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Primary Care Case Management as an Option for
Medicaid Managed Care

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I. INTRODUCTION

Primary care case management (PCCM) originated in the 1980s and involves creating a link between Medicaid beneficiaries and primary care providers (PCPs) and then paying those PCPs a monthly fee to administer a wide range of care management services.¹ The care management activities usually involve the providers authorizing emergency room (ER) and specialist visits.² Additionally, the PCPs and other providers are paid a fee for each service that they perform.³ Recently, states have begun enhancing their PCCM programs with new features, including more thorough care management and coordination for high-need beneficiaries, disease management, medical home initiatives, improved financial incentives for PCPs, and an increase in the use of performance and quality measures.⁴

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1. James M Verdier, et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, CENTER FOR HEALTH CARE STRATEGIES 1 (2009), available at http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf.

2. *Id.*

3. KAISER FOUNDATION, *MEDICAID AND MANAGED CARE* (2001), available at <http://www.statehealthfacts.org>.

4. Verdier, *supra* note 1.

This paper will begin by identifying the purpose of Medicaid and how states can customize their Medicaid benefit delivery systems. Then this paper will introduce how Medicaid managed care is administered through a PCCM model. Following that discussion, this paper will focus on the successes and failures that individual states have experienced following implementation of a PCCM model in their Medicaid managed care system. To determine whether a state has experienced benefits or problems from the implementation of a PCCM program, three metrics will be used: overall quality of care, level of access to care, and cost containment.

II. MEDICAID AND STATE WAIVERS

In 1965, Congress enacted Medicaid and Medicare simultaneously in an amendment to the Social Security Act of 1935.⁵ Medicaid is an entitlement program that comprises a large amount of mandatory spending in the federal budget and is financed by both the federal and state governments.⁶ The purpose of Medicaid is to provide medical assistance to families with dependent children, the elderly, blind, and permanently disabled people who have insufficient income and resources to meet the costs of necessary medical care.⁷ Participation by states is optional, and all fifty states have opted in.⁸ Once a state opts-in, it must follow certain federal rules to receive federal funding, unless the state receives a waiver from the Secretary of Health and Human Services.⁹ These waivers, once approved by the Centers for Medicare and Medicaid Services (CMS), grant a state greater flexibility in administering Medicaid coverage and costs.¹⁰

In 1997, Congress enacted §4701 of the Balanced Budget Act, which allowed states to put most Medicaid beneficiaries into managed care

5. Social Security Act of 1935, *amended by* Social Security Amendments of 1965, Pub. L. No. 89-97, §1901, 79 Stat. 288.

6. Elicia J. Herz, *MEDICAID: A PRIMER*, CONG. RES. SERV. 1 (2010), *available at* <http://aging.senate.gov/crs/medicaid1.pdf>.

7. Social Security Amendments of 1965 § 1901.

8. Herz, *supra* note 6.

9. *Id.*

programs, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), without requesting a federal waiver.¹¹ Frequently, a state will try to move certain existing Medicaid populations into managed care arrangements, which will help to free up funds to provide coverage for individuals that would not otherwise be eligible for Medicaid under an approved waiver.¹²

III. MANAGED CARE AS A WAY OF ADMINISTERING MEDICAID

Managed care is a method used to deliver Medicaid benefits to beneficiaries. Generally, managed care is “[a] medical delivery system that attempts to manage the quality and cost of medical services that individuals receive.”¹³ States manage such costs by attempting to “improve access and reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care.”¹⁴ Medicaid managed care is a way for states to work with third party payers, such as HMOs and PPOs, to provide treatment to beneficiaries and payment for those provided medical services.¹⁵ In most states, beneficiaries are encouraged to use HMOs and PPOs that are offered by the state’s managed care system for the beneficiary’s needed health care services.¹⁶ There are two major Medicaid managed care models.¹⁷ In the risk-based model, the state pays a managed care organization (MCO), such as an HMO, a fixed monthly fee per enrollee (also known as capitation) and the MCO assumes all or some of the financial risk for the services provided.¹⁸ In the PCCM model, PCPs or other providers are paid a monthly case management fee

10. *Id.* at 12.

11. DEAN M. HARRIS, *CONTEMPORARY ISSUES IN HEALTHCARE LAW AND ETHICS* 133 (2008).

12. Herz, *supra* note 6, at 12.

13. HEALTH INSURANCE RESOURCE CENTER, *HEALTH INSURANCE GLOSSARY*, available at <http://www.healthinsurance.org/glossary>.

14. KAISER FOUNDATION, *supra* note 3.

15. *Id.*

16. HEALTH INSURANCE RESOURCE CENTER, *supra* note 13.

17. KAISER FOUNDATION, *supra* note 3.

18. *Id.*

per-patient and a set fee for each service provided (also known as fee-for-service or FFS), thus the provider does not assume any of the financial risk associated with unpredictable costs.¹⁹ In mid-2007, PCCM models were in use in twenty-nine states and accounted for 13.6% of Medicaid enrollees.²⁰

IV. HOW PRIMARY CARE CASE MANAGEMENT WORKS

Basic Structure

PCCM is a way of administering Medicaid without the use of HMOs.²¹ In a PCCM system, a recipient chooses a PCP to act as their “medical home.”²² As the recipient’s medical home, the PCP has a larger role in the oversight of a patient’s care by becoming responsible for managing the care of the recipient by providing all routine preventative care and providing 24-hour access to information, emergency treatment and referrals.²³ The PCPs can include primary care physicians, clinics, group practices, nurse practitioners, and others.²⁴ In some states, PCPs may also act as a “gatekeeper” for specialty services.²⁵ As a gatekeeper, the job of the PCP is to “approve and monitor the provisions of services to beneficiaries.”²⁶

Additionally, state Medicaid PCCM programs have been providing medical homes for their beneficiaries since their establishment over two decades ago.²⁷ While PCCM programs follow the same general structure, many states have made “enhancements” to their programs.²⁸ Currently, medical homes usually include “pay-for-performance (P4P) financial incentives for physicians, patient-focused and practice-focused care

19. *Id.*

20. Verdier, *supra* note 2.

21. Sakena Abedin, *Primary Care Case Management and Medicaid: 2006 Update*, CONNECTICUT HEALTH POLICY PROJECT, available at http://www.cthealthpolicy.org/pccm/pccm_medicaid.pdf.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. KAISER FOUNDATION, *supra* note 3.

27. Verdier, *supra* note 1, at 9.

management improvements, greater use of information technology, and more extensive monitoring and performance reporting.”²⁹ While the current concept of medical homes has become more elaborate and multi-faceted than when PCCM programs began, many state PCCM programs still maintain some of the original elements of medical homes.³⁰

While a PCCM program is mostly FFS, there are also elements of capitation. In most state PCCM programs, physicians are paid on a monthly per-member basis for care coordination services and all physicians and other providers are then paid on a FFS basis for services performed.³¹

Enhancements

Not only have states enhanced their medical homes, but they have also enhanced their overall PCCM programs to provide for better quality of services and to reach more people. States that have enhanced their PCCM programs have made the changes from the basic model to something that is better tailored to meet the needs of the individual beneficiaries within the state.³² For example, in Massachusetts the per-member per-month (PMPM) fee paid to physicians for coordination of care was raised from three dollars to ten dollars in exchange for an increased level of certain primary care services.³³ Maine introduced a version of P4P reimbursement system by “paying providers additional amounts for reducing inappropriate ER visits and providing more preventive services.”³⁴ Oklahoma raised its capitation arrangement above the expected cost of additional services in an effort to encourage more rural physicians to enter the program and thus provide greater access to health care.³⁵ In addition to increasing payments to induce greater physician participation, a number of states have implemented

28. *Id.*

29. *Id.*

30. *Id.*

31. Abedin, *supra* note 21.

32. *Id.* at 1.

33. *Id.* at 8.

34. *Id.* at 8-9.

disease management programs to target chronic long-term diseases.³⁶

V. BENEFITS AND PROBLEMS FOLLOWING ADOPTION OF PCCM

States have cited different reasons for adopting PCCM programs within their borders, and it appears that adoption of the program has usually helped increase access to care and quality of care to Medicaid beneficiaries. For example, “North Carolina and Florida turned to PCCM[s] to increase provider options in rural areas where there was no HMO coverage,” and Vermont adopted a PCCM program after HMOs left the state.³⁷

Accessibility

States that have adopted PCCM programs as a solution to their Medicaid woes have had varying degrees of success following implementation. Two groups that states have been successful in expanding coverage to are children and those that live in rural areas. For example, Alabama and Georgia saw an increase in accessibility of children covered by Medicaid.³⁸ A study in those states showed that children that resided in “communities with higher Medicaid physician-to-enrollee ratios were more likely to use health care services than children living in communities with fewer Medicaid physicians per enrollee.”³⁹ Where there is an increase in the availability of physicians participating in Medicaid there is also a greater ability for child beneficiaries to utilize health care services.

Additionally, Texans have benefited from an increase in the accessibility of care because their PCCM program covers 202 counties that were not previously covered by an MCO.⁴⁰ The counties in Texas that are covered under the PCCM program are primarily rural areas, whereas the

35. *Id.* at 9.

36. *Id.*

37. Abedin, *supra* note 21.

38. Karen VanLandeghem & Cindy Branch, *Impact of Primary Care Case Management Implementation on Medicaid and SCHIP*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 2 (March 2009), available at <http://www.ahrq.gov/chiri/chiribrf8/chiribr8.pdf>.

39. *Id.*

40. TEX. HEALTH & HUMAN SERVS. COMM’N, *Chapter 6: Medicaid Managed Care* 6-15

metropolitan areas are covered by standard MCOs.⁴¹ By locating the PCCM facilities in rural areas, the populations in those areas are likely able to receive care that they may not have been able to obtain without traveling long distances to the closest metropolitan areas. Furthermore, Florida implemented a PCCM program because it was apparent that “HMOs were not willing to expand into some of the less populated counties.”⁴² By expanding the geographic coverage area of Medicaid plans more physicians were able to participate in Medicaid managed care.⁴³ Many other states, including Oklahoma, have seen an expansion of coverage to rural areas.⁴⁴

However, not all states have experienced an increase in accessibility following adoption of a PCCM system. In Alabama and Georgia, the proportion of office-based physicians that participated in Medicaid declined with the adoption of a PCCM delivery system.⁴⁵ This is likely due to the increased requirements that providers had to meet to participate in the PCCM system, such as taking on a minimum number of Medicaid enrollees and providing 24/7 phone or office access.⁴⁶

Quality

In addition to changes in accessibility to a state’s Medicaid beneficiaries, states that have implemented PCCM programs have seen an increased level in quality of care. Children, in particular, have seen a substantial increase in their quality of care. One group in particular that has experienced an increase in quality of care is children. In Texas in 2008, seventy-six percent of children aged three through six “received the recommended number of well-child visits. . .” and adolescent well-child visits exceeded the national Medicaid mean of forty-two percent with a sixty-one percent visitation

(2011), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PDF/Chp-6.pdf>.

41. *Id.*

42. Abedin, *supra* note 21.

43. *See, e.g.*, Verdier, *supra* note 1, at 5.

44. *Id.*

45. VanLadeghem, *supra* note 38.

46. *Id.*

rate.⁴⁷ Furthermore, a Consumer Assessment of Health Plans Survey (CAHPS) of Texas PCCM child beneficiaries reported high scores showing that children usually or always received the type of care needed.⁴⁸ The Texas survey was mirrored in another CAHPS survey of Vermont's PCCM program.⁴⁹ The Vermont PCCM scored considerably better than the national average for Medicaid in all five areas covered under the survey.⁵⁰ Similar results have been shown in Oklahoma's PCCM program.⁵¹

Additionally, when given a choice, it appears that patients prefer the PCCM programs to other alternatives. For example, Massachusetts Medicaid beneficiaries had a choice between a PCCM or HMO and the beneficiaries "overwhelmingly" chose to participate in the PCCM program.⁵² Similarly, a survey of Vermont consumers found that their PCCM program performed "very well" compared to other Medicaid managed care plans across the country.⁵³

Furthermore, beneficiaries covered under a PCCM program receive higher quality care than they received under a different plan. In Virginia, a study revealed that children enrolled in a PCCM plan had higher immunization rates than those in HMO programs.⁵⁴ Virginia implemented a disease management program as a part of their PCCM program and as a result saw a reduction in ER visits for asthma.⁵⁵ In 1999, North Carolina reported a "significant improvement" in quality of care for asthmatic

47. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, at 6-17. A well-child visit consists of a visit to a health care provider on a set schedule that coincides with the developmental stages of a child. During these visits, the provider will conduct a complete physical exam while checking on the growth and development of the child to ensure that the child is healthy and developing properly. Jennifer K. Mannheim et al., *Well-Child Visits: MedlinePlus Medical Encyclopedia*, NATIONAL INSTITUTE OF HEALTH, available at <http://www.nlm.nih.gov/medlineplus/ency/article/001928.htm>.

48. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, at 6-17.

49. Abedin, *supra* note 21.

50. *Id.* (noting the five criteria for the survey are: ". . . getting needed care, getting care without long waits, doctors who communicate, helpful and courteous office staff and customer service.")

51. Verdier, *supra* note 1, at 35.

52. Abedin, *supra* note 21.

53. *Id.*

54. *Id.*

children as a result of their disease management program.⁵⁶ Sixty-seven percent of asthmatic children were on long-term controller medication, as opposed to only fifty-three percent of asthmatic children in a FFS program.⁵⁷

However, not all states experience an increase in the quality of care following implementation of PCCM programs. Although children in Alabama and Georgia were less likely to visit the ER, they were also less likely to use well-child and other primary care, such as a visit to a PCP for an acute illness or a chronic condition.⁵⁸ One reason given for this decline is that in many cases Medicaid beneficiaries were assigned to a PCP instead of choosing one, which damaged the doctor-patient relationship.⁵⁹ Although families had the ability to choose their PCP under state law, many families were unaware how to change their assigned provider or found it to be too difficult.⁶⁰

Cost Containment

Many states that have implemented a PCCM for their Medicaid beneficiaries have reduced the costs associated with delivery of medical services. PCCM programs aim to lower costs through an increase in preventative services while simultaneously reducing the use of costly services, like ER visits.⁶¹ A cost-effectiveness analysis of Virginia's asthma management program "projected a \$3-\$4 saving to Medicaid for every incremental dollar spent providing disease management support. . ."⁶² This projection is due to the decrease in ER visits of enrollees with asthma.⁶³ Similarly, a cost analysis of Iowa's PCCM program showed that

55. *Id.*

56. *Id.*

57. *Id.*

58. VanLandeghem, *supra* note 38, at 1.

59. *Id.* at 3.

60. *Id.*

61. Abedin, *supra* note 21.

62. *Id.*

63. *Id.*

the PCCM program “was associated with substantial aggregate cost savings over an eight-year period.”⁶⁴

North Carolina contracts with Mercer Government Human Services Consulting (Mercer) to provide estimates of savings that the state will realize from its PCCM program.⁶⁵ In 2009, an analysis by Mercer revealed that North Carolina’s PCCM program created a savings of \$147 million in 2007, representing a total savings of around eleven percent of Medicaid costs.⁶⁶ Mercer did a similar study in Pennsylvania, which concluded that, from July 2005 through June 2006, Pennsylvania’s PCCM program had medical costs six percent below the MCO program.⁶⁷ The same study showed that the administrative costs associated with Pennsylvania’s PCCM program were forty-five percent lower than the MCO program.⁶⁸ Both cases represent an enormous overhead reduction that could free up money to be spent on the actual provision of medical services to Medicaid beneficiaries.

VI. CONCLUSION

PCCM programs are a viable option for states considering overhauling their current Medicaid programs to increase quality and access while decreasing costs. Many states that have implemented PCCM programs have had an increase in quality of care for children and beneficiaries with chronic diseases, such as asthma.⁶⁹ Several states that have surveyed their Medicaid beneficiaries have shown that the PCCM program is favorable when compared to other options.⁷⁰ PCCM programs also enable Medicaid beneficiaries in rural areas to receive needed care when HMOs or other managed care options decide not to expand their geographical coverage

64. *Id.*

65. Verdier, *supra* note 1, at 27.

66. *Id.*

67. *Id.* at 28.

68. *Id.*

69. Abedin, *supra* note 21.

70. *Id.*

area.⁷¹ Finally, PCCM programs enable cost savings through increasing prevention and decreasing use of more costly alternatives, like ER visits.⁷² For cost-conscious states looking for a way to increase access to care while also increasing quality of care the PCCM model is a great alternative to other Medicaid managed care programs.

71. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, *see also*, Abedin, *supra* note 21.

72. Abedin, *supra* note 21.