

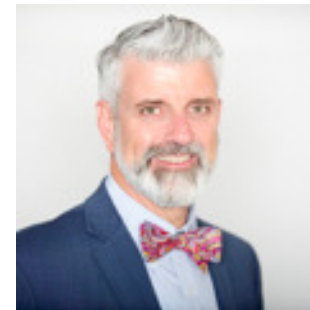
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A Resource Center for Today's Case Manager

Understanding Health Care Financing in 2022



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



Ed Quick, CDMS, CRC
Chair-Elect
Commission for Case
Manager Certification



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Agenda

- Welcome and Introductions:
 - Nancy Freeborne, DrPH, MPH, PA-C
Senior Advisor for Educational Programming
Health2 Resources
 - Ed Quick, CDMS, CRC
Chair-Elect
Commission for Case Manager Certification
- Presentation:
 - Dr. Gilbert Gimm
Associate Professor in Health Administration and Policy
George Mason University



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Learning Outcomes

After this presentation, the successful participant will be able to:

1. Describe how accountable care organizations differ from patient-centered medical homes, and their overlap with value-based programs;
2. Identify several reasons for the growing popularity of Medicare Advantage plans and key differences with original Medicare programs;
3. Compare and contrast traditional Medicaid fee-for-service payments and more recent cost control strategies used by Medicaid managed care organizations; and
4. Summarize how the changing landscape of health care financing affects clients and the role of case managers and disability management specialists.

Exam Prep Resources



Quiz App



Practice Exam



Glossary App



Certification 360
Virtual Workshops



Printable
Glossary



Exam Prep
References



8-Week
Prep Circuit

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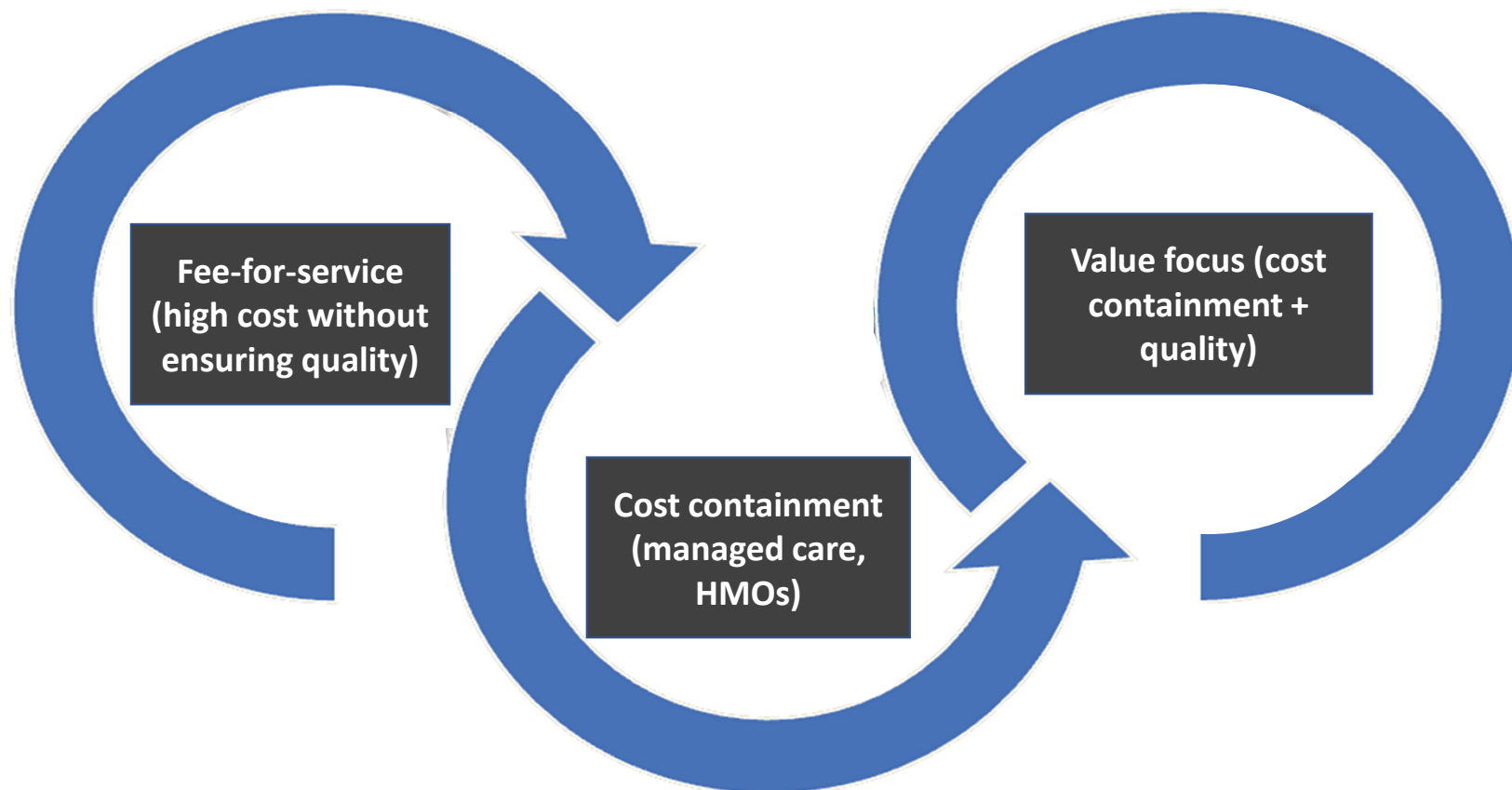
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Health Care Payment Models: Volume to Value



Further Payment Reforms

- **Triple Aim of health care:**
 1. Improving the patient experience of care
 2. Improving the health of Populations
 3. Reducing the per capita cost of care
- **Newer models: Value-based care, Patient-Centered Medical Homes**
- **Electronic medical records & metrics track quality**



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Health Care Financing in 2022:

Value-Based Purchasing, Accountable Care, and
Managed Care in the U.S. Health Care System:
Implications for Case Managers

Gilbert Gimm, Ph.D.

Associate Professor

September 26, 2022



Today's Agenda

- Value-Based Purchasing (VBP)
 - Managed Care vs. Fee-for-Service (FFS)
 - Accountable Care Organizations (ACOs)
- Medicare: Federal Program
 - Older Adults + Adults with Disabilities
 - Growth of Medicare Advantage (Pros & Cons)
- Medicaid: Joint State/Federal Program
 - Low-income households (children + some adults)
 - Managed Care Organizations

Personal Background

MATHEMATICA Policy Research



- Disability and aging
- Program evaluation
- Medicare / Medicaid payments
- Community health workers



Managed Care Terms

- **Fee-for-service (FFS):** a method of paying for medical services in which each unit of service (billing code) is reimbursed. Also, known as “unmanaged care”.
- **Managed Care:** health insurance arrangements that seek to integrate the financing and delivery of services.
- **HMO** = health maintenance organization that has a closed network of providers; HMOs have lower premiums than PPOs.



What is Value-Based Purchasing?

- Linking provider payments to **improved performance** by health care providers.
- This form of payment holds health care providers accountable for **both the cost and quality of care** they provide.
- It attempts to **reduce inappropriate care** and to identify and reward the best-performing providers.

Source: www.healthcare.gov/glossary/value-based-purchasing-vbp/



Implications of Value-Based Purchasing for Case Managers

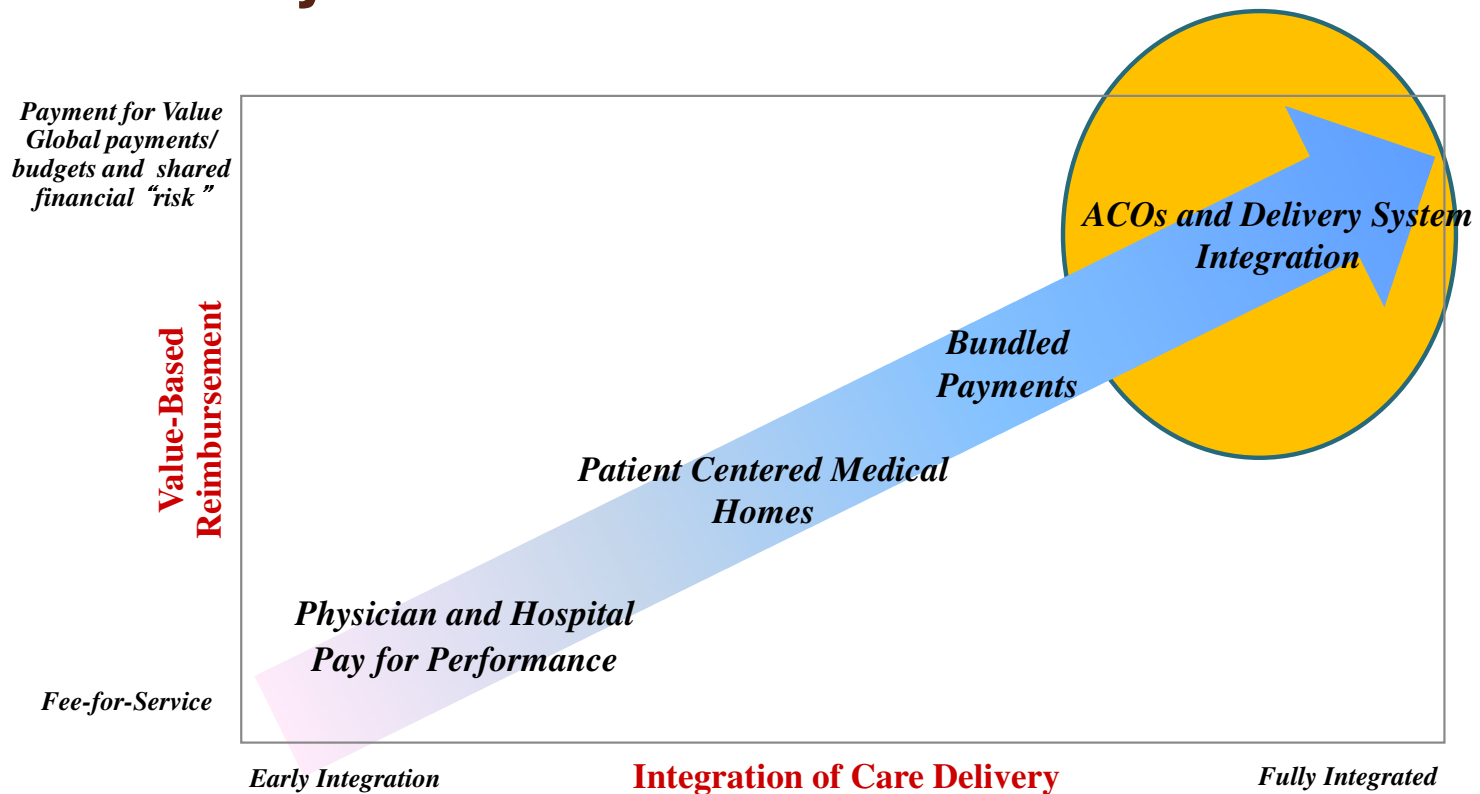
- The shift toward value-based care puts some emphasis on quality and outcomes rather than only the volume of services provided.
- This care model focuses on prevention, recognizing that many medical conditions can be avoided or addressed through:
 - Lifestyle changes
 - Simple medical procedures like screenings
 - Holistic treatment (psychological and social)
 - **Patient-centric treatment** (bringing them into the decision making, meeting their needs, etc.)



Why is Payment Reform Needed?

- **FFS payments reward volume**
 - “More services = more income”
 - Does not reward quality or value of care
- **Fragmented Care Delivery**
 - **Lack of coordination across services**
 - Limited accountability for patient hand-offs
(e.g., PCPs to specialists to hospitalists)
 - Barriers to data sharing across providers
 - HIPAA rules, lack of standardized format

Degree of Integration and Payment Reform Models



Source: Health Affairs Briefing, September 2012



What is an Accountable Care Organization (ACO)?

- A **network of providers** that assumes risk for the quality and cost of care delivered to “assigned” beneficiaries
- **ACOs were authorized and implemented by the 2010 Affordable Care Act (ACA)**
 - CMS initially awarded 153 ACO contracts in 2012
 - ACO concept originated in a 2007 paper by Dr. Elliot Fisher (Dartmouth Medical School)
 - “freestanding hospitals and physicians can form virtual ACO organizations”



ACO Requirements by CMS

- Formal legal structure encompassing defined set of PCPs; contract with CMS
- At **least 5,000 Medicare beneficiaries** cared for by PCPs
- Spending benchmarks and targets based on historical spending over prior 3 years
- Shared savings with Medicare



Medicare ACOs (in 2021)

- **10.7 million beneficiaries** are part of an ACO, making it far and away the largest alternative payment model in Medicare
 - Over 467,000 clinicians + 1,300 hospitals in ACOs
- **41% of ACOs** are in **two-sided** risk contracts
 - Provider gets a bonus (or penalty) if performance benchmarks are met (or not met)
- **59% of ACOs** are in **one-sided** risk contracts
 - Eligible for bonus (without risk of penalty)



Background on PCMH Models

- FFS payment system tends to support fragmented delivery of health care
- Better **care coordination** seeks to improve quality of care and “bend the cost curve”.
- Mixed evidence from rigorous studies with a comparison group (Peikes et al. 2012)
 - Of 14 evaluation studies (from 2000 to 2010), a few showed reductions in cost or ED use, a few showed higher costs, others were inconclusive.

Program Elements



- **Financial incentives**
 - 12% fee bump for initial participation
 - Annual, retroactive payment bonuses
- **Nurse care coordinator**
 - External staffing support paid by CareFirst
 - Follow-ups with patients having multiple chronic conditions and a careplan
- **Searchlight data portal**
 - Access to downstream cost data on patients



PCMH Research Implications

(Gimm et al., 2019; Gimm et al. 2016)

- **Providers found the external nurse care coordinators to be the single most useful and visible element of the PCMH program.**
- Small primary care practices were especially receptive to **external care coordination** resources.
- The one-time 12% payment bump raised short-term awareness of the program, but it did not sustain long-term provider engagement.
- The searchlight data portal was the least useful of the program elements mostly because it was difficult and time-consuming to access and navigate.



Four Key Components of Effective Case Management

1. Intake of Patient Information
2. Needs Assessment,
3. Service Planning, and
4. Monitoring and Evaluation.

Organizations (both large and small) require **good implementation** of all four components to support successful client outcomes.

PCMH practices strongly valued care coordinators who played a key role in improving patient outcomes (sharing information with providers).



What is Medicare?

- A **federal** health insurance program
 - for people who turn **65 years** old,
 - for working-age adults (18-64 years) with certain **disabilities** (who receive Social Security Disability Insurance payments)
 - and for persons of any age with end-stage renal disease (ESRD) or Lou Gehrig's disease



Authorizing Legislation

- **Signed in 1965** by President L.B. Johnson (**Title 18 of the Social Security Act**) to provide economic security and health care access to seniors 65 years or older
- **Expanded in 1972** to cover **younger adults with certain disabilities** (after 2 year waiting period) or end-stage renal disease (ESRD)
- Outpatient prescription drugs added in 2003; **implemented in 2006** (Part D)

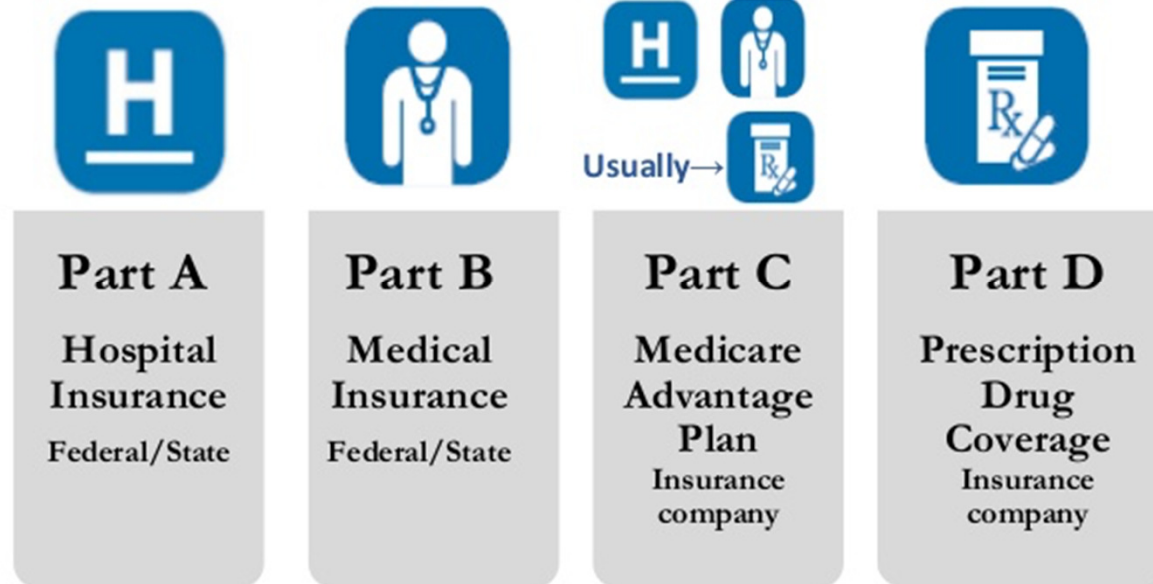


Who is covered by Medicare?

- In 2016, Medicare covered **57 million people** (17% of the US population), including 9 million working-age (<65 yrs.) adults with disabilities
- Covers individuals and spouses **regardless of income or medical history**
- Benefits include hospital visits, physician services, post-acute care services, and prescription drugs through private plans

Medicare in 4 Parts

Four Parts of Medicare





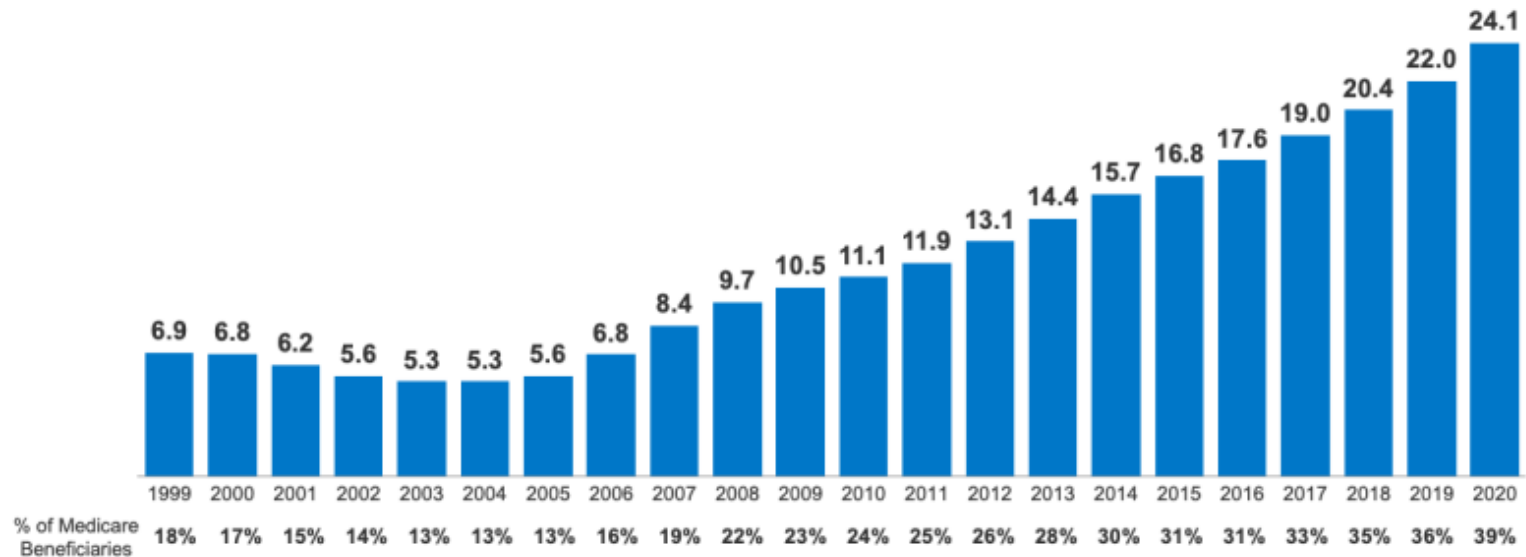
What is Medicare Advantage (Part C)?

- Introduced in **1997 Balanced Budget Act**
- Alternative to traditional Medicare Part A/B
- Beneficiaries can enroll in a **private plan** to receive all Medicare-covered benefits and often extra benefits (vision, dental, etc).
 - Includes HMOs, PPOs, and private-fee-for-service (PFFS) plans
 - 75% of MA enrollees in HMOs or PPOs

Medicare Advantage (Part C) Enrollment Growth Trend Continues

Figure 1

Total Medicare Advantage Enrollment, 1999-2020 (in millions)



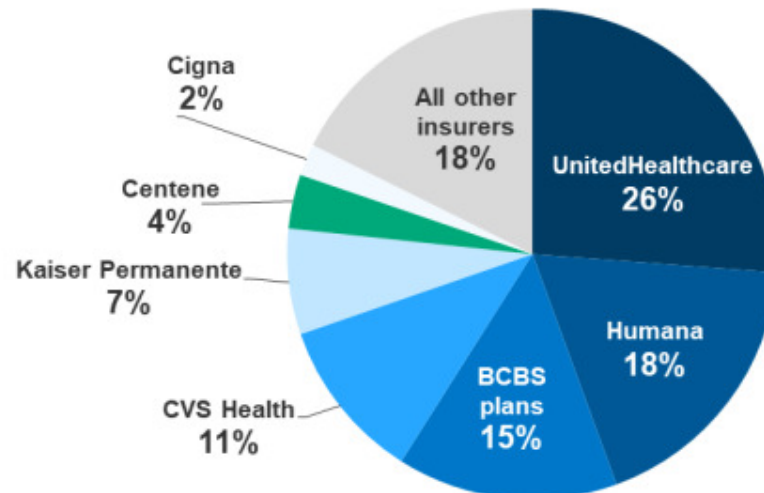
NOTE: Includes cost plans as well as Medicare Advantage plans. About 62 million people are enrolled in Medicare in 2020.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files 2008-2020, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April. Number of people eligible for Medicare comes from the CMS Medicare Advantage Penetration Files for years 2008-2009; for years 2010-2020, number of people eligible for Medicare comes from the Medicare Enrollment Dashboard.

Medicare Advantage (Part C) is Highly Concentrated by “Big 3 Firms”

Figure 4

Medicare Advantage Enrollment by Firm or Affiliate, 2020



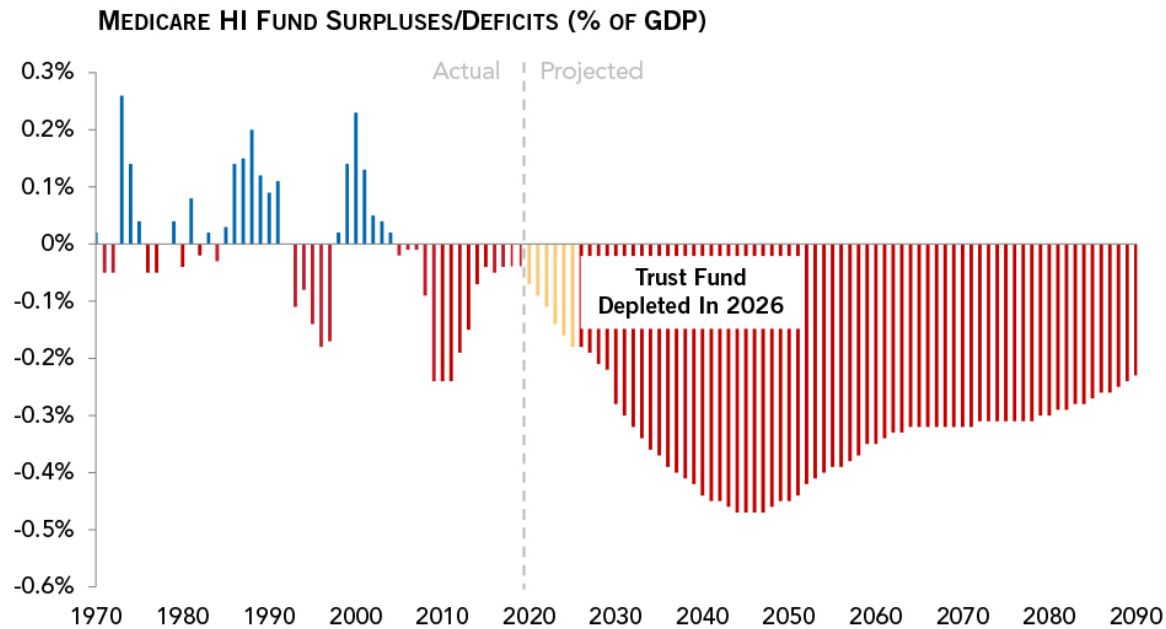
Total Medicare Advantage Enrollment, 2020 = 24.1 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are less than 2% of total enrollment. Percentages may not sum to 100% due to rounding.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2020.

Medicare Sustainability to 2026



Medicare's Hospital Insurance trust fund will be depleted in 2026



SOURCES: Social Security Administration, *The 2020 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, April 2020; and Centers for Medicare and Medicaid Services, *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 2020.

NOTE: Data exclude interest income.
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Challenges to Medicare Program

1. Aging population through 2050
2. New technology (high prices) that leads people to live longer, but increases Medicare spending
3. Fewer U.S. workers (and young children) to support current (and future) beneficiaries

Policy Options

- Future payment cuts? (Congress)
- Increase Medicare Part A taxes?
- Greater use of HMOs (Medicare Advantage)

What is Medicaid?



- A **public** health insurance program
 - for **low-income persons** who meet specific financial & eligibility group criteria
 - plays a key role in long-term care coverage
 - in 2014, Medicaid expansions (optional) began in many states under the ACA



Origins of Medicaid

- **Signed in 1965** by President L.B. Johnson
(**Title 19 of the Social Security Act**)
 - companion legislation to Medicare
- **Joint Federal-State program**
 - federal matching funds to states
 - states have some flexibility with the design of **program eligibility, benefits, and payment rates**
- **Means-tested**, focus on welfare population
 - single parents with dependent children
 - aged, blind, and disabled



Medicaid: Eligibility Categories (baseline federal eligibility rules)

- **Pregnant women** with family income below 133% of the poverty level (FPL);
- **Children** under 6 years with family income below 133% of the poverty level (FPL); children 6 to 19 in households with family income below 100% FPL
- **Parents with dependent children** (who qualified for 1996 welfare programs – often below 50% FPL)
- Low-income **aged, blind, and disabled** (ABD) persons with supplemental security income (SSI)

2020 Federal Poverty Level

Guidelines for 48 Contiguous States & DC

HH	2020					
Size	100% FPL	133%	150%	200%	300%	400%
1	\$12,760	\$16,971	\$19,140	\$25,520	\$38,280	\$51,040
2	\$17,240	\$22,929	\$25,860	\$34,480	\$51,720	\$68,960
3	\$21,720	\$28,888	\$32,580	\$43,440	\$65,160	\$86,880
4	\$26,200	\$34,846	\$39,300	\$52,400	\$78,600	\$104,800
5	\$30,680	\$40,804	\$46,020	\$61,360	\$92,040	\$122,720
6	\$35,160	\$46,763	\$52,740	\$70,320	\$105,480	\$140,640
7	\$39,640	\$52,721	\$59,460	\$79,280	\$118,920	\$158,560
8	\$44,120	\$58,680	\$66,180	\$88,240	\$132,360	\$176,480

Note: Higher FPL rates for Alaska, Hawaii.



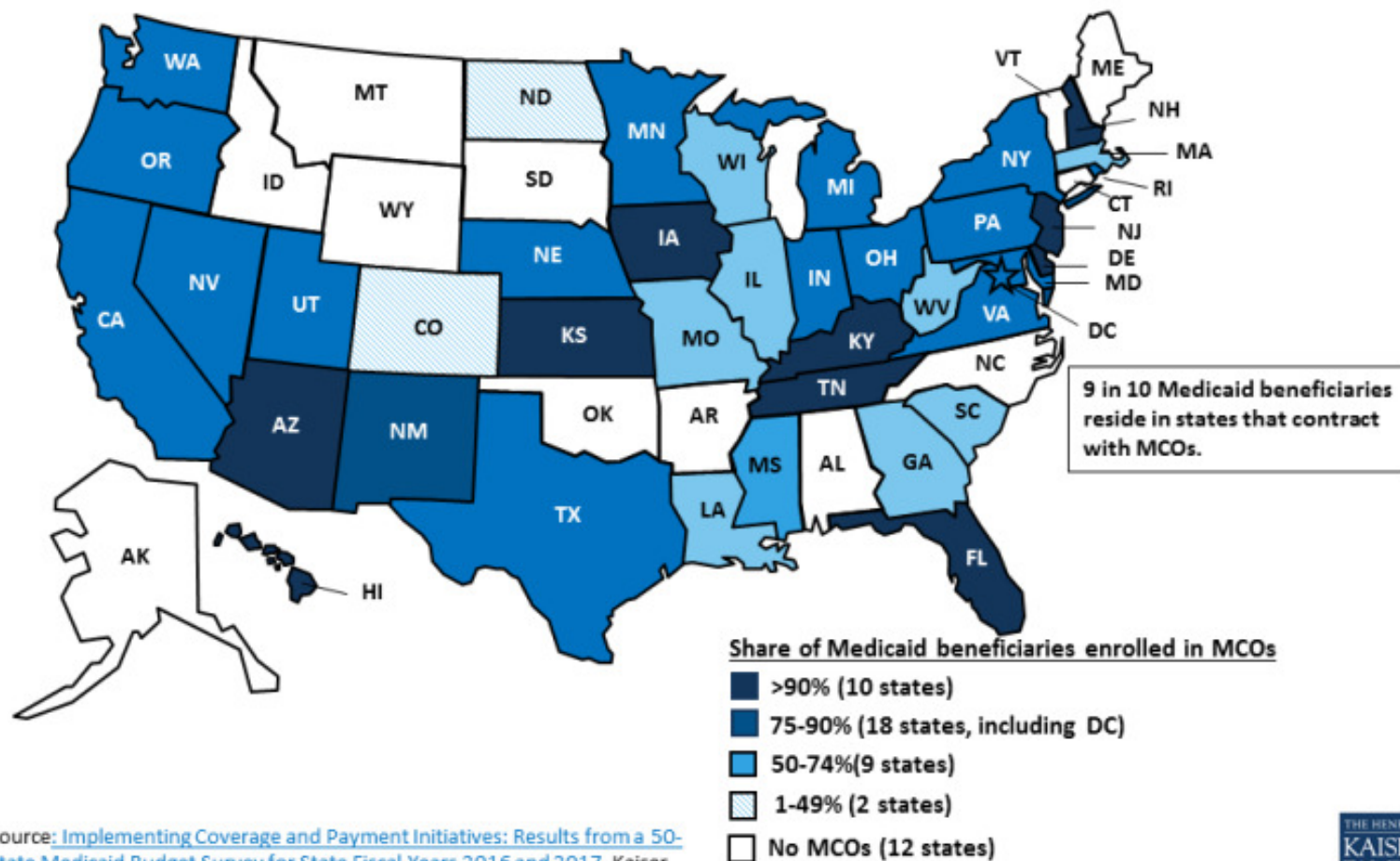
Medicaid Payments

- **Traditionally fee-for-service payments**
 - But many states have low reimbursement rates (to help states meet their balance budget requirements).
 - Downside is that provider availability can be limited
- **Managed care organizations (MCOs)**
 - Receive a fixed payment (**per member per month – PMPM**) to “manage” the care of Medicaid patients
 - Private companies accept financial risk in exchange for the opportunity to improve cost and quality
- **Prevalence of Medicaid MCOs varies by state**
 - **Arizona – nearly 100% Medicaid managed care**
 - **Wyoming, Alaska – less than 15% in Medicaid managed care**

Figure 1

A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.

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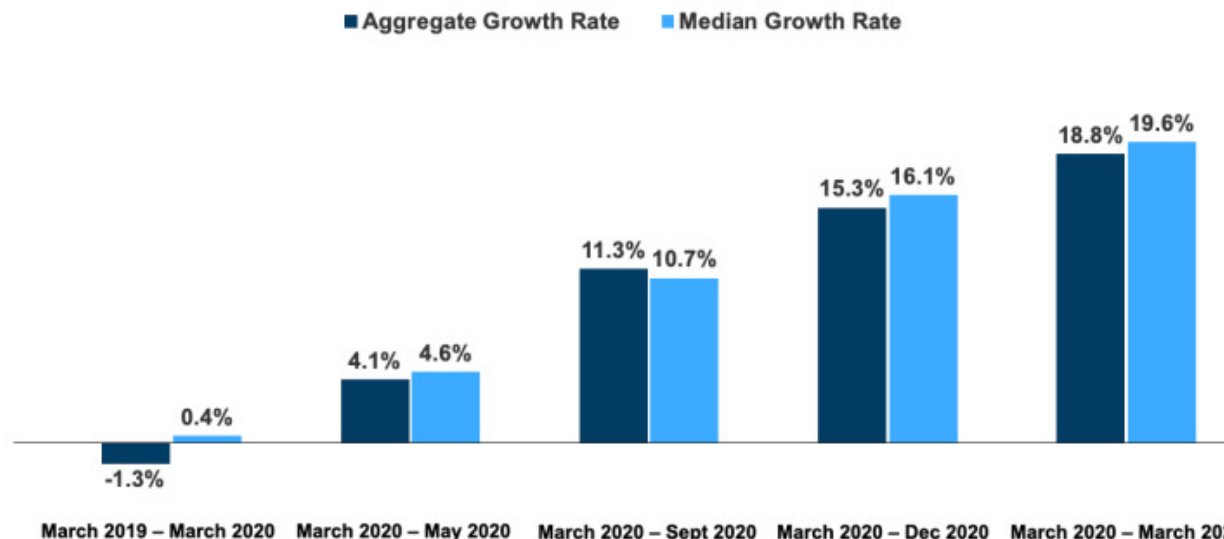


Source: [Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017](#), Kaiser Family Foundation, October 2016.

Medicaid Managed Care (Rapid Growth during COVID-19)

Figure 1

MCO Enrollment Growth Rates: March 2019 – March 2021



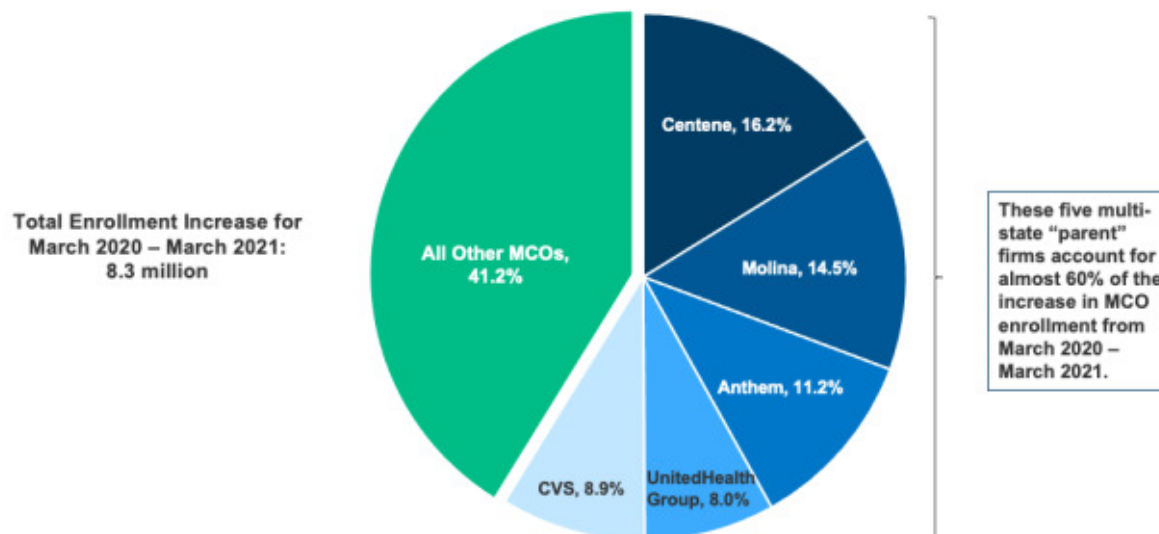
NOTE: Aggregate growth rates were calculated using states that reported in both periods. March 2019 – March 2020, 32 states reported in both periods. March 2020 – May 2020, 27 states reported in both periods. March 2020 – September 2020, 32 states reported in both periods. March 2020 – December 2020, 30 states reported in both periods. March 2020 – March 2021, 29 states reported in both periods.
SOURCE: KFF analysis of state Medicaid managed care enrollment reports.

KFF

Medicaid Managed Care

Figure 3

Five Fortune 500 firms made almost 60% of the increase in MCO enrollment in 28 states from March 2020 – March 2021



NOTES: The total increase of MCO enrollment from March 2020 to March 2021 was around 8.3 million. Market shares and enrollment increases were calculated for the 29 states that reported in both March 2020 and March 2021. Parent firms are firms that owns Medicaid MCOs in two or more states. Aetna was acquired by CVS in November 2018. WellCare was acquired by Centene in January 2020. Magellan Complete Care was acquired by Molina in December 2020.

SOURCE: KFF analysis of state Medicaid managed care enrollment reports.

Example of Case Managers in a Medicaid MCO (Anthem)



Anthem Blue Cross Cal MediConnect Plan
(Medicare-Medicaid Plan)



If you need help managing a medical problem or chronic condition, such as diabetes, a Case Manager can help you. A Case Manager is a nurse or other health care professional who helps you get the medical care and other services you need to [manage your condition](#).

Your Case Manager can assist in completing your Health Risk Assessment (HRA), help to schedule your appointments, etc.



Summary of Key Points

- **Value-based payments (ACOs) are widespread and affect Medicare beneficiaries**
 - Older adults (65 year or more) AND younger adults (18-64 years) with **certain disabilities** (who receive SSDI benefits)
 - These payments seek to improve **quality of care** (which is not rewarded under a traditional fee-for-service system)
- **Rise of managed care plans (primarily HMOs)**
 - Medicare Advantage (Part C) – has many HMOs
 - Medicaid managed care organizations (MCOs)
- **Care coordination for patients**
 - Value-based payment by itself cannot improve quality; it depends on case managers (what you do matters!)



Thank You!

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Q&A



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Closing Remarks



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Thank you!

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