



Healthcare for Uninsured Kids and Youth

Primary Care Case Management:

A New Approach to Primary Care in Medicaid

*Connecticut's Primary Care Case Management
(PCCM) Pilot Program*

Primary Care Case Management

- Overview:
 - HUSKY Program structure
 - HUSKY transition
 - PCCM – other state experiences
 - PCCM pilot in Connecticut
 - Why now?
 - Why should you participate?

Connecticut's HUSKY Program

- Healthcare for Uninsured Kids and Youth
 - HUSKY A – Medicaid (Title XIX)
 - HUSKY B – SCHIP (Title XXI)
 - HUSKY Plus - children with special health care needs (Title V)

Currently serving 340,000 'covered lives'

Connecticut's HUSKY Program

- Where we've been:
 - 1996 – 1915B waiver – mandated all Medicaid covered children, parents or custodians, and pregnant women be placed into managed care programs.
 - 1998 – SCHIP (HUSKY B) added
 - Originally 11 participating MCOs
 - By 2000, 4 participating MCOs

Connecticut's HUSKY Program

- Where we are: HUSKY Program transition
 - Governor Rell: maximum transparency under Connecticut's Freedom of Information Act
 - January, 2008 – non-risk contracts
 - February, 2008 – single DSS pharmacy benefit
 - April, 2008 – HealthNet and Wellcare leave HUSKY
 - Summer, 2008 – New HUSKY Program contracts combined with Charter oak Program roll out

Connecticut's HUSKY Program

- Where we're going: HUSKY and Charter Oak
 - At risk contracts for both programs
 - 3 managed care plans – Aetna's Better Health, AmeriChoice by United Healthcare, and Community Health Network of Connecticut
 - Voluntary enrollment
 - September, 2008 – Middlesex County
 - October and November – 3 and 4 more counties respectively
 - December, 2008 – final assignment of plans, Blue Care Family Plan leaves HUSKY

Primary Care Case Management

- Pilot Program:

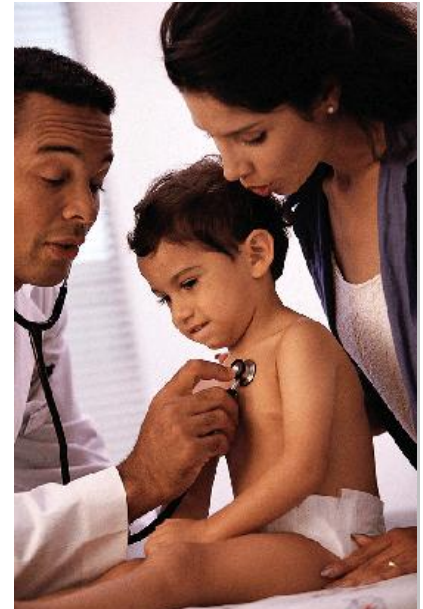
- Why more changes?
- Why now?

Section 16, Public Act No. 07-2, June Special Session directs the Commissioner of Social Services to:

“develop and implement a primary care case management pilot program of not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits.”

What is PCCM?

- Primary Care Case Management (PCCM) is a system in Medicaid in which primary care providers manage and direct care, without the use of managed care plans.
- PCPs are paid a per member per month care coordination fee in addition to fee for service payments



Why Primary Care Case Management?

- Exploring a provider-managed system of care for HUSKY members
 - Across 28 states, over 6 million Medicaid members are enrolled in PCCM
- The goal of PCCM is to:
 - Improve medical outcomes
 - Improve access to care and patients' "peace of mind"
 - Improve provider-patient satisfaction
 - Lower overall medical expenditures

PCCM North Carolina Experience

Community Care of North Carolina

- Established in 1991 as North Carolina Access
- Regional collaborative networks of providers partnering with the state
- Original pilot paired networks against MCO
- By 1998, 9 networks with 20 participating practices
- Networks were more successful than MCOs
- 1998 – PCCM implemented statewide as Community Care of North Carolina

Community Care of North Carolina

Built upon the experience of Carolina Access and its 4 key findings:

- Local control and physician leadership are essential to building sustained community care systems;
- Improving quality through population management must be the primary focus;
- Creating a true public/private partnership that brings together all of the key local healthcare and social services providers is necessary, otherwise 'outside forces' take control;
- State and local responsibility must be shared in developing the tools to manage the Medicaid population, including a system of new initiatives to better align state and community goals with desired outcomes.

Community Care of North Carolina Outcomes:

- Mercer Government Human Services Consulting:
 - Compared to fee for service, PCCM \$195 – 215 million annually.
 - Even if other similar cost control measures had been implemented, PCCM still saved the state an additional \$118 – 130 million in 2004.
- University of North Carolina:
 - PCCM disease management initiatives in asthma and diabetes saved the state \$1.6 and 1.1 million/year, respectively.

Community Care of North Carolina Outcomes:

In addition

- PCCM client satisfaction measures consistently exceed those enrolled in FFS and MCOs.
- Provider satisfaction measures are similarly high in PCCM.

So then:

Why not PCCM?

Connecticut's PCCM Pilot: How will it work?

- **Families** will be offered a choice of a managed care plan or enrolling with a PCCM provider.
- **Providers** (family practitioners, pediatricians, obstetricians, APRNs, PAs) may enroll as PCCM providers and agree to manage the care of a defined number of PCCM patients.
- The **State** will offer PCCM to clients and providers, pay PCCM providers a \$7.50 PMPM case management fee, convene a Providers Advisory Group, and offer technical assistance to support the pilot.

Provider' Responsibilities:

- Enroll in Connecticut Medicaid and follow existing policies:
 - Make appropriate referrals to the CT-BHP and DBM for patients assessed as requiring either behavioral health or dental services;
 - Utilize the Department's Preferred Drug List and PA process.
 - Coordinate care with the patient's behavior health and-dental providers.

Provider' Responsibilities (continued):

- See patients a minimum of 30 hours per week;
- Maintain hospital admitting privileges or a collaborative relationship that allows for hospital admissions.
- Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week and allow same or next business day appointments for urgent visits.
- Offer weekend and/or evening office hours
- Provide access and referral to specialty services, second opinions.

In other words, all the things you are doing already

New Provider Responsibilities (?)

- Establish written care plans signed by both the patient and the PCP;
- Implement and provide disease management services, such as management, support and education for asthma, depression, diabetes, and childhood obesity ;
- Review emergency department utilization-integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees.

New Provider Responsibilities

- **Case Management**
 - Each selected PCP or group practice will identify and designate a case manager who will help develop, implement, and evaluate the case management strategies.
 - Case managers may be social workers, nurses or other trained staff. They will work with other community based health and social service organizations to assure patients receive all necessary and coordinated services.

Case management

- Performing risk assessment
- Written care plans
- Coordinating care and access
- Disease management and education
- Providing referrals for hospitals, specialists and procedures

New Provider Responsibilities

Participate in pilot development and evaluation:

- Implement and EMR **OR** electronic disease registry;
- Exchange secure patient enrollment, utilization and outcome data with DSS;
- Participate in quality improvement and disease management programs;
- Participate in the **Provider Advisory Group.**

Provider Advisory Group

- A group of participating PCPs will guide the direction of the program; all PCPs are expected to give input.
- Committee will work with DSS to develop:
 - Quality initiatives;
 - Disease management programs;
 - Reporting methodologies, including for clinical and process data;
 - Practice guidelines.

DSS' role

The Department will:

- Establish a collaborative relationship with PCPs;
- Schedule and facilitate provider advisory committee meetings;
- Collect and review data and provide utilization feedback to providers;
- Coordinate member enrollment with participating providers;
- Provide training and technical assistance to providers concerning the PCCM program.

Potential future components by DSS

- Nurse advice line for 24/7 coverage;
- Bonuses to providers for quality of care;
- Provider support services.

Why is PCCM not Medical Home?

- “Medical Home” is not a recognized managed care methodology in Federal statute.
- Section 16, Public Act No. 07-2 mandates DSS to develop and implement a “primary care case management” pilot program.

Otherwise, PCCM = Medical Home

An example of management fee totals

- In a group practice of 5 PCPs, each PCP cares for 100 HUSKY NAME members
- **Per PCP**: $\$7.50 \text{ pmpm} * 100 \text{ members} =$
\$750 per month
\$9,000 per year
- **For the practice**: $\$7.50 * 500 \text{ members} =$
\$3,750 per month
\$45,000 per year

Next Steps: Targeted Timeline

- September-October: Begin sending out provider applications, conduct provider information sessions, and negotiate provider contracts.
- October – November: Begin client outreach and mailings.
- November: Convene Medical Advisory Group.
- January: PCCM Pilot begins.

Connecticut PCCM Pilot: Conclusion

Please join us!

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