Care Management and Medicaid: Implications for Family Medicine

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Medicaid was established as a voluntary federal-state health care program by Congress as Title XIX of the Social Security Act in 1965. The Medicaid program allows states "to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care." Medicaid is administered by each state with federal funding available for the provision of health care services and various administrative functions. The level of federal funding is determined by comparing a state's per capita income to the national average. Although each state is responsible for the operation of its Medicaid program, the Center for Medicare and Medicaid Services (CMS) is the federal agency charged with administrative oversight of all Medicaid programs, including the approval of each state plan and all state applications for Medicaid waivers.

Medicaid provides an entitlement to medically necessary health care for 42 million low-income and elderly individuals, families, and to certain people with disabilities. Children and youth make up nearly one-half of all Medicaid beneficiaries; people with disabilities are about one-fifth of the total Medicaid population. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Background

States have been increasingly concerned about the rising costs of Medicaid. For most states, the Medicaid program is the most rapidly growing item in the state budget, and is second only to education in state expenditures. In just four years (2001-2004), overall total Medicaid spending increased by over 50%. In 2003, Medicaid accounted for 17% of all U.S. health care expenditures, and paid for 19% of the entire prescription drug market. Medicaid inflation has increased on average twice as fast as general inflation.

In the 1990s, states turned to managed care (in particular to HMO's) to contain costs and assure "predictable costs" and quality. Waivers were sought from CMS in order to require mandatory enrollment of certain groups of Medicaid patients in managed care (waiver of "freedom of choice)." Some states also used the waiver and demonstration authority to expand eligibility for Medicaid services. Managed care has now grown to be the dominant delivery system in Medicaid. Many commercial managed care plans that entered the market, however, were unsuccessful and withdrew from the Medicaid line of business. In 1998, on average, one commercial Managed Care Organization (MCO) entered the Medicaid market for every six MCOs that exited; in 1997, the ratio was closer to one entering for every two exiting.[1]

[1] Susan Felt-Lisk, The Changing Medicaid Managed Care Market: Trends in Commercial Plans Participation. (Washington,DC: Mathematica Policy Research Inc. 1999.

With fewer MCOs in the market, Primary Care Case Management (PCCM) programs have become a long-term managed care alternative, even for states that originally intended to move all their Medicaid populations to risk-based MCOs. The National Academy for State Health Policy reports in a 2002 survey that 58% of all beneficiaries were enrolled in at least one managed care program.[2]

With more than three-quarters of current Medicaid spending devoted to people with chronic conditions, and the number of Americans with at least one chronic condition is expected to rise at least 25% by 2020, states are pursuing efficiencies through various types of "care management" strategies for high-cost individuals.[3] People with chronic conditions represent less than 30% of enrollees but account for over 70% of spending. States are now focusing on programs to improve access, quality of care and reduce unnecessary spending for these populations. Principles of case management, disease management and care management are being applied in the Medicaid program. While these principles are often used interchangeably, there are differences in definition.

Primary Care Case Management means a system under which a primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary care services to Medicaid recipients.
Primary Care Case Manager is a provider (usually a physician, a physician group practice, or an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

(1) A physician assistant
(2) A nurse practitioner
(3) A certified nurse midwife

Case management programs tend to target "high risk" patients—those at risk of suffering costly hospitalizations and adverse health outcomes because of complex social and medical vulnerabilities. These high-risk patients tend to have diverse combinations of health, functional and social problems.[4]

Disease Management is a multidisciplinary, systematic approach to health care delivery that: (1) includes all members of a chronic disease population; (2) supports the physician-patient relationship and plan of care; (3) optimizes patient care through prevention, proactive, protocols/interventions based on professional consensus, demonstrated clinical best practices, or evidence-based interventions; and patient self-management; and (4) continuously evaluates health status and measures outcomes with the goal of improving overall health, thereby enhancing quality of life and lowering the cost of care.

Qualified Disease Management programs should contain the following components:

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[2] Kaye, Neva. Medicaid Managed Care: Looking Forward, Looking Back. National Academy for State Health Policy, June, 2005

[3] Code of Federal Regulations, Title 42, Volume 3, Revised as of October 1, 2002.
Centers for Medicare and Medicaid Services, Department of Health and Human Services.

[4] Stretching State Health Care Dollars During Difficult Economic Times: Overview, Sharon Silow-Carroll, M.B.A.,M.S.W., and Tanya Alteras, M.P.P., The Commonwealth Fund, October, 2004.

- Population Identification processes;
- Evidence-based practice guidelines
- Collaborative practice models that include physician and support-service providers.
- Risk identification and matching of interventions with need;
- Patient self-management education (which may include primary preventions, behavior modification programs, support groups, and compliance/surveillance
- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loops (which may include communication with the patient, physician, health plan and ancillary providers, in addition to practice profiling); and
- Appropriate use of information technology (which may include specialized software, data registries, automated decision support tools, and call-back systems).[5]

Disease Management Program Options available through Medicaid.

Disease Management through Individual Providers
State Medicaid programs can offer disease management through individual fee for service providers in the community. The providers often agree to undergo specified training, and bill on a fee for service basis for disease management services provided.

Disease Management through an Enhanced Primary Care Case Management (PCCM) Program
In this program the state works with the PCCM providers to enhance the care it delivers to its enrollees with certain chronic conditions. The state may also provide additional support in the form of case managers for complex cases and furnish ongoing monitoring reports on enrollee utilization. PCCM providers are often paid enhanced case management fees for providing disease management, in addition to the regular fee for service reimbursement for other Medicaid services they provide.

Disease Management through Contracting with a Disease Management Organization (DMO)
The DMO manages the overall care of the Medicaid beneficiary, but does not actually prior authorize or otherwise restrict access to other Medicaid services. The state often requires performance guarantees, including capitating the DMO for disease management services as well putting the DMO at risk for reducing overall expenditures.[6]

Care Management (*aka* coordinated care) is the coordination of care in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions and promote independence and self care. It incorporates practices and methods of case management and disease management.

Care management programs manifest themselves in a wide variety of ways. While they vary in goals, strategies, target populations, specific services provided or emphasized, administrative practices, and assessment capabilities, all states but one makes optional care managements

[5] Disease Management Association of America. 701 Pennsylvania Avenue NW, Suite 700, Washington, D.C. 2004
[6] Centers for Medicare and Medicaid Services, Department of Health and Human Services, State Medicaid Directors Letter #04-002, February 25, 2004.

available to at least one Medicaid population. Care management programs may be categorized as follows:

- **Medical vs. long-term-care oriented**. Some programs target people with complex medical conditions, while others focus on those with multiple needs or disabilities who are eligible for nursing-home care but whom-with proper support and coordinated social and long-term care services-could be maintained within the community.
- **Targeted diagnosis.** Some programs target individuals with specific diseases. For example, fourteen states provide care management for Medicaid beneficiaries with asthma, fourteen states focus on those with diabetes, and six target patients with congestive heart failure.
- **High use or cost.** Some programs target people with high risk of hospitalization and adverse outcomes. These individuals may, for example, have more than a certain number of chronic conditions, take more than a specified number of prescription medications, be considered high-cost users (e.g., claims reach a designated amount or are within the top ten percent of Medicaid cost per enrollee), or make a higher-than-average number of trips to the hospital emergency department.
- **Key intervention.** Some programs (generally disease-based) provide educational materials on proper care that reflect evidence-based management guidelines; others focus on pharmaceutical management; and others use intensive one-on-one "advanced care" interventions by nurses or other health professionals.[7]

Current Models of Medicaid Care Management and Disease Management

Between 2002 and 2005, 42 states began or plan to begin Medicaid disease management and case management programs with the aim of reducing overall health care costs of patients with chronic diseases by avoiding unnecessary utilization of acute care services. Evaluations of some of the older statewide care-management programs (e.g. Florida) found improvements in care quality but mixed results in terms of net savings to the state.

Florida

Florida was one of the first states to implement Medicaid disease management programs. The state contracts with eight disease management organizations to implement strategies for each high-cost chronic disease. In 2001, an independent evaluation of the asthma program found a decline in inpatient hospital costs of $70.86 per month; asthma-related outpatient costs decreased $38.06 per month; and total Medicaid expenditures for program participants decreased by 33% (approximately $3,525). Another study found that the program reduced medical claims costs by 38% for patients with hemophilia, and 39.7% for HIV/AIDS patients, versus previous years' expenditures. Some analysts believe that the main benefit of disease management is not so much

[7] Stretching State Health Care Dollars During Difficult Economic Times: Overview, Sharon Silow-Carroll, M.B.A.,M.S.W., and Tanya Alteras, M.P.P., The Commonwealth Fund, October, 2004.

cost savings but the improvement of care by providers and administrators, which in turn has lasting effects on health outcomes.[8]

A key finding of the Florida experience is that the unique characteristics of low-income populations, such as increased mobility, lower health literacy, language barriers and data limitations about their past medical histories, change the way disease management programs should be designed, delivered and measured in these programs. Medicaid beneficiaries were found to be more mobile, less trusting of outsiders, have lower literacy, and have poorer health than their counterparts in private health care. The Florida program had to develop entirely new health education materials –written in two languages and at the fourth grade level and be more willing to use more unconventional methods to contact and interact with their patients.[9]

In Maryland, a Medicaid managed care plan called Maryland Physicians Care, implemented a care management program for physicians treating diabetes patients. The program, developed collaboratively and sponsored in part by manufacturers, provides physicians with comprehensive information, tools, and counseling relative to treating beneficiaries with diabetes through an integrated approach. A preliminary analysis of the program found a 14% decrease in the number of beneficiaries with a high level of blood glucose.[10]

North Carolina

North Carolina has embraced the concept of state and local partnerships in the development and implementation of Community Care of North Carolina (CCNC), (formerly known as Access II and III). It builds upon its Primary Care Case Management program - Carolina Access. State agency officials viewed the development of infrastructure at the local level to be one of the most important aspects of their successful PCCM initiatives.[11]

Community Care was designed to address several critical issues, including:

- No real care coordination system at the local level
- The primary care physicians felt limited in their ability to manage care in the current system
- Local public health and area mental health programs were not coordinated into the medical care management process
- Duplication of services a the local level
- State "silo funding" [12]

[8] "Florida Disease Management Program Provides Key Insights for New Initiatives in Medicaid and Medicare." News Release, Duke University. The Fuqua School of Business. March 29, 2005.
[9] **"**Disease Management: Florida's MediPass Program." The Commonwealth Fund. October, 2004.
[10] "Clinical Pharmacy Management Programs Improve Care While Reducing Medicaid Costs: New Study Provides Framework for State Action. Science Blog. April 28, 2003.
[11] "Emerging Practice in Medicaid Primary Care Case Management Programs" Joanne Rawlings-Sekund, Deborah Curtis and Neva Kaye, National Academy for State Health Policy, June, 2001.

[12] "Community Care of North Carolina", R.Allen Dobson. Jr. MD, FAAFP, Assistant Secretary, NC Department of Health and Human Services. Powerpoint Presentation, 2005

The CCNC program is a partnership of essential local providers. Community physicians, hospitals, health departments and departments of social services work cooperatively to plan and to develop programs for meeting the health needs of local Medicaid enrollees. The State provides the resources, information and technical support to help the CCNC networks effectively deliver and manage enrollee care. Participating networks address the overall health status of enrollees by pro-actively managing their care. By employing such tools as risk stratification, disease management, case management and access management, the networks are establishing the care management processes and support mechanisms needed to improve enrollee care and achieve program objectives.

As of May 2004, more than 3,000 North Carolina physicians were serving some 530,000 Medicaid members in 13 networks, which covered nearly 75 of the 100 counties in the state and about 73% of the Medicaid PCCM population. The state pays a total of $5 per member per month (pmpm): the networks receive a $2.50 enhanced care management fee, and $2.50 pmpm is paid to the primary care provider. Each network is required to address four quality-improvement program areas:

- Disease management (e.g. asthma, diabetes, congestive heart failure, gastroenteritis)
- High-risk high-cost patients
- Pharmacy management (Prescription Advantage List or PAL)
- Emergency Department Utilization [13]

A study comparing the costs and utilization of Medicaid recipients with asthma or diabetes who were enrolled in CCNC or the basic PCCM found lower costs and fewer emergency-room visits and hospitalizations among the CCNC managed patients. The study estimates overall CCNC savings of $3.3 million and $2.1 million on asthma care and diabetes care, respectively, over the three year 2000-2002 period. [14]

Future plans include the exploration of options for incorporating financial incentives for physicians and expanding disease-management protocols beyond asthma and diabetes to other common chronic diseases.[15] North Carolina's most recent legislative session mandated CCNC to include management of the aged, blind and disabled population, and granted the Division of Medical Assistance permission to approach the Centers for Medicare and Medicaid (CMS) to institute a pilot for the dual eligible (Medicaid and Medicare) beneficiaries.[16]

Importance to Family Physicians

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13 Silow-Carroll and Alteras, Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness.

14 Thomas C. Ricketts, Sandra Greene. Pam Silberman, Hilda A. Howard, and Stephanie Poley, Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002 (Chapel Hill North Carolina Rural Health Research and Policy Analysis Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina Chapel Hill, April 2004).

15 Silow-Carroll and Alteras, Stretching State Health Care Dollars.

16 R. Allen Dobson, Jr. MD, FAAFP, "Community Care of North Carolina."

The Institute of Medicine, in the report Crossing the Quality Chasm, cites the fact that more than 40% of people with chronic conditions have more than one such condition and the need for more care coordination. The widespread application of evidence-based care and effective methods of communication, both among caregivers and between caregivers and patients are critical to providing high quality care. Processes must be redesigned for coordinated, seamless care across settings and clinicians and over time.[17]

In a study of primary care practice coordination versus physician continuity published in the journal, Family Medicine (January 2004), it was found that physician continuity was not associated with any patient outcome on four measures of outcomes: cancer screening in women, diabetic management examinations, patient satisfaction ratings and ambulatory costs. Some aspect of system continuity or practice coordination, measured by shared practice, team tenure, and medical clinic size, was significantly associated with higher rates of cancer screening, diabetic management and patient satisfaction. Physician continuity was significantly associated with only one outcome-patient satisfaction-and that relationship was inverse.

When physicians formally share the responsibility for a patient population with the cooperation of staff and patients, behavior changes may result for all. Physicians sharing patients need to assure some consistency among them to avoid the appearance of confusion to the patient. Therefore, where guidelines are established the physicians might be more likely to adhere to them. Roles of other staff members may be articulated better or repetitive tasks are more likely to be delegated. Positive relationships between durability of a team and outcomes may be related to effective team member interactions and stronger roles for the non-physician members.[18] The utilization of a multi-disciplinary team using evidence based clinical guidelines is also recommended to improve quality and outcomes by the Institute of Medicine study.[19]

Care management programs in Medicaid have shown the efficacy and improvement in prevention and the care of people with chronic conditions. The added fee paid to primary care physicians for managing patient care recognizes the value of this service.

The AAFP has recognized the need for a redesign of the delivery and financing of family medicine for improved quality and cost-effectiveness. The six components of the chronic care model: self-management, decision support, delivery system design, clinical information systems, health care organizations, and community resources have been tested and proven. They are applicable to the needed redesign of primary care and its interfaces with community and public health for all people but are not currently financed in a way to support this inclusion.[20]

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[17] Crossing the Quality Chasm: A new Health System for the 21st Century. Institute of Medicine. National Academy Press. Washington, D.C. 2001.

[18] Patricia H. Parkerton, PhD, MPH; Dean G Smith, PhD; Hugh L. Straley, MD. "Primary Care Practice Coordination Versus Physician Continuity." Family Medicine. Vol. 36, No.1. January 2004

[19] Crossing the Quality Chasm: A new Health System for the 21st Century. Institute of Medicine.

[20] The New Model of Primary Care: Knowledge Bought Dearly. Official Policy of the American Academy of Family Physicians. March, 2004

The specialty of family medicine is in a unique position to provide leadership in the re-design of American healthcare to reduce errors, improve quality and constrain costs. Family physicians are uniquely trained in community oriented primary care and utilize community resources on behalf of their patients. Family physicians are committed to the core values of continuing, comprehensive, compassionate and personal care for their patients in the context of patients' lives as members of their family and community.

Crossing the Quality Chasm defined the framework for the health care system of the 21st century as being: safe, effective, patient centered, timely, efficient and equitable. The core values of family medicine are consistent with this framework for the 21st century and distinguish family medicine from other medical specialties. These core values are coupled with an identity of family physicians which is centered upon the need to make people whole by humanizing medicine and providing science-based health care and medical services. People cannot become whole in a system that is fragmented.

Family medicine, therefore, is in a unique position to provide leadership for the development of the 21st Century health care system by redesigning the model of practice. This new model of practice is articulated in the Task Force 1 Report of the Task Force on Patient Expectations, Core Values, Reintegration, and the New Model of Family Medicine. Patient care in this New Model will be provided through a multidisciplinary team approach and will be dependent on a deep understanding of the population served by the practice. Staffing will typically include physician assistants and nurse practitioners, as well as nutritionists, health educators, and behavioralists in some cases. Practice staff will share decision making regarding patient care, with explicit accountability for their work to patients, to each other, and to each patient's personal physician. Systems of care will be honored and supported. New Model practices will develop collaborative relationships with specialists for the purposes of improving and better integrating patient care.[21]

Medicaid care management models, particularly Community Care of North Carolina, should be carefully evaluated as a laboratory for valuable lessons learned which can be integrated with the New Model. The early results are encouraging both in cost savings and improved quality of care outcomes. By embracing the New Model of Family Medicine family physicians have the opportunity to redesign the health care system of the 21st century.

[21] Task Force 1. Report of the Task Force on Patient Expectations, Core Values, Reintegration, and the New Model of Family Medicine. Annals of Family Medicine 2:S33-S50 (2004).