

# ISSUE BRIEF

## Primary Care Case Management: Lessons for Medicare?

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A discussion featuring

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## Primary Care Case Management

***Overview**—This paper looks at primary care case management (PCCM) as a tool that states have used to manage the delivery of care to their Medicaid populations, an alternative to contracting with commercial managed care plans. PCCM has proved a flexible means of advancing state policy goals, including quality improvement, disease management, and coverage of special-needs populations. The paper considers provider and beneficiary perspectives on PCCM as well as state agency objectives and accomplishments. Finally, it raises the question of adapting the PCCM model for Medicare. Speakers at the accompanying Forum session will expand on these topics.*

While enrollment in Medicare+Choice, Medicare's managed care program, has not borne out the expectations of the Balanced Budget Act of 1997, the transition of Medicaid programs to managed care has continued for almost two decades. More than half the nation's Medicaid beneficiaries are now enrolled in a managed care plan.<sup>1</sup> As defined by the Centers for Medicare and Medicaid Services (CMS, previously the Health Care Financing Administration, or HCFA), that category includes commercial health maintenance organizations (HMOs), Medicaid-only HMOs, various prepaid arrangements under state Medicaid waivers, and state-sponsored primary care case management (PCCM) programs.

"Primary care case management" is an appellation coined for Medicaid, describing a model that combines features of fee-for-service and managed care. Today, 29 states have PCCM programs, which range from local and voluntary, as in Utah, to Arkansas's statewide mandatory ConnectCare. In several states, PCCM is the default enrollment for a beneficiary who fails to make a choice of plan.

Many states have introduced PCCM in selected counties before making it available statewide. Some continue to offer PCCM as an alternative to one or more managed care organizations (MCOs) in urban areas, where the latter commonly operate, while PCCM is the model of choice for rural areas, where a relative scarcity of providers and a scattered population make a risk-based approach infeasible. PCCM can also serve as the vehicle to extend health insurance coverage to hard-

to-serve populations, such as Supplemental Security Income (SSI) beneficiaries.

Typically, a PCCM program pays participating primary care physicians (PCPs) a small monthly administrative fee to coordinate care for Medicaid patients. The PCP must sign a contract with the state, agreeing to certain conditions of participation, such as providing access to a defined package of primary care services 24 hours a day, seven days a week. Medical services provided by the PCP generally are reimbursed on a fee-for-service basis rather than by capitation, as is common in HMOs. Other responsibilities, such as participation in quality improvement projects, are included in some state PCCM contracts.

States have developed PCCM programs for a variety of reasons. At a time when managed care was just emerging, PCCM was viewed as a way to bring some structure and organization to the delivery system and begin to hold providers accountable while still saving state dollars.<sup>2</sup> As time went on, some states viewed PCCM as a possible transition between traditional fee-for-service and the new exigencies of managed care organizations. Today, with commercial MCOs exiting Medicaid in many markets, PCCM is seen by some as a sequel rather than a precursor, a method viable in its own right for maintaining a Medicaid managed care delivery system.

A defining PCCM characteristic is that states themselves are in charge. The state Medicaid agency either administers PCCM or manages a contractor who

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does so. Administration entails responsibility for everything from provider recruitment to patient education, though a contract for independent evaluation is common. This range of responsibilities can be a more demanding prospect than awarding and monitoring an MCO contract or paying claims in a traditional fee-for-service world. State Medicaid executives are challenged to acquire the skills of commercial health plan managers. However, PCCM also offers managers an opportunity to tailor a program to the state's own population, culture, and public health priorities. Further, PCCM provides an assurance of continuity: unlike a for-profit MCO, a state agency cannot consider leaving when a market turns unprofitable.

PCCM's flexibility is demonstrated by its use in urban and rural areas, in specific markets and across states, and under voluntary and mandatory conditions. Its aims have encompassed disease management, performance measurement, and population health. As discussed below, both patients and physicians express satisfaction with PCCM participation. As federal and private-sector managers seek ways to broaden access and improve quality in a time when signals from commercial MCOs are mixed, looking at the PCCM model may offer some insight.

## LEGAL FRAMEWORK

PCCM as an approach to Medicaid was enabled by an amendment to Title XIX of the Social Security Act in the Omnibus Budget Reconciliation Act of 1981. Its Section 1915(b) created a means by which states could waive statutory requirements that Medicaid programs offer comparable benefits statewide and offer beneficiaries freedom of choice in obtaining services. With an approved 1915(b) waiver, which was good for two years and could be renewed, a state could mandate that beneficiaries enroll in a managed care plan. It could also pilot-test plan refinements in a single county or metropolitan area.

The Balanced Budget Act of 1997 (BBA) extended further support to Medicaid managed care by permitting states—without need of a waiver—to require that beneficiaries enroll with managed care entities. Managed care entities were defined to include both MCOs and PCCM programs. Limitations were as follows:

- Mandatory enrollment could not be imposed on children with special health care needs, children in foster care, or certain Medicaid-eligible Medicare beneficiaries.
- Native Americans and Alaskan natives could be mandated to enroll only in an Indian health, urban Indian, or tribal managed care entity.

- States were required to offer all beneficiaries a choice of at least two plans or, under PCCM, at least two PCPs.

The BBA specified that primary care case management services (including “locating, coordinating, and monitoring of health care services”) would be Medicaid-covered services.<sup>3</sup> A qualifying PCCM program must make provision for 24-hour emergency treatment, reasonable geographic availability of service delivery sites, and a sufficient number of physicians to serve the Medicaid population “promptly and without compromise to quality of care.”

## PCCM AND MANAGED RISK PLANS

Both legally recognized as managed care plans, PCCM programs and MCOs often share significant characteristics. Both comprise a panel of physicians and charge one PCP with primary responsibility for each patient. Both seek to structure incentives (to physicians and patients) to encourage appropriate use of medical services. Both can and typically do undertake utilization review, patient education programs, and quality monitoring activities. Independent evaluations of PCCM programs have recorded initial savings in the range of 5 to 15 percent compared to a similar fee-for-service population, comparable to savings achieved by MCOs.<sup>4</sup>

PCCM programs may have been more fortunate in their public image, in part because of terminology: a “care coordinator” or even a “case manager” sounds less forbidding than a “gatekeeper,” the pejorative label MCOs have been saddled with. Another factor affecting satisfaction is the history of enrollee populations. Many Americans who were moved into managed care by their employers found new restrictions irritating, whereas many Medicaid beneficiaries entering PCCM have found a stable relationship with a physician that had previously been difficult to achieve. In fact, as Charles Milligan—a former New Mexico Medicaid director now with the Lewin Group—has observed, PCCM has enjoyed a steady popularity with both patients and primary care providers.

While specialists and enrollees sometimes were unhappy with the arrangement, since enrollees couldn't just present for specialty care without a PCP referral, you haven't heard much discontent in the provider or enrollee ranks about PCCM programs, especially since no providers were considered “out of network” and referrals generally weren't second-guessed. No entity really injected itself between doctors and patients.<sup>5</sup>

A major difference between a PCCM program and an MCO, frequently, is the sharing of financial risk. In accepting capitation from an MCO, providers assume financial risk for the care of a patient population. PCCM physicians, with fee-for-service reimbursement supplemented by a management fee, do not take on additional risk by virtue of their contracts. Some physicians might argue that contracting with Medicaid always entails some risk—the legislature may cut rates again, for example—but a doctor who finds himself with a sicker-than-average group of patients is not disadvantaged under PCCM as in a risk contract. On the other hand, a provider not at risk has less incentive to keep a careful eye on costs.

What Milligan characterizes as “second-generation” PCCM has moved beyond the simple gatekeeping fee, drawing from the more sophisticated repertoire of commercial managed care such enterprises as provider credentialing, member surveys, and quality improvement initiatives. In short, said Milligan, these programs have come to “closely resemble risk-based managed care,” with the state, rather than MCOs, controlling the overall enterprise.”<sup>6</sup> (It is interesting to note that a resemblance grows from both directions: MCOs have become less forceful in their oversight, with broader networks and reduced requirements for prior authorization.)

Competition between PCCM programs and MCOs can have both positive and negative ramifications. In a market where both are feasible, competition can increase beneficiary choice and motivate both MCO and PCCM programs to improve quality and service. The existence of a PCCM alternative can give the state greater bargaining leverage with the MCO, and it serves as a place for beneficiaries to go should an MCO decide to leave the state. However, the existence of a PCCM program may actually encourage MCO withdrawal if the state is not careful to apply access, quality, and reporting standards evenhandedly. Massachusetts has taken this consideration to heart and rates its PCCM

program along with MCOs in the state according to the standardized performance measures derived from the National Committee on Quality Assurance’s Health Plan Employer Data and Information Set (HEDIS). Indeed, Massachusetts regards the PCCM program as a state-managed HMO, not a fancier version of fee-for-service.<sup>7</sup>

## PCCM DESIGN

A state may have one or more objectives in establishing a PCCM program, such as increasing access, holding providers more accountable, establishing state control over medical quality, replacing exiting MCOs, or responding to the “managed care backlash.” Obviously, the objective will drive program development. But states that have successful PCCM programs, and their evaluators, agree on certain key considerations: state resources, capabilities, and culture; provider involvement; reimbursement and funding; and beneficiary involvement.

### State Resources, Capabilities, and Culture

As researchers Jim Verdier and Cheryl Young put it in a report on what works and what does not in managed care purchasing, “States should not design programs they cannot administer.”<sup>8</sup> This seems self-evident, but the authors go on to explain,

If states are considering programs that could require collection and analysis of complex data for rate-setting purposes, for example, or extensive counseling of beneficiaries on a variety of managed care options, they should determine up-front whether they have or can obtain the necessary resources either in-house... or by contracting out.

Different states have made different decisions. Some state agencies rely entirely on their own personnel. By contrast, Texas em-

plloys Birch & Davis, a private contractor, to administer its Texas Health Network. Oklahoma contracts out only

### Massachusetts: Competing with the HMOs

The Primary Care Clinician Plan (PCCP), may fairly be regarded as the “grande dame” of PCCM. The use of “plan” in the title was intentional, as PCCP was designed to resemble a commercial HMO. It has engaged in a sophisticated menu of managed care activities, including provider performance measurement, member satisfaction surveys, and well-defined quality improvement projects. With voluntary enrollment, approximately 82 percent of eligible beneficiaries—450,000 people—select PCCP participation. More than 1,300 primary care practices participate in the provider network.

very specific functions, such as provider training. North Carolina relies on county-based personnel for many patient- and provider-relations functions.

Some states that ventured into PCCM chose to regard it as a stepping-stone. Michigan, which in 1982 became the first state to implement PCCM, dismantled its program in 1997 in favor of contracting with competitive MCOs. New Mexico, citing a 23 percent increase in the previous fiscal year's Medicaid costs, made a similar decision the same year.<sup>9</sup>

By contrast, other states that did not join the initial PCCM foray are finding that the idea has promise almost two decades later. For example, Ohio is looking at standard PCCM and a disease management version to improve service to its Medicaid clients, especially in the absence of HMO competition in some areas of the state.<sup>10</sup> Nevada and Idaho are looking at expanding PCCM into rural counties as a replacement of the current fee-for-service arrangement. Indiana and Washington are exploring the use of care coordination and case management in the SSI population. Several states are considering how PCCM could improve service to people eligible for both Medicare and Medicaid.<sup>11</sup>

Overall, says Nikki Highsmith of the Center for Health Care Strategies, states are applying value-based purchasing tools to PCCM programs and are achieving better access and quality than Medicaid fee-for-service as a result. Linking overall programmatic goals with appropriate physician incentives is also a key to a state's success.

### Provider Involvement

Provider buy-in to PCCM from its inception is certainly a boon to program management. Some states made considerable effort to involve physicians from the beginning of the design phase. Texas held public meetings around the state to solicit provider input. North Carolina's Access II and III refinements of its basic Access I PCCM program are described by the state as "provider-driven," and physicians were asked to develop their own best

practices and quality improvement measures. Massachusetts government has a tradition of working closely with providers; the state's effort to include groups such as the Massachusetts Medical Society and the League of County Health Centers in program design and provider recruitment has "paid off again and again," says a former PCCM program director.<sup>12</sup> Several states have formed physician councils to serve as advisors on policy and provider concerns.

States have invested significantly in provider relations staff and programs. As the authors of a National Academy for State Health Policy review of state programs observed,

Since PCCM success relies on having a sufficient number of primary care providers to coordinate beneficiary access to appropriate care, provider recruitment becomes more of an issue for the state than under either fee-for-service Medicaid where the beneficiary is responsible for finding his or her own provider, or under an HMO model where the HMO takes responsibility for provider recruitment.<sup>13</sup>

States encourage both providers and enrollees to spread the word. Some states, such as Maine, use outside contractors for recruiting. Beyond recruiting lies the corollary challenge of provider retention.

In Arkansas, Connect-Care representatives visit each PCP twice a year, establishing a relationship and serving as a liaison to the state's Department of Human Services. The department, working with Elec-

tronic Data Systems, Inc., developed an automated eligibility verification and claims submission system for physicians in 1992. This provides online eligibility and utilization data on beneficiaries and allows online billing for Medicaid claims. Its popularity in part accounts for the state's proud claim that enrolled physicians represent the capacity to serve four times the existing caseload.<sup>14</sup>

Oklahoma conducts regional forums to address the questions and concerns of its participating providers. Several states have employed a 24-hour nurse advice

### Arkansas: Collaborating with Stakeholders

ConnectCare representatives visit each PCP twice a year, establishing a relationship and serving as a liaison to the Department of Human Services. The department, working with Electronic Data Systems, Inc., developed an automated eligibility verification and claims submission system for physicians in 1992, which provides online eligibility and utilization data on beneficiaries and allows online billing for Medicaid claims. Physicians, who had viewed Medicaid patients as sources of inherent frustration, became enthusiastic ConnectCare supporters.

line for enrollees and, where nurses are empowered to make specialist and hospital referrals, allow this to serve as partial fulfillment of the 24-hour access requirement imposed on PCPs.

Educational programs also play a role in provider relations. States may disseminate best practices associated with certain diseases or conditions, make available Web-based instructional modules, or draw physicians' attention to new research. This offers an opportunity to emphasize state health priorities; for example, educational communications to providers may dwell heavily on AIDS, diabetes, or asthma, depending on what the state has chosen to measure.

Feedback to providers is seen as a critical support in many states. Provider profiling shows a physician how his practice patterns compare to those of peers in his region or statewide. An enhancement can tell the PCP things about his patients he might otherwise not have known. For example, Alabama actively encourages emergency room physicians to contact a patient's PCP, and North Carolina includes emergency room use in quarterly reports on patient utilization of services prepared for PCPs.

### **Reimbursement and Funding**

It is not surprising that reimbursement plays a significant role in providers' enthusiasm and loyalty. Nor is it surprising that providers, wherever located, are virtually unanimous in finding Medicaid rates too low. But some states have been able to address provider as well as budgetary concerns in their reimbursement design—and to further population-health goals as well.

The original PCCM concept incorporated a case management fee of \$3.00 per member per month (PMPM) paid to the PCP in compensation for the additional duties of care coordination, such as making referrals and reviewing overall care.<sup>15</sup> The \$3.00, a capitated amount that is paid regardless of whether any service is provided that month, is a de facto increase in Medicaid reimbursement. Depending on how many Medicaid patients enrolled with the primary care provider, the aggregate PMPM payments might or might not represent a significant motivator. Some skeptics have questioned what kind of quality enhancement a state could really expect for \$3.00.

As PCCM programs evolved and state managers studied MCO practices to learn the techniques of managed care, some state agencies have gone beyond the basic fee approach. Massachusetts abandoned the \$3.00 standard. Instead, to encourage the provision of

certain specified primary care services, the primary care clinician receives an "enhanced" payment of \$10.00 when such services are provided to a Medicaid enrollee. Oklahoma has adopted partial capitation for primary care, paying a set amount for basic office visits (such as well-child care) and an enhanced payment for Medicaid's EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) service for children. In Maine, PCPs receive a PMPM payment and also participate in a bonus pool that is distributed annually based on a composite measure of the physician's Medicaid caseload, emergency room use, and predefined prevention and quality goals.

The level of provider reimbursement is not the only issue: timeliness and accuracy are also important. A state without an excellent claims payment system, notes PCCM expert Vernon Smith, is going to have difficulty administering a PCCM program—and keeping providers.<sup>16</sup> Massachusetts urges its providers to do their part—"If you do not verify a member's eligibility before providing services, you might not be paid for those services"—and makes available a verification system to make it easy.

### **Beneficiary Involvement**

Identifying and enrolling eligible beneficiaries presents the same basic challenges for a PCCM program as it does for other Medicaid and SCHIP plans. That is, get the word out, go where the potential clients are likely to be, and anticipate communications difficulties from illiteracy to not speaking English to distrust of giving information to "the government."

Many states have chosen to contract with enrollment brokers to assist beneficiaries in making plan and/or provider decisions; others have allocated staff positions to this activity. In 1997, 37 of the 40 states offering managed care plan choice had established some form of enrollment counseling.<sup>17</sup> Member hotlines are a common service. For example, Arkansas offers a 24-hour help line to answer questions about enrolling with a PCP or changing enrollment as well as to address beneficiary complaints.

Program design decisions—such as whether PCCM enrollment will be voluntary or mandatory and whether that will vary based on where a person lives—have framed communications issues in some states. Some studies have shown a trend toward voluntary PCCM enrollment. For example, the Maternal and Child Health Policy Research Center reported that, for children receiving Temporary Assistance for Needy Families

benefits or eligible for Medicaid because of poverty, 19 percent of PCCM states had a voluntary enrollment policy in effect in at least some part of the state in 1996, while 34 percent did so in 1999.<sup>18</sup> On the other hand, the BBA provision eliminating the need for a 1915(b) waiver also prompted, or at least enabled, several states to promulgate mandatory managed-care enrollment.

Voluntary enrollment by definition entails a choice of whether to participate. Even where enrollment is mandatory, beneficiaries are called upon to make decisions, such as choosing a PCP. In Indiana, choice of provider in fact drives choice of plan; beneficiaries are enrolled in an HMO or the PCCM program according to their chosen physician's affiliation.

It may happen that a beneficiary desires to sign up with a PCP not currently participating in a state's managed care program. Some PCCM programs make considerable effort to accommodate these wishes. For example, area office staff in Florida will visit a nonparticipating PCP requested by a beneficiary to see whether that physician can be persuaded to enroll, even if only to treat that single beneficiary.<sup>19</sup> When an Arkansas beneficiary without a PCP appears in the emergency room for nonemergent care, emergency room staff are permitted to assist the patient in selecting a PCP; for this service, the state pays a small fee and allows the emergency room to bill Medicaid for the care provided.

After enrollment, states have developed incentives—such as points or coupons that mothers earn for a well-child visit or immunization, redeemable for diapers, clothing, or gasoline—to encourage members to see their PCPs to receive preventive services. There may also be procedures to discourage inappropriate behavior; for example, Maine's quality management nurses send letters to PCCM members who have visited the emergency room for common ailments such as coughs and colds, advising them to see their PCPs instead.<sup>20</sup>

## EXPANDING THE MODEL

### Disease Management

As state officials have grown comfortable with the evolution from claims-payer to active plan administrator that PCCM entails, they have considered ways to expand the model's reach. For example, PCCM has been recognized as a model that particularly improves quality of care for persons who need assistance navigating the medical care system, prompting state Medicaid programs to include more population groups in PCCM over time.<sup>21</sup>

These may include the disabled, children with special health care needs, even the institutionalized.

In Florida, where approximately half of Medicaid recipients were covered under the PCCM program, MediPass, the legislature in 1997 authorized the establishment of a chronic disease management (CDM) program. The Agency for Health Care Administration (AHCA) determined that approximately 19 percent of MediPass enrollees met the criteria for CDM.<sup>22</sup> AHCA sought bids from disease-management vendors to provide service for MediPass members with specified high-cost, high-prevalence conditions for which clinical treatment patterns had been observed to vary. Initially, these were HIV/AIDS, diabetes, asthma, congestive heart failure, and hemophilia; the legislature subsequently added end-stage renal disease, cancer, sickle-cell anemia, and hypertension.

An evaluation of the program by researchers from Medimetrix and the Center for Health Care Strategies found that CDM offers states new tools for integrating and managing costly care, particularly where HMOs are withdrawing from Medicaid. The evaluators note that,

Disease management strategies move away from typical demand management (e.g., utilization review and prior authorization) toward [a focus] on provider and member support and education about how to appropriately manage, treat, and live with chronic illness.<sup>23</sup>

A question about the CDM program is its reliance on disease-specific vendors, which seems to presuppose that patients have a single diagnosis. This is not necessarily the case among the chronically ill; indeed, multiple and interdependent conditions are the norm in some populations, such as the elderly. To serve such beneficiaries well, the agency needs to assure that communication occurs, for example, that the disease management firm treating hypertension coordinates its services with the PCP treating headaches or the specialist treating macular degeneration.

Case management programs utilizing nonphysician care managers (often nurses) are fairly common in the private sector; many insurers, third-party administrators, and even large employers have adopted case management as a means to manage catastrophically expensive cases and, increasingly, to identify and intervene in cases that have the potential to become complicated and expensive. The goal here is to coordinate all care a patient needs and receives. States could follow this example—as some have begun to do—either employing their own case managers or contracting for this service. It should be noted that preventive case management,

that is, analyzing a population to identify potentially at-risk cases, requires a sophisticated information system and access to timely and accurate data.

A strength of the PCCM model is its assurance of case management. As with any Medicaid program, however, a challenge for PCCM as a disease management model is that Medicaid eligibility is not necessarily stable. If a beneficiary goes in and out of eligible status and employment and family circumstances change, tracking his or her condition and quality of care over time could easily be disrupted. It is possible for a state to address this with a policy of continuous guaranteed eligibility for a specified period of time, such as a year.

### Quality Partnerships

Taking a leaf from the private-sector notebook, state managers learned to pay attention to their contracted MCOs' scores on standardized quality measures such as HEDIS and patient satisfaction instruments such as the Agency for Healthcare Research and Quality's consumer assessment of health plan's survey, or CAHPS. It was not then a huge stretch to apply the same standards to their PCCM programs. Here again, state officials saw an opportunity to advance health goals appropriate to their populations by emphasizing certain measures and looking for steady improvement rather than performance to a national norm.

North Carolina's refinement of basic PCCM was directed toward providers. State officials cite "the ongoing challenge" of structuring incentives for physicians that do not require greater expenditure.<sup>24</sup> One way, they thought, was to increase PCPs' sense of ownership of the program by decentralizing, promoting support and feedback while deemphasizing edicts, and giving doctors tools that would make provider groups a real alternative to MCOs.

Access I, basic PCCM, was rolled out to all counties beginning in 1991. Under Access II, implemented in six counties beginning in 1997, beneficiaries enroll with a

group practice that has a previously approved plan for managing a Medicaid population. The state adds a supplemental \$2.50 PMPM to help finance information systems and quality improvement projects. Access III, piloted in 1999, allows a physician group to manage an entire county's Medicaid caseload, working with county agencies to address various human services issues that affect population health. Access III currently operates in two counties.

### BEYOND MEDICAID?

State Medicaid directors can point to successes in using PCCM to address the challenges of delivering health care to populations such as the disabled and the elderly. Not all the disabled and elderly are Medicaid beneficiaries, of course. It seems only logical to ask if PCCM could prove a fruitful approach for Medicare.

This is not a new question. The National Academy of Social Insurance's 1998 report *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare* suggested that case management held promise for both the cost and quality of care given to fee-for-service Medicare beneficiaries. The Clinton administration plan for Medicare reform first announced in June 1999 called for the implementation of a voluntary PCCM alternative for fee-for-service beneficiaries. A bill introduced in the 107<sup>th</sup> Congress by Sens. Blanche Lincoln (D-Ark.) and Harry Reid (D-Nev.) would authorize Medicare coverage of

assessment and care coordination services provided by physicians to qualified frail elderly and those at risk of institutionalization, functional decline, or death.<sup>25</sup>

Within CMS, investigation of this concept is proceeding in small stages. Maine's pilot MaineNET program for beneficiaries dually eligible for Medicare and Medicaid aims to coordinate primary, acute, and long-term care services. In addition to signing up with a PCP, each beneficiary is assigned a "care partner" who coordinates access to social and community

#### North Carolina: Enabling Local Management

The state's PCCM design goal was to increase PCPs' sense of ownership of the program by decentralizing, providing support and feedback while deemphasizing edicts, and giving physicians tools that would make provider groups a real alternative to MCOs. Medical groups in some counties have applied for state approval of a plan to manage a Medicaid population, working with county agencies to address various human services issues that affect population health.

services as well as assisting the beneficiary in choosing and managing long-term care services. Other states are also considering a PCCM approach to serving dual eligibles; they are concerned, however, that current law (or its current interpretation) prohibits them from requiring case management—perceived as a restriction—on Medicare beneficiaries under fee-for-service.

The BBA authorized a case demonstration in Medicare, and HCFA in January 2001 announced the selection of 15 sites for a pilot project designed to test “whether paying for coordinated care services for Medicare fee-for-service beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs.”<sup>26</sup> The sites, hospitals and other medical centers, each submitted a proposal detailing a specific chronic care program—for conditions such as congestive heart failure or cancer—that could benefit Medicare patients. This is thus a disease management rather than a full PCCM foray.

In preparation for the demonstration, HCFA commissioned a study of best practices in managed care. The resulting report suggested that a coordinated care program (whether focused on overall case management or more specific disease management) should

serve chronically ill persons at risk for adverse outcomes and expensive care . . . by (1) identifying those medical, functional, social, and emotional needs that increase their risk of adverse health events; (2) addressing those needs through education in self-care, optimization of medical treatment, and integration of care fragmented by setting or provider; and (3) monitoring patients for progress and early signs of problems.<sup>27</sup>

The authors concluded that a demonstration of a coordinated care approach in fee-for-service Medicare was feasible and appeared to have a reasonable chance of being cost-effective.

Examples of programs selected are QMED of McLean, Virginia, which will target cancer, and CorSolutions of Buffalo Grove, Illinois, which will focus on congestive heart failure. Pilot projects are being implemented on a rolling basis; each receives funding for four years and will be formally evaluated every two years. If the agency’s evaluators find that the projects are indeed cost-effective and that quality of care and satisfaction are improved, the effective projects (or the effective aspects thereof) may be continued. The number of sites may be expanded.<sup>28</sup>

To think about making PCCM a wholesale approach to fee-for-service Medicare naturally raises knottier policy questions than a demonstration does. One of the first is the issue of provider contracting. Medicare fee-

for-service is in essence an any-willing-provider system, wherein a physician willing to accept Medicare’s fee schedule is accepted as a participant. PCCM may impose more obligations on a PCP, raising the possibility of physician opposition.

As discussed above, many Medicare beneficiaries are chronically ill, suffering multiple illnesses. Coordinating care for a patient in this category may require more time and effort than a PCP is willing to expend in exchange for a modest administrative fee. It may be that a form of case management that targets high-cost cases and utilizes professionals hired as case managers rather than practicing physicians will prove more suited to Medicare.

The idea has been raised that Medicare could contract with states to provide services to Medicare beneficiaries via existing PCCM programs. This would be a departure from the established practice of each program’s independent purchasing but may be worthy of investigation—particularly at a time when the future participation of MCOs in Medicare+ Choice is in some doubt. An issue that would need to be resolved is the differences that currently exist in Medicaid-covered benefits from one state to another, which may exceed the regional differences in what is covered under Medicare.

Proponents praise PCCM as a model that gives the Medicaid beneficiary a medical home, encouraging a relationship with a particular physician who can coordinate care. Physicians, they say, like it for its sense of partnership and lack of risk, and patients like it because it offers choice. It can be effective in rural as well as urban settings. Finally, it provides structure and organization to the delivery system that supports quality improvement and accountability.

Not all of these claims would carry over to Medicare, which would face operational and public-relations challenges in modifying its basic fee-for-service premise—notably, that beneficiaries have had and always will have free choice of provider. PCPs are likely to find the demands that complex cases can impose more prevalent. Nevertheless, as policymakers question whether an uncontrolled fee-for-service model can survive the demands of the baby boomers, those who have experience with PCCM programs suggest that it may be provident to look to that model’s strengths.

## THE FORUM SESSION

The session for which this issue brief serves as background will examine the development of the

PCCM model and various adaptations currently operating. **Vernon Smith, Ph.D.**, will give an overview of his extensive research into PCCM program operations. Smith is a principal with Health Management Associates and previously served as Medicaid director for the State of Michigan.

Representatives of two state PCCM programs—**L. Allen Dobson Jr., M.D.**, from North Carolina and **Rebecca Pasternik-Ikard** from Oklahoma—will describe how these programs are tailored to further state policy goals. Dobson, a family physician, is president of Cabarrus Family Medicine and serves as medical director of ACCESS II and III. Pasternik-Ikard is director of the SoonerCare program and care management services for the Oklahoma Health Care Authority.

**Christine Nye**, senior vice president, Medicare and Medicaid development, for Schaller Anderson, Inc., and former director of the HCFA Medicaid Bureau and the Wisconsin Medicaid program, will talk about extending the PCCM model beyond the Medicaid population. **Robert Berenson, M.D.**, former director of HCFA's Center for Health Plans and Providers and now senior advisor at the Academy for Health Services Research and Health Policy, will offer his comments on PCCM and Medicare.

Questions to be addressed include the following:

- What has prompted states to adopt the primary care case management model for their Medicaid populations? How has the model been refined over time to serve particular state policy goals?
- How does a PCCM approach differ from contracting with MCOs?
- Does PCCM furnish additional access by attracting more physicians as Medicaid providers than fee-for-service or managed risk? If so, why? What do physicians see as the model's strengths and weaknesses? Do specialists have a view different from that of primary care practitioners?
- How does PCCM foster provider accountability?
- Are primary care physicians the most appropriate case managers? What assistance might they need in managing complex cases?
- How has PCCM been modified to support disease management programs? How has it been expanded to include special-needs populations?
- What elements of PCCM might work to the benefit of the Medicare program? What legislative or regulatory changes would be necessary?

## ENDNOTES

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