of-network care.
- **Preferred Provider Organization (PPO)**¹ – Type of health plan that contracts with medical providers to create a network of participating providers. Using providers in the network will cost less, and out-of-network providers can be used at a higher cost.
- **Value-based purchasing (VBP)**¹ – Links provider payments to improved performance, holding provider accountable for both quality and cost of care provided. Attempts to reduce inappropriate care and reward best-performing providers.
- **Patient Centered Medical Home (PCMH)**² – An approach to providing comprehensive, holistic and integrated primary care for clients. It is a care setting that facilitates partnerships among individual clients, clients' support systems and their primary care providers.

¹ "HealthCare.gov Glossary. In: *Health Insurance Marketplace*. U.S. Centers for Medicare & Medicaid Services. <https://www.healthcare.gov/glossary>

² Case Management Body of Knowledge. Commission for Case Manager Certification. <https://cmbodyofknowledge.com/>

Health care payment reforms over the last few decades have primarily focused on value — containing costs, enhancing quality of care and improving outcomes. While fee-for-service (FFS) remains the dominant payment method in much of the U.S. today, the shift toward managed care organizations and value-based payment models will affect how case managers and disability management specialists support clients in years to come.

Drawbacks of the traditional fee for service (FFS) model

Historically, health care financing in the U.S. has exclusively relied on a fee for service payment model for reimbursement of each individual unit of service provided.

“Decades ago, when health insurers began to cover health care services, the arrangement was relatively simple. If a client needed a service, they would get it, and insurance would often cover (services) based on unit fee schedules and contract allowances.”

— Ed Quick, MA, MBA, CRC, CDMS

“So, for example, a client named ‘Charlie’ might need gallbladder surgery. The surgeon would recommend such surgery, Charlie would have the procedure, and then Charlie’s surgeon would bill for the surgery. At that time, insurance would likely cover without question; the insurers would trust the medical providers to make the right decision.”

Unfortunately, in complex care cases, the FFS model can grow costly, incentivizing over-use of individual services. FFS payments limit longitudinal episode-of-care oversight to ensure high quality of care and health outcomes. Without oversight, it’s unclear whether surgeries and procedures are always truly warranted. Care delivery under the traditional FFS system is often fragmented due to lack of coordination across services, limited accountability for patient hand-offs and cost and quality management, and barriers to data sharing across providers such as differing systems. These FFS limitations can lead to excess ordering, procedures, and labs—incurring higher costs for clients and insurers³.

“An example of inappropriate care might be the duplication of an X-ray in three different settings within the same month,” states Dr. Gilbert Gimm, Associate Professor in Health Administration and Policy at George Mason University. “A patient might go to see a primary care physician, a radiologist and then a specialist.

In a FFS world, duplicated X-rays would result in three separate streams of revenue for all three providers. But for the health care system, that can be quite wasteful.”

Payors’ shift to managed care seeking value and return-on-investment (ROI)

In the year 2000, 13% of the U.S.’ gross domestic product (GDP) was health care-related, while most industrial countries spent an average 8% of their GDPs on health care⁴. The U.S. spent more on health care without seeing improved quality of care compared to countries where less was spent. This drove payors to seek ways to contain costs and improve quality, shifting to introduce managed care, health maintenance organizations (HMOs), and creating value-based payment models.

New payment and care delivery models have emerged to more effectively coordinate, manage and create accountability for cost and quality across multiple health providers.

Value-based payment models have grown more common in many states, which has not only spurred the development of Patient Centered Medical Homes (PCMHs), bundled payment models, and ACOs,

³ Eddy DM. Balancing cost and quality in fee-for-service versus managed care. *Health Aff. (Millwood)*. 1997;16(3):162-173. doi:10.1377/hlthaff.16.3.162

⁴ Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It’s The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*. 2003;22(3):89-105. doi:10.1377/hlthaff.22.3.89

but also created stronger incentives for provider consolidation and delivery system integration. As a result, the coordination of patient care and quality is more carefully monitored to improve health outcomes. Unfortunately, health care spending has not receded—the percentage of the U.S. GDP spent on health care increased to an estimated 19.7% in 2020 during the COVID-19 pandemic⁵.

Public payors shift: Medicare and Medicare Advantage explained

As growth of the aging U.S. population and economic recessions increase reliance on public programs, the number of public insurance (Medicare and Medicaid) enrollees has grown in turn.

Case managers and disability management specialists are important allies in helping clients with public insurance navigate and interpret these evolving payment models.

Medicare is a federal health insurance program administered and financed by the federal government for adults ages 65 years or older, adults ages 18-64 years with certain disabilities who receive Social Security Disability Insurance payments, and people with end-stage renal disease. The payor for this program is the Centers for Medicare & Medicaid Services (CMS). In 1965, Congress authorized legislation creating Medicare to provide health insurance for the elderly. Medicare covered about 57 million people in 2016 and includes hospital visits under Part A, physician services under Part B, post-acute services

and outpatient prescription drugs through private plans under Part D.

Medicare includes four parts (see figure 1):

- **Part A:** Federal hospital insurance, the original Medicare program authorized by 1965 legislation.
- **Part B:** Federal supplemental medical insurance, covering physician visits and outpatient care under the original program.
- **Part C:** A delivery innovation implemented in, Medicare Advantage plans offer Part A, Part B, and sometimes Part D benefits, bundled by private insurers as a one-stop coverage option.
- **Part D:** Outpatient prescription drug plans designed and covered by private insurers, available either as its own coverage or bundled into a Part C Medicare Advantage plan.

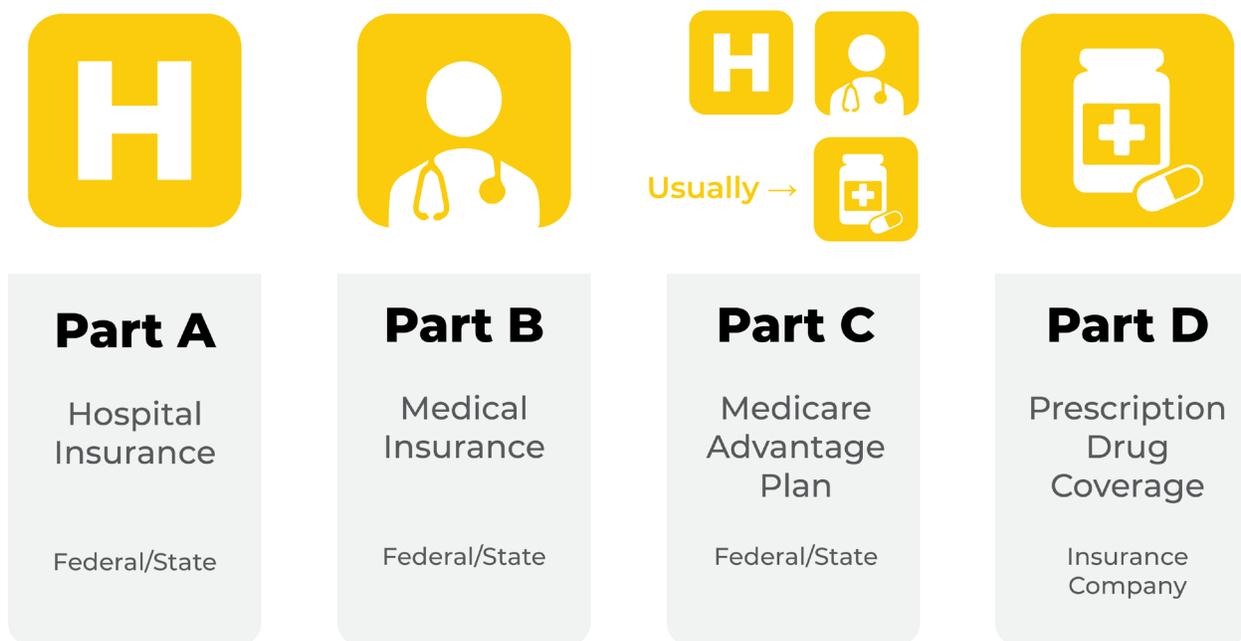


Figure 1

⁵ Centers for Medicare and Medicaid Services, NHE Fact Sheet | CMS. Cms.gov. Published December 16, 2020. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet>

Once a client qualifies for Medicare Part A coverage, they can sign up for Parts B and Part D, select a plan online, and pay monthly premiums for Parts B and D. Under Medicare Advantage (Part C), the process is bundled into a single enrollment process that includes Parts A, B, and D. While a Medicare Advantage HMO network is closed with fewer providers available, this simplified process is popular compared to the cumbersome process of signing up individually for various parts, driving steady growth of Medicare Advantage enrollment since its enactment in 1997 and implementation in 1999. Today, nearly 48% of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan (see Figure 2)⁶. Since Medicare Advantage was first introduced, it has allowed beneficiaries to enroll in a private plan providing all

Medicare-covered benefits and some extra benefits such as vision, dental, and more⁷.

In the future, the Medicare program will face major challenges. The rapidly growing aged U.S. population is increasing the number of beneficiaries and demand for services; new technology will increase prices, spending, and life spans; and declining birth rates will lead to fewer U.S. workers to support beneficiaries financially through the FICA system. To meet these future challenges and improve system sustainability, policymakers may cut payments to health care providers, increase Medicare Part A taxes, or support greater use of HMOs, such as through Medicare Advantage.

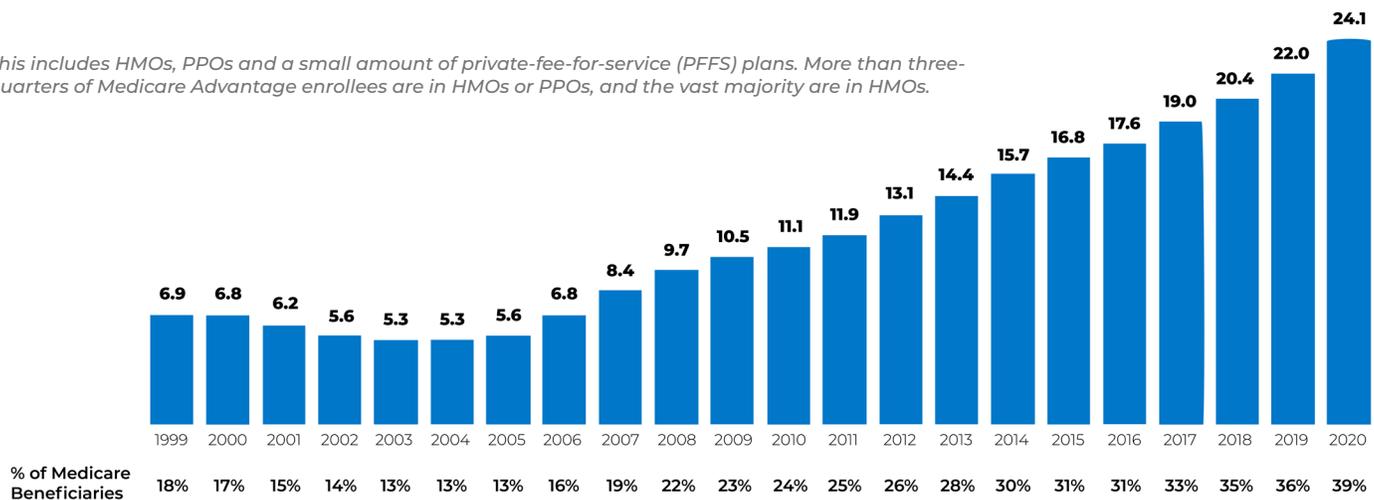
“Medicare Advantage is part of the solution to try to improve the sustainability of the Medicare program, which faces

many challenges,” Gimm says. “As (enrollment in) Medicare Advantage increases, this helps to not only improve patient outcomes and quality, but by bending the cost curve, this reduces some of the pressure on the financing of the Medicare program going forward.”

Medicare Accountable Care Organizations’ growth drives demand for Board-Certified Case Managers

Accountable Care Organizations (ACOs) integrate payment and care delivery in a value-based purchasing model authorized by Congress in the Affordable Care Act (ACA) of 2010⁸. Under ACOs, a large, integrated provider network assumes risk for quality and cost of care delivered to assigned Medicare beneficiaries. This model is

This includes HMOs, PPOs and a small amount of private-fee-for-service (PFFS) plans. More than three-quarters of Medicare Advantage enrollees are in HMOs or PPOs, and the vast majority are in HMOs.



Note: Includes cost plans as well as Medicare Advantage plans. About 62 million people are enrolled in Medicare 2020.

Source: Freed M, Damico A, 2022. Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. KFF. Published August 25, 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>



Figure 2

⁶ Freed M, Damico A, 2022. Medicare Advantage in 2022: Enrollment Update and Key Trends. KFF. Published August 25, 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

⁷ How do Medicare Advantage Plans work? Medicare.Gov. <https://www.medicare.gov/sign-up/change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work>

⁸ Accountable Care Organizations (Updated). Published online September 13, 2010. doi:10.1377/hpb20100813.757461

intended to improve care coordination, improve quality of care, improve patient outcomes, and reduce costs.

ACOs are the largest alternative payment model in Medicare, with over 11 million beneficiaries⁹. ACO risk contracts may be one-sided or two-sided: Under two-sided risk contracts, providers can receive bonuses and penalties if they do or don't meet performance standards, while under one-sided risk contracts, providers are only eligible for bonuses without risking a penalty¹⁰. Some ACOs have also expanded to include some patients who are privately insured¹¹.

The role of case managers within ACOs is highly valued, as they can serve as points of contact who drive the full

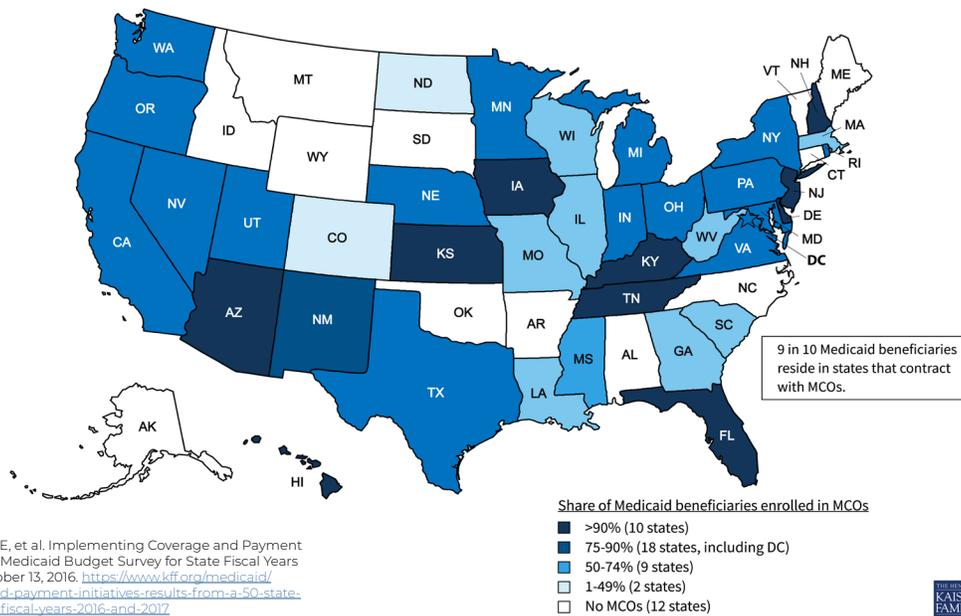
client experience in managing care coordination and tracking resource consumption. Many ACOs require whole-person solutions that extend beyond simple provider care, examining clients' full situations to propose creative solutions¹².

Medicaid and Medicaid Managed Care Organizations (MCOs)

Medicaid is a joint state-federal program for low-income people who meet specific financial and eligibility group criteria. The federal government matches state funding based on per capita income relative to the national average¹³. The Medicaid program is means-tested, or conditional based on financial need, designed for Americans whose income and assets fall

below an eligibility threshold based on the federal poverty level, as well as low-income aged, blind and disabled (ABD) people who receive supplemental security income (SSI).

Medicaid has traditionally used fee for service payments. However, in many states, low reimbursement rates due to balanced constraints and Medicaid payment cuts in times of economic recession have limited access to care. Fewer providers in states with low Medicaid reimbursement rates are willing to accept new Medicaid patients under the fee for service system, requiring clients to travel long distances or face long waiting lists as they struggle to find providers. Safety-net community health providers, such as federally



Source: Smith VK, Gifford K, Ellis E, et al. Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017. KFF. Published October 13, 2016. <https://www.kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017>



Figure 3

9 King R. Number of ACOs increases modestly to 483 for 2022, which advocates say should be wake-up call. Fierce Healthcare. Published January 26, 2022. Accessed October 19, 2022. <https://www.fiercehealthcare.com/payer/number-acos-increases-modestly-to-483-for-2022-as-advocates-say-should-be-wake-up-call>

10 Accountable Care Organizations (ACOs). Centers for Medicare & Medicaid Services. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO>

11 Private accountable care organizations take off; What to know about these value-based models. Healthcare Finance News. Published March 14, 2016. <https://www.healthcarefinancenews.com/news/private-accountable-care-organizations-take-what-know-about-these-value-based-models>

12 Need for case managers is rising with recent boom in ACOs. Case Manager Advisor. Published June 1, 2015. <https://www.reliamedia.com/articles/135480-need-for-case-managers-is-rising-with-recent-boom-in-aco>

13 Matching rates. Medicaid and CHIP Payment and Access Commission. <https://www.macpac.gov/subtopic/matching-rates/>

qualified health centers (FQHCs), offer primary care and dental services for many Medicaid enrollees to try to fill this gap¹⁴.

Over time, Medicaid managed care organizations (MCOs) have grown substantially—especially during the recent COVID-19 pandemic as states cut Medicaid funding to balance their tightening budgets. MCOs receive a fixed, per member per month (PMPM) payment to manage care of Medicaid members. Many Medicaid beneficiaries are enrolled in these MCOs, but rural states are less likely to contract with MCOs as it is more difficult to create a network of providers across vast distances (**see figure 3**). Through MCOs, private companies accept financial risk in exchange for the opportunity to improve quality and reduce cost. Examples of Medicaid MCOs include Molina, Anthem, United, Centene and CVS¹⁵.

“If the cost of care exceeds the PMPM payment, the MCO will lose money on that patient,” Gimm notes. “But if the MCO is efficient and the cost of care is below that PMPM payment, the MCO gets to keep that difference as net income or profit. This provides an economic incentive that’s different from fee for service, where the more you bill the more you receive, to one in which if you’re efficient, below the PMPM payment, the MCO is better off financially.”

Case managers can be essential to the health

outcomes of enrollees in Medicaid MCOs, advocating for clients with chronic conditions, helping them complete health risk assessments and schedule appointments, and otherwise coordinating care.

While these MCOs exist to manage care, they cannot successfully do so without the fundamental coordination that case managers and disability management specialists provide to support clients’ return to health and productivity.

For example, Gimm notes that in his research, he has found some clients with disabilities may have transportation challenges that personal assistant services can help them overcome.

“Personal assistant services are the single most valuable benefit of the Medicaid program for adults with disabilities,” Gimm states. “Personal assistance can mean that an individual helps accompany a person with a disability to a medical office visit. However, timely transportation is a major challenge for adults with disabilities. Medicaid MCOs help to expedite flexibility of medical and non-medical transportation which provide a very valuable service. To the extent that case managers may be interacting with patients who have a disability and a personal assistant, just remember that the personal assistant is a key partner for the patient, and

Medicaid is often providing funding support in states that have adopted waivers for personal assistance services.”

Board-certified case managers and disability management specialists are essential in value-based care models

Newer payment models that emphasize greater quality of health outcomes require closer attention to clients that case managers and disability management specialists often provide. Gimm points out that in value-based purchasing models, practitioners play a vital role in identifying and addressing unmet needs to support client wellbeing.

He mentions that some medical conditions can be avoided or mitigated through lifestyle screenings and changes. Case managers and disability management specialists can assess a client’s need by conducting motivational interviews, coach them on lifestyle issues, inform and advocate for them, and otherwise coordinate care. The unique understanding of clients’ needs that case managers and disability management specialists bring is vital to improving client outcomes in cases outside of the traditional fee-for-service model.

¹⁴ Medicaid and Safety-Net Providers: An Essential Health Equity Partnership. www.commonwealthfund.org. Published April 6, 2022. <https://www.commonwealthfund.org/publications/fund-reports/2022/apr/medicaid-safety-net-providers-equity-partnership>

¹⁵ Stolyar L, Hinton E, Singer N, 2021. Growth in Medicaid MCO Enrollment during the COVID-19 Pandemic. KFF. Published March 5, 2021. <https://www.kff.org/coronavirus-covid-19/issue-brief/growth-in-medicaid-mco-enrollment-during-the-covid-19-pandemic/>

“The value-based purchasing model focuses much more on prevention. Patient-centric treatment—placing patients at the center of the health care model, bringing them into a shared decision-making process, understanding their underlying needs after they’re discharged home...these are areas that case managers can delve in on, which perhaps a primary care physician...may not be as aware of or have the time to fully assess in 5 to 10 minutes.”

— Dr. Gilbert Gimm, Ph.D

Case managers can actively drive value-based care by improving quality of care in these systems.

Gimm saw firsthand the importance of patient-centric care in a study he conducted that assessed a Patient Centered Medical Home developed by CareFirst Blue Cross Blue Shield of Maryland. In this study, providers noted that nurse care coordinators were the single most valuable element of the program—even more important than short-term financial incentives.

These nurse care coordinators improved health outcomes by following up with clients who had multiple chronic conditions, creating care plans with the guidance of provider staff, answering clients’ questions at home between office visits, and communicating client needs to providers¹⁶.

The high value that primary care practices placed on the nurse care coordinators in this study demonstrates the critical importance of personal attention, advocacy, and management of clients’ needs in enhancing outcomes and quality of care. ACOs and PCMHs both require strong intake of client information, assessment of client needs, planning of service, and monitoring and evaluation to improve outcomes. Board-certified case managers and disability management specialists, whose roles often overlap to optimize outcomes for clients, can and often do play a cornerstone role—not just in ensuring these needs are met, but also going above and beyond to provide clients with the best possible outcomes and experiences.

“New value-based payment initiatives encourage providers and insurers to think through and problem-solve barriers to high quality health care,” Quick states. “These new approaches and that of the Patient-Centered Medical Home, which assures good communication between patient and provider,

show promise for improving U.S. health care. Recently, health analysts have proposed adding health equity as a critical focus for health systems. Use of these newer programs may truly help set the stage for quality, relatively low-cost health care that improves the health of all U.S. populations equitably.” ■

¹⁶ Gimm G, Goldberg DG, Ghanem N, et al. Provider Experiences with a Payer-Based PCMH Program. *Journal of General Internal Medicine*. 2019;34(10):2047-2053. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6816616/>

About the Experts



Dr. Gilbert Gimm, Associate Professor in Health Administration & Policy, George Mason University



**Ed Quick, MA, MBA, CDMS
Commissioner, Commission for
Case Manager Certification**

Dr. Gilbert Gimm is an Associate Professor in Health Administration & Policy at George Mason University in Fairfax, Virginia. He is a health economist by training with research focus areas in disability and aging, program evaluation, and health care payment reforms. Prior to joining Mason in 2011, Dr. Gimm was a senior researcher for 6 years at Mathematica Policy Research in Washington, DC, where he conducted program evaluations for CMS on the Medicaid Buy-In program, early interventions for workers with chronic conditions, and the financial viability of rural hospitals.

Dr. Gimm received his Ph.D. degree in health economics and policy from the Wharton School at the University of Pennsylvania. He is currently a principal investigator of a 3-year CDC grant sub-award to evaluate sustainable financing models for community health workers in Virginia and is a co-investigator in a 2-year NIDILRR center grant that uses national survey data to examine rural-urban disparities in access to care for adults with disabilities. His research work has been published in *Disability and Health Journal*, the *Journal of General Internal Medicine*, and the *American Journal of Public Health*.

Ed Quick has over 30 years of experience in health and productivity management. Currently a global senior leader in the integrated leave, disability and time away space for a large technology company, he was also the Executive Director of Disability Management Services for JP Morgan Chase in Chicago, Illinois, and the Global Leader, Employee Health and Productivity, for General Electric. He earned his Master's in Vocational Rehabilitation from the University of Cincinnati and a Master of Business Administration in Human Resource Management from American University.

Quick has been a volunteer for the certified case manager community for over 25 years, holding various committee and leadership roles for the Certified Disability Management Specialist Commission, including National Chair before the merger with the Commission for Case Manager Certification. He has served as the Chair of the DE&I Committee, in addition to his service on Finance, Symposium, and CDMS test development and assessment committees and taskforces. Quick has served as an outside member of the Healthcare Quality Certification Committee and as a Special Panel Member for the Society for Human Resource Management Occupational Safety Committee.



Commission for Case Manager Certification

1120 Route 73, Suite 200 · Mount Laurel, NJ 08054
(856) 380-6836 · ccmchq@ccmcertification.org
www.ccmcertification.org

**Join our community of
professional case managers!**

