Connecticut Health Policy Project

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Primary Care Case Management
A Primer for Providers

What is Primary Care Case Management?

Primary Care Case Management (PCCM) is a way of running Medicaid, or HUSKY, without HMOs. Consumers choose a Primary Care Provider (PCP) who serves as their medical home. The PCP is responsible for managing their care including providing routine primary and preventive care services, coordinating care, and arranging for specialty services. In PCCM, PCPs have only one entity to work with rather than four HMOs, reducing hassles and standardizing administrative processes.

Providers bill the state directly 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 service fees to compensate for care management. Providers bear no financial risk for the services they provide or approve. Providers can specify how many patients they will accept responsibility for. They can also specify the types of patients they accept, for example limiting by age or only serving existing patients.

Is PCCM used in other states?

Yes, currently 30 other states use some form of PCCM; the majority have both PCCM and HMO programs, often in the same area of the state. Several states with both PCCM and HMOs believe that the competition of parallel systems makes both programs stronger and makes HMOs more responsive to the needs of providers and consumers. States with PCCM programs experienced an increase in preventive care, a decrease in inpatient care and some experienced a decrease in emergency room visits.

Providers in PCCM states are generally satisfied with the program. Maine experienced a dramatic increase in the number of physicians (to 85%) participating in Medicaid. Providers are far more positive about PCCM than HMOs. Providers have more control over medical decision-making and the administrative burden is far less than with HMOs. Several states that had been planning to or had converted to HMOs from PCCM, decided to reverse that decision because of savings and provider participation. Surveys of consumers consistently find greater satisfaction with PCCM programs. Consumers with a choice between PCCM and HMOs overwhelmingly choose PCCM.

What types of providers participate in PCCM?

States vary in which providers are qualified as PCPs. All states include family practice physicians, pediatricians, internists, general practice physicians, and community health clinics. Some states include OB/GYNs, nurse practitioners, physician assistants, nurse-midwives, osteopaths, local health departments, area health education centers (AHECs), outpatient hospital departments, and various physician specialists. Most states include a flexibility option in which a patient can apply on a case-by-case basis for assignment to a PCP not on the state's specified list, if that makes sense for their needs.

PCPs agree to provide 24 hour, 7 day a week access to information and care for all their assigned patients. PCPs also are required to assemble a referral network of specialists for their patients. To encourage providers to participate, many states have systems in place to help with these functions. Many states also provide assistance with case management functions such as arranging transportation.

How could PCCM work for Connecticut?

In PCCM, providers contract directly with the state and bill for their services under fee-for-service. PCPs also receive compensation for care management, generally a flat per-member-per-month fee. In some states, that fee is increased for practices that have a larger number of Medicaid patients allowing investment in administration and staffing. The reduction in administrative burden by eliminating HMO hassles allows reassignment of current staff to case management functions.

HMOs are not involved in PCCM; providers deal directly with the state or an Administrative Services Organization (ASO). States vary in how they manage provider networks and recruit new providers. States also vary in whether PCPs serve as gatekeepers to specialty services. It is imperative that PCPs receive timely, accurate information concerning services accessed by their assigned patients.

Most states include a disease management program in PCCM. These programs are designed with providers and coordinate services closely with PCPs. In PCCM, the state in collaboration with providers, decides who to contract with for disease management, allowing all Medicaid members to benefit from the best program.

Consumers may not notice much change at all with PCCM. They now choose a PCP after they choose an HMO. They should notice an increase in the number of available providers, both because more providers will be willing to participate in PCCM, and because they can choose any provider who takes Medicaid, not just those from their HMO's network. They no longer will have to figure out who to call with a problem – they call their PCP.

States vary in how they manage their provider networks, provider recruitment, data collection and analysis, quality monitoring and improvement, patient education, disease management, and enrollment. Some states perform all these functions in-house by state employees, other states contract out some or all of these functions. Most states monitor client and provider satisfaction with surveys.

Maine operates a PCP incentive payment program – a pool of money beyond case management and service fees – that is targeted to PCPs who provide quality care. The mechanism of judging and measuring quality was designed with providers.

What is important to implementing a successful PCCM program?

It is clear from other states' experiences that it is critical to design PCCM in an open process that includes meaningful input from consumers, providers, policymakers, researchers, and advocates. This feedback must be an on-going part of the program and policies must adapt in response.

Some important design questions --

- How will effective communications and data systems be developed that allow for timely, accurate, useful interactive communication between PCPs, the state (or an ASO) and other providers?
- How will the state communicate with PCPs? Many states have newsletters, regional meetings, hotlines and other tools for busy providers to get answers and address concerns.
- Will the state provide PCPs with assistance in meeting the 24 hour, 7 day a week coverage requirement and developing a network of specialists for referrals?
- How will performance be measured? How will feedback reports, comparing performance with colleagues, be designed?
- How will claims processing and timely payments be handled?
- Which functions should the state perform and which should be contracted out? How will providers have input into who is hired and the evaluation of their performance?
- Should the state institute a performance pool for PCPs based on quality of care? How should performance be measured? What level of incentives is meaningful?
- Should PCPs be gatekeepers?
- How to design effective quality improvement and data collection processes that integrate with current practices?
- How to provide effective training/education and materials for providers and patients?

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