CHCS Center for Health Care Strategies, Inc.

Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States

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Report Overview

State Medicaid programs have been operating primary care case management (PCCM) programs since the 1980s. These programs typically link beneficiaries to primary care providers (PCPs) and pay providers about $3 per beneficiary per month for basic care management activities. Beginning in the 1990s and increasingly today, states have sought to enhance basic PCCM programs with additional features, including more intensive care management and care coordination for high-need beneficiaries, improved PCP incentives, and increased use of performance and quality measures.

Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States, a resource paper published by the Center for Health Care Strategies (CHCS), examines enhanced PCCM programs in five states — Oklahoma, North Carolina, Pennsylvania, Indiana, and Arkansas. The paper describes several options for enhancing PCCM programs with a focus on strategies that can improve care management for beneficiaries with chronic illnesses and disabilities. It is aimed at states that are seeking to create accountable systems of care, particularly for beneficiaries with complex needs, but may not have the option of contracting with fully capitated managed care organizations (MCOs) and/or want to consider non-capitated options.

Themes

The enhanced PCCM programs examined in the five states evolved differently, reflecting the context of each state. Table 1 (reverse side) outlines the enhanced PCCM features for the five state programs, as well as additional background. Following are overall themes that are detailed in the report:

- Each program uses different resources for care coordination and care management (i.e., state staff in Oklahoma and Pennsylvania; local community networks in North Carolina; outside contractors in Indiana, Oklahoma, Pennsylvania, and Arkansas; and physician practices to varying degrees in all states).
- All the programs support care coordination with provider payment incentives, information sharing, and performance and quality reporting.
- The focus of care coordination varies by state, with some focusing on a limited range of diseases and conditions and others focusing more on beneficiaries with multiple conditions.
- Care coordination methods vary. Most states work primarily with beneficiaries, but efforts are increasing in several of the states to work more closely with PCPs. Most states rely primarily on telephone rather than in-person contact, and each state uses a somewhat different mix of clinical and social services staff.
- The featured state programs have significant limitations in their ability to reduce hospital use, since the states have few direct ways of controlling that use, and PCPs are not financially at risk for hospital costs.
- The five states have taken varying approaches to estimating the costs and savings of enhanced PCCM programs. Some prepared return-on-investment projections, some commissioned retrospective savings estimates by outside actuaries, and some commissioned formal evaluations of their new programs.

For More Information

States interested in learning more about these five states' PCCM approaches and developing enhanced PCCM programs to improve quality and control costs for beneficiaries with complex needs can download the full report at **www.chcs.org**.

Table 1. Overview of Enhanced Primary Care Case Management Programs in Oklahoma, North Carolina, Pennsylvania, Indiana, and Arkansas

State	Program Name and Start Date	PCCM Enrollment	Share of Total State Medicaid Enrollment	Fully Capitated MCO Enrollment	Care Management and Care Coordination	Provider Reimbursement	Performance Monitoring and Reporting	Cost and Savings Estimates
Oklahoma	SoonerCare Choice 1996	415,982 (7/09) (10% ABD, 90% TANF)	64%	0	▪ State-employed nurse care managers (32) and social services coordinators (2) ▪ Health Management Program for 5,000 high-cost enrollees ▪ Office-based PCPs	▪ $4 to $9 PMPM care management fee ▪ Additional P4P payment incentives ▪ 2008 Medicaid FFS reimbursement = 100% of Medicare	▪ HEDIS ▪ CAHPS ▪ Provider profiles	▪ Some preliminary ROI estimates
North Carolina	Community Care 1998	944,667 (5/09)	68%	0	▪ 14 local community-based networks made up of physicians, hospitals, and local health and social services departments	▪ $2.50 PMPM to PCPs ($5 for ABD enrollees) ▪ $3 PMPM to local networks ($5 for ABD enrollees) ▪ 2008 Medicaid FFS reimbursement = 95% of Medicare	▪ HEDIS ▪ CAHPS, consumer focus groups, disenrollment survey ▪ Practice profiles	▪ Mercer actuarial savings estimates for SFY 2003 to 2007 ▪ Community Care staff estimates of administrative costs for 2002 and 2003
Pennsylvania	ACCESS Plus 2005	297,791 (12/08)	16%	1,116,952 (12/08)	▪ Disease management and care coordination vendor ▪ 40-person unit in state Medicaid agency for intense medical case management	▪ Additional P4P payment incentives to PCPs ▪ 2008 Medicaid FFS reimbursement = 73% of Medicare	▪ Care coordination process and utilization measures ▪ HEDIS ▪ Chronic illness survey	▪ Mercer 2007 comparison of ACCESS Plus costs to voluntary capitated managed care program
Indiana	Care Select 2008	63,781 (2/09) (58% ABD, 42% other)	7%	532,705 (6/07)	▪ Two care management organizations (CMO) ▪ Office-based PCPs	▪ $15 PMPM administrative fee to PCPs ▪ $40 per-patient fee to PCP for care coordination conferences ▪ $25 PMPM fee to CMOs, with 20% contingent on performance on quality measures ▪ 2008 Medicaid FFS reimbursement = 69% of Medicare	▪ CMO quality-related performance measures	▪ Randomized controlled trial of previous chronic disease management program showed flattening of cost growth for enrollees with congestive heart failure and diabetes ▪ 1915(b) waiver cost-effectiveness estimates being prepared
Arkansas	ConnectCare 1994	467,713 (6/07)	75%	0	▪ Office-based PCPs	▪ $3 PMPM case management fee to PCPs ▪ Additional P4P payments based on EPSDT screens ▪ 2008 Medicaid reimbursement = 89% of Medicare	▪ HEDIS ▪ CAHPS ▪ Provider profiles	▪ No formal savings estimates