Enhancing Medicaid Primary Care Case Management to Improve Care Management and Accountability

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for the

Fourth National Medicaid Congress
Washington, DC
June 2, 2009
Introduction and Overview

● Evolution of primary care case management (PCCM) programs in Medicaid
  - From basic PCCM to enhancements for monitoring and reporting, disease and care management, care coordination, pay for performance (P4P), information sharing, and “medical homes”

● Discussion of five states with various levels and types of PCCM enhancement (OK, NC, PA, IN, and AR)
  - All require enrollment of ABD/SSI* populations in PCCM
  - Some also operate fully capitated Medicaid MCO programs

● Conclusions and lessons for states considering enhanced PCCM models for ABD/SSI populations

● More details are forthcoming in Mathematica report for Center for Health Care Strategies and Oklahoma Health Care Authority

* ABD = Aged, blind, and disabled; SSI = Supplemental Security Income
From Basic PCCM to Medical Homes

- Basic PCCM (1980s to the present)
  - $3 per member per month (PMPM) payment to primary care providers (PCPs)
  - Limited PCP access and utilization screening requirements

- Enhancements (mid-1990s to the present)
  - Reimbursement-related performance incentives for PCPs
  - Performance and quality reporting (HEDIS, CAHPS)
  - Limited disease management add-ons
  - Care coordination using nurse care managers and social services workers
  - Better information for PCPs on their patients
  - P4P reimbursement incentives
  - Management of complex conditions rather than single diseases
  - “Medical home” initiatives

- 29 states had PCCM programs in 2007, with 6.3 million enrollees (14% of Medicaid beneficiaries)
Enhanced PCCM Programs in Five States

- OK, NC, PA, IN, and AR
  - Each program evolved differently, reflecting state context and history

- Each uses different resources for care coordination and care management (state staff, local community networks, outside vendors, physician practices)

- All support care coordination with payment incentives, information sharing, and performance and quality reporting

- Care coordination differs by state (different diseases and conditions, beneficiary vs. PCP focus, telephone vs. in-person contact, mix of clinical and social services staff)

- All face financing challenges (savings offsets, return on investment [ROI] expectations)
Oklahoma SoonerCare Choice

- Details are in January 2009 Mathematica evaluation report on Oklahoma web site (http://www.ohca.state.ok.us/)

- SoonerCare Choice PCCM program started in 1996 in rural areas
  - Capitated MCO model (SoonerCare Plus) started in 1995 in three urban areas
  - SoonerCare Choice had a unique partial capitation feature that paid PCPs about $12 PMPM up front to cover office visits and some tests
    ◆ Aimed at attracting more rural physicians

- Mandatory ABD enrollment started in 1999
  - Their costs were hard to predict; put pressure on MCO rates

- Increasing Medicaid budget pressures in 2002-2003 from national recession
Oklahoma SoonerCare Choice (Cont.)

- MCOs threatened to withdraw in 2003 unless they got sizable rate increases
  - State decided to end MCO program and extend SoonerCare Choice to urban areas
  - Medicaid got extra funding and 99 extra staff to operate SoonerCare Choice
    ♦ Hired 32 nurse care managers and 2 social services coordinators, many from MCOs

- Other SoonerCare Choice enhancements
  - Performance and quality monitoring and reporting since 1997 (HEDIS and CAHPS)
  - New Health Management Program in 2008 provides care coordination for 5,000 high-cost, high-need beneficiaries
    ♦ Evaluation being conducted by Pacific Health Policy Group
  - “Medical home” initiative in 2009 replaced partial capitation with more targeted P4P financial incentives
Community Care of North Carolina (CCNC)

- CCNC began in 1998 as a small pilot focused on reducing emergency room (ER) use for beneficiaries with asthma
  - Outgrowth of a basic PCCM program that started in 1991

- Now operates throughout the state with nearly 900,000 enrollees (2/3 of state Medicaid enrollment)

- CCNC won Ford Foundation-Kennedy School Innovations in American Government Award in 2007

- Most distinguishing feature is its reliance on 14 local physician-led networks of physicians, hospitals, and local health and social services departments
  - Networks employ their own clinical coordinators, case managers, and pharmacists
Community Care of North Carolina (Cont.)

- State pays networks $3 PMPM and PCPs $2.50 PMPM
  - Networks and PCPs each get $5 PMPM for ABD beneficiaries
    - ABD enrollment is mandatory as of 2008
  - Average network gets over $2 million per year from state in PMPM fees

- Program has been extensively evaluated
  - See “Program Impact” section of web site at:
    http://www.communitycarenc.com/

- Enhancements include quality monitoring and reporting, quarterly practice profiles and Rx prescribing scorecards, network-based statewide disease and care management initiatives, and a physician incentive program
  - See “Quality Improvement” section of CCNC web site for details
Pennsylvania ACCESS Plus

- ACCESS Plus PCCM program began in 2005 to extend managed care to rural areas
  - Fully capitated MCO program (HealthChoices) started in urban areas in 1997
  - Enrollment is mandatory, including SSI and related beneficiaries

- State has contracted with Automated Health Systems (AHS) for administration and McKesson for disease management (asthma, diabetes, COPD, CAD, and CHF)

- 40-person unit in state Medicaid agency provides additional resources for complex medical case management for both ACCESS Plus and HealthChoices
  - Transplants, cancer, pain management, high-risk pregnancies
  - Generally excludes diseases managed by McKesson
Pennsylvania ACCESS Plus (Cont.)

- State has developed a sophisticated P4P incentive program for both ACCESS Plus and HealthChoices providers
  - Started in 2005 with “pay for participation” incentives
  - In 2007, began focusing more on actual performance in dealing with chronic disease, pediatric care, women’s health, maternity care, and access to care
  - Uses both HEDIS and PA-specific performance measures

- New ACCESS Plus RFP (to be awarded in 2009) covers broader disease categories, requires greater emphasis on in-person community-based care coordination, and includes more resources for coordination with physicians and hospitals

- State has extensive resources for care coordination
  - Challenge with new ACCESS Plus vendor(s) may be to make sure that all the care coordinators are coordinated
Indiana Care Select

- Indiana started basic PCCM and capitated MCO programs in 1994
  - Programs existed side-by-side throughout the state
  - Mandatory enrollment for TANF and related, voluntary for ABD

- Responding to a legislative directive, Medicaid agency established a disease management program in 2003 for ABD beneficiaries with diabetes or CHF
  - Published evaluations of disease management program in 2006, 2008, and 2009 were generally favorable

- Also in 2003, state began requiring ABD beneficiaries to enroll in a slightly enhanced version of the PCCM program (Medicaid Select)
In early 2008, both disease management and Medicaid Select programs were ended and replaced by new Care Select program. Care Select covers ABD and home- and community-based services (HCBS) waiver enrollees. Physicians and other primary medical providers (PMPs) have main care coordination responsibility.

The state has also contracted with two Care Management Organizations (CMOs): ADVANTAGE, a not-for-profit joint venture owned by four Catholic hospital systems and partnering with Aetna, and MDwise, a not-for-profit health plan owned by two major Indianapolis hospital systems and partnering with AmeriHealth Mercy.
Indiana Care Select (Cont.)

- State pays each CMO approximately $25 PMPM for care management activities, with about 20 percent withheld and paid contingent on quality-based performance

- CMOs are responsible for initial screening, development of care plans, and care management
  - Each CMO has its own care management system

- Care managers and coordinators employed by CMOs do most of their work by phone from a central location, although there is some in-person contact with patients and physicians

- State pays participating physicians $15 PMPM for each enrollee, plus $40 per patient for one-hour care coordination conferences with the CMO on individual patients

- Evaluation of program by Burns & Associates is in early stages
Arkansas ConnectCare

- ConnectCare PCCM program began in 1994
  - Enrollment is mandatory for almost all beneficiaries, including ABD
  - No capitated Medicaid managed care in AR

- ConnectCare is administered largely through a division of Arkansas Foundation for Medical Care (AFMC)
  - Because AFMC is an EQRO, state gets enhanced 75% federal match instead of usual 50% administrative match

- Enhancements include:
  - Quarterly physician profile reports on patient service utilization and comparisons to statewide averages
  - Annual HEDIS and CAHPS reports

- Care management and coordination is handled by PCPs
  - No special assistance from state or AFMC
Financing Enhanced PCCM Programs

- Enhancements that involve care management and coordination that extends beyond what physicians themselves can do in their offices can be resource-intensive and expensive
  - Nurse care managers, social services coordinators, information systems, outside contractors
  - OK, PA, NC, and IN programs all include these care management features; AR does not

- P4P and other financial incentives for physicians may also add costs
  - Underlying Medicaid physician reimbursement is an important variable
    - OK paid 100% of Medicare in 2008, NC 95%, AR 89%, PA 73%, and IN 69%

- Provider profiling and HEDIS and CAHPS reporting are relatively inexpensive
Financing Enhanced PCCM Programs (Cont.)

- More expensive enhancements may need to be financed out of savings in hospital and ER costs
- Demonstrating this kind of return on investment (ROI) can be challenging
  - Collecting and properly allocating costs of PCCM is not easy, especially if PCCM administration is only part of what state staff and contractors do
  - Calculating impact on hospital and ER use is even more challenging
    ◆ Did PCCM cause change in hospital and ER use, or was it due to “regression to the mean” by specific patients, broader market forces, or something else?
    ◆ Looking just at trends over time can provide misleading answers
    ◆ Reliable estimates require evaluations with control or comparison groups
Can Care Coordination and Care Management Pay For Itself?

- Mercer actuaries have estimated substantial savings from NC program from 2003 to 2007
  - See “Program Impact” section of CCNC web site at: http://www.communitycarenc.com/
  - Savings based on projected vs. actual costs
    - No control or comparison groups

- Mercer has estimated that PA ACCESS Plus costs less than capitated HealthChoices managed care program in rural areas
  - State has also estimated savings from DM and P4P

- OK has done preliminary ROI estimates, and IN actuary is preparing a cost-effectiveness estimate for its Care Select waiver; AR has not prepared savings estimates

- Key issue: How can care coordination and care management reduce hospital costs?
Impact of Care Coordination on Hospital Costs — Lessons From Medicare

- Lessons from Medicare care coordination demonstrations

- Programs that reduced hospital costs for Medicare beneficiaries with multiple chronic conditions who were generally not cognitively impaired included these features:
  
  - **Targeting** of patients at substantial but not extremely high risk of hospitalization
  - **In person contact** with patients, not just by telephone
  - **Close interaction between care coordinators and physicians**
  - **Access to timely information on hospital and ER admissions**
  - **Medical education and social services to patients**, including education on self-management of care (especially medications) and social supports when needed
Care Coordination in Enhanced PCCM Programs

- Care coordination in PCCM programs we reviewed had some of these characteristics, but not all
  - Targeting (OK, PA, IN)
  - In-person contact with patients (some in OK, PA, NC, and IN, but most is by telephone)
  - Close interaction of care coordinators with physicians (best in NC, more limited in other states)
  - Timely info on hospital and ER admissions (generally lacking in all states)
  - Medical education and social services for patients (some in all states but AR)

- In considering lessons from Medicare, keep in mind differences between Medicare and Medicaid beneficiaries
  - Medicaid beneficiaries generally have lower education and income levels, fewer family and community supports, more mental health and substance abuse problems, and more housing problems
Conclusions and Lessons for States Considering Enhanced PCCM Programs for ABD/SSI Beneficiaries

- Almost all PCCM enhancements we reviewed added value for ABD/SSI enrollees, compared to FFS Medicaid
  - Many are relatively low cost
    - Provider profiling, quality and satisfaction reporting, P4P

- Meeting the complex medical and social needs of chronically ill beneficiaries is difficult for physicians alone to do
  - Need help from nurse care managers, social services coordinators, and other care coordinators

- Financing this additional help with savings from hospital and ER use is challenging for PCCM programs
  - Most PCCM programs have few direct ways of influencing hospital behavior
    - Hospitals make money by treating patients, not by reducing use
  - Puts a premium on using care coordination resources efficiently
    - Focus highest-cost efforts on high-need, high-return enrollees
Conclusions and Lessons (Cont.)

- Programs should focus on beneficiaries with complex chronic conditions, not just on one or a few diseases
  - Most beneficiaries do not have just one disease or condition; need to treat the whole person

- Performance and quality measurement is crucial, but most existing measures (HEDIS and CAHPS) measure care coordination only indirectly
  - Medical home initiative in OK and P4P in PA are moving toward more direct and precise measures

- Many states do not have the option of capitated MCOs for ABD/SSI beneficiaries
  - MCOs may not be interested or have needed capabilities
  - Opposition from providers and beneficiary advocates may be too strong
  - Limited availability of hospitals and physicians in rural areas may make it difficult for MCOs to build networks
Conclusions and Lessons (Cont.)

- Enhanced PCCM programs may be as good for ABD/SSI beneficiaries (and taxpayers) as good capitated MCOs, but only if they do most of the things that good MCOs do (care coordination, preventive services, utilization management).

- Some states may have the resources to perform MCO-like functions with state staff (OK, PA), local community networks (NC), or outside contractors (OK, PA, IN, AR).

- Even in states with strong Medicaid MCO programs, enhanced PCCM programs can provide competition for MCOs, options for beneficiaries, and bargaining leverage for states.