

Primary Care Case Management A Primer for Policymakers

What is Primary Care Case Management?

Connecticut's HUSKY program is struggling – families have great difficulty getting care and the current HMOs in the program are resisting Freedom of Information court orders of accountability. Only half of HUSKY children get a check up each year. Only 5.7% of Connecticut physicians accept Medicaid, and only a subset of them takes HUSKY. Many policymakers are looking for an alternative, to give families and the state another option.

Primary Care Case Management (PCCM) is a way of running Medicaid Managed Care without HMOs. Recipients choose a Primary Care Provider (PCP) who acts as their “medical home”. The PCP is responsible for managing their care including providing preventive health services, arranging for specialists and other needed treatment, and coordinating care. PCPs provide 24 hour, 7 days a week access to information and emergency treatment referrals (sometimes with help from a state contractor) and are expected to provide all routine preventive care. PCPs can include primary care physicians, clinics, and nurse practitioners, among others.

Providers bill the state under fee-for-service for the services they provide. PCPs also receive a flat per-member-per-month fee or an increase in their preventive care service fees to compensate for care management. Some states also pay providers bonuses for meeting quality standards and/or for taking more Medicaid patients. Providers bear no financial risk for the services they provide or authorize.

Is PCCM used in other states?

Yes, thirty states now successfully use PCCM for their Medicaid programs. The majority have both HMOs and PCCM systems, often both running in the same areas, allowing families a choice and providing competition that makes both systems perform better.

States with PCCM programs report significant cost savings. States implementing PCCM programs have seen increases in preventive care more than offset by reductions in costly hospital care. PCCM-associated disease management programs have saved Virginia \$3 to \$4 for every dollar spent. Immunization rates in Virginia are higher for children in PCCM programs than for those in HMOs.

Providers are more likely to participate in Medicaid PCCM programs than HMOs. Institution of PCCM in Maine led to 85% of the state's physicians accepting Medicaid patients. Providers have more control over medical decision-making in PCCM and their administrative burden is far less than with HMOs.

Surveys from states with PCCM programs find greater satisfaction among consumers. Consumers from states with both programs overwhelmingly choose PCCM over HMOs.

Many states are considering starting PCCM programs or expanding the programs they have because HMOs are leaving the state or, as in Connecticut, the HMOs are not serving families well.

How could PCCM work in Connecticut?

Consumers will likely find that they have more providers to choose from and that their PCP has more time to coordinate their care. They can choose any provider who takes HUSKY and will not be limited to only those on their HMO's list. They will no longer have to make dozens of calls to get care – they only have to call their PCP.

States vary in how they manage their provider networks, provider recruitment, data collection and analysis, monitoring, quality improvement, patient education, grievances, disease management programs and enrollment. Some states perform all these functions in-house by state employees, some contract out some or all of these functions. States monitor quality in a variety of ways including provider and consumer satisfaction surveys.

In PCCM, the state “owns” the program data and any best practices identified by monitoring. All recipients benefit from effective disease management programs, not just those in one HMO. In PCCM the state has more control over provider contracts and the quality of services delivered to clients, as the state is paying for them directly. There would be no HMO Freedom of Information accountability issues Connecticut is now struggling with.

Maine operates a PCP quality incentive program – a pool of money beyond care management and service fees – that is targeted to PCPs who provide higher quality care. The mechanism for judging quality was designed together with providers. Some states give higher care management fees to PCPs who accept a higher number of Medicaid consumers.

What are important questions in designing a PCCM program for Connecticut?

A clear key to the success of other states is developing the PCCM program in an open process built on meaningful input from consumers, providers, policymakers, researchers and advocates.

There are several important design questions –

- Which administrative functions should the state perform and which should be contracted out, if any?
- How should PCPs be reimbursed for care management – a per-member-per-month fee or an increase in preventive service fees?
- Should the state create a performance pool for PCPs based on quality of care?
- Should PCPs be gatekeepers?
- How to ensure that the program is designed and evolves with effective public input?
- How to design a cost effective, responsive information technology system that meets the needs of all users?
- How to monitor utilization and costs?
- How to measure health care access, quality and outcomes?
- How to provide effective training/education for consumers, providers, contractors, state agencies, community organizations and other stakeholders?
- If the state runs PCCM parallel to the current HMO system, how to fairly inform clients so they enroll in the right program to meet the needs of their families?
- How to ensure that clients with special needs get the care they deserve?

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