

Primary Care Case Management and Medicaid: 2006 Update

Definition of PCCM

Primary care case management (PCCM) is a way of running Medicaid without HMOs. Recipients choose a primary care provider (PCP) who acts as their medical home. The PCP is responsible for managing their care and, in some states, acting as a gate keeper to specialty services. This gives the PCP a greater role in the oversight of a patient's care. PCPs must provide 24-hour access to information, emergency treatment and referrals, and are expected to provide all routine preventive care. PCPs include primary care physicians, clinics, group practices and nurse practitioners, among others.

Prevalence of PCCM

As of June 30, 2005, approximately 26% of the almost 25 million Medicaid enrollees who were enrolled in a comprehensive managed care plan were enrolled in a primary care case management program (PCCM).¹

- These 6.5 million consumers participate in PCCM programs in 30 states.
- There are 11 states which offer PCCM as the only managed care option.
- Georgia, North Carolina, Louisiana and Florida have the largest PCCM programs, each with over 700,000 enrollees.

Organization of PCCM programs

In traditional PCCM programs, providers bill the state directly under fee-for-service for the services they provide. HMOs are not involved. PCPs also receive a flat per member per month fee or an increase in preventive service fees to pay for case management services. Physicians bear no financial risk for the services they provide or approve. State Medicaid agencies may include additional activities, such as medical management, network management or performance incentives, to improve outcomes and generate cost savings.

States vary in how they manage provider networks, provider recruitment, data collection and analysis, monitoring, quality improvement, patient education, disease management programs and enrollment. Some states perform all these programs in-house using state employees; other states contract out all or some of these functions.

What has led states to choose PCCM?

Vermont started its PCCM program when HMOs suddenly left the state. North Carolina and Florida turned to PCCM to increase provider options in rural areas where there was no HMO coverage. Florida also used PCCM and HMOs together in some counties; PCCM provided competition for HMOs and allowed the state to hold HMOs accountable.

Outcomes of PCCM

1. Improved patient outcomes
2. Cost effectiveness
3. Increased provider participation
4. Consumer satisfaction
5. Social service coordination
6. Potential for quality improvement
7. Direct access to data and accountability

1. Improved patient outcomes.

PCCM has been shown to improve patient outcomes. The assignment of responsibility for each patient to one PCP facilitates the delivery of appropriate preventive care. A study of Medicaid-enrolled children in Virginia found that immunization rates were higher among PCCM enrollees than among enrollees in either mandatory or voluntary HMO programs.²

In addition, disease management programs, a prominent part of many PCCM programs, have been shown to improve health outcomes by fostering cooperation between PCP and patient. An asthma management program for PCCM providers in Virginia led to a reduction in Emergency Room visits for asthma.³ Florida and North Carolina have both created systems for disease management and case management, which are the center of their PCCM programs. In North Carolina, care management is delivered through provider-led community networks that participate in statewide disease management initiatives. Florida contracts with different disease management organizations for different conditions, matching the best managers with the appropriate populations. Both states have identified chronic conditions and/or high cost utilization areas to target through their disease management programs. Some of those initiatives include projects to reduce inappropriate emergency department (ED) utilization, as well as case management for diabetes, asthma, HIV/AIDS, end-stage renal disease (ESRD), chronic heart failure, hypertension and other disorders.

Enrolled recipients in the programs in North Carolina and Florida are also assigned care managers who provide health education, care coordination, and patient monitoring services. These care managers are especially important resources in practices where PCPs have limited clinical or administrative support.⁴

2. Cost Effectiveness

In FY 2003, Connecticut's Medicaid program made an average payment of \$1920 per child enrolled; CT is ranked ninth among states in terms of average payment per child. Of the 40 states that spend less than CT, 64% have PCCM programs.⁶

The cost effectiveness of PCCM is thought to derive from increased preventive services and less use of costly services such as Emergency Room visits. A recent cost analysis of the Iowa PCCM program found that PCCM was associated with substantial aggregate cost savings over an 8-year period, and that this effect became stronger over time.⁷

Virginia initiated a program to provide support in asthma management to providers in its PCCM program. A cost-effectiveness analysis of this asthma management program projected a \$3 - \$4 saving to Medicaid for every incremental dollar spent providing disease management support, due mostly to decreased frequency of ER visits by asthma patients.³

3. Increased Provider Participation

Some states have introduced PCCM because HMO coverage is not possible for all areas of a state. Several years after introducing Medicaid HMOs in Florida, it became apparent that it would not be possible to offer HMO coverage to Medicaid beneficiaries in all parts of the state because the

HMOs were not willing to expand into some of the less populated counties. In 1990, Florida developed a PCCM program to implement in areas without HMOs and to serve as an alternative where they did exist. By 1996, MediPass had expanded into a statewide program. Other states have had success recruiting providers who were no longer interested in working with HMOs. Providers in PCCM states are generally satisfied with the program and are far more positive about PCCM than HMOs.

4. Consumer Satisfaction

Surveys from states with PCCM programs find greater satisfaction among consumers with PCCM. Massachusetts consumers, who have a choice between PCCM and HMOs, overwhelmingly choose PCCM. Vermont surveyed consumers of its new PCCM program in 2001. They found that their PCCM program performs very well when compared to other Medicaid or commercial managed care plans throughout the country. Vermont's PCCM plan scored significantly better than the national Medicaid average in all five areas of the Consumer Assessment of Health Plans Survey (CAHPS): getting needed care, getting care without long waits, doctors who communicate, helpful and courteous office staff and customer service.⁵

5. Social service coordination

PCCM can lead to improved access to needed services. In states such as North Carolina and Florida, enrolled patients are assigned to care managers, who often help to provide social service coordination for enrollees.⁴ A study of pregnant women receiving prenatal care in either an HMO or PCCM program in Baltimore found that PCCM enrollees had higher rates of initiation of social services (WIC, Food Stamps and AFDC) during pregnancy, compared to those in an HMO.⁸

6. Quality Improvement

The initiation of PCCM creates opportunities for quality improvement. North Carolina's PCCM program was designed to improve the quality of care provided to Medicaid patients with certain chronic health conditions. As noted earlier, the program does this by managing patients with chronic health conditions when there is evidence that shows that using certain practices can lead to improved patient outcomes. At least one provider in each local practice must be designated as the quality improvement expert in a particular area and be trained in the use of evidence-based practice guidelines. Process and outcome measures for each health condition are chosen by a committee of stakeholders. Performance is measured through chart audits, claims data and physician profiling. The asthma disease management program in North Carolina led to significant improvement in quality of care for children with asthma; in 1999, 67% of children with asthma in the PCCM program were on a long-term controller medication, compared to just 53% of children with asthma in a fee-for-service program.⁴

7. Direct access to data and accountability

Without HMOs, PCCM programs have one less layer of administration. Data flows directly from providers to the state, without managed care company handling or loss of data. As PCCM programs are fee-for-service, providers do not get paid unless they submit complete data. With more comprehensive data in one state-controlled source, policymakers have direct access to more information to assess the program's performance and enhance accountability.

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