Quality Oversight In Medicaid Primary Care Case Management Programs

As HMOs depart, are state Medicaid agencies ready to take the stage?

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ABSTRACT: As health maintenance organizations (HMOs) have curtailed participation in Medicaid, enrollment in primary care case management (PCCM) programs has grown. To examine state Medicaid agencies' monitoring of PCCM and HMO programs, we surveyed Medicaid agency directors of forty-six states and the District of Columbia. Agencies were less likely to collect performance data in PCCM programs than in HMO programs. Few PCCM programs reported performance results for the public or providers. Reporting states tended to emphasize utilization results over quality-measure results. Despite growing enrollment, PCCM programs appear less likely to use the quality-oversight strategies employed by Medicaid health plans.

HEALTH AFFAIRS

DURING THE PAST DECADE state Medicaid agencies have increased managed care enrollment tenfold to more than twenty-five million people (59 percent of all Medicaid beneficiaries) enrolled as of 2003.[1] Many state Medicaid agencies monitor the quality performance of health plans and encourage or require them to pursue quality improvement activities.[2] Some of these approaches have almost certainly improved quality of, access to, and continuity of care for Medicaid beneficiaries.[3] However, many commercial health plans have recently abandoned Medicaid contracts, and some rural areas of the United States have been unable to attract health plans.[4]

Primary care case management (PCCM) programs are playing an increasingly prominent role in states where commercial health plans have abandoned Medicaid contracts, such as Maine and Colorado, and those with few or no health plans, such as Arkansas. Within the past five years, Virginia, Utah, and Vermont have

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started new PCCM programs. More than four-fifths of PCCM programs registered enrollment growth between 1999 and 2003. PCCM accounts for nearly a quarter of all Medicaid managed care enrollment (more than 6.2 million beneficiaries), with much higher proportions in some states.[5]

PCCM programs are distinct from capitated managed care plans in that the Medicaid agency purchases health care services as if it were a health plan, selecting and contracting directly with primary care providers and paying them a management fee to coordinate and authorize care for a panel of patients.[6] In principle, PCCM programs might require providers to meet additional standards for training, licensure, certification, and available office hours; subject them to review of malpractice history; and conduct on-site reviews of office facilities.

Despite their increasing enrollment, little is known about the strategies PCCM programs use to monitor quality. They may act as traditional fee-for-service (FFS) payers, paying a case management fee but conducting minimal quality oversight. Conversely, their quality oversight programs may rival those of sophisticated health plans.[7] In this paper we describe the current status of quality oversight by PCCM programs and compare it with that of health plans serving Medicaid beneficiaries.

Study Data And Methods

■ **Sample, survey development, and data collection.** The sample of state Medicaid agencies, survey development, and data collection protocol have been described in detail elsewhere.[8] The Centers for Medicare and Medicaid Services (CMS) identified thirty states offering PCCM programs as of 1 July 2001. Three programs on this list were excluded from this study (New York State had a small enrollment in a single county-run program, California subcontracted risk to organizations that acted as health plans and therefore did not meet our study definition, and Utah initiated its PCCM program after the study year).

The Medicaid agency managed care survey included questions about quality oversight by Medicaid health maintenance organizations (HMOs) and also a distinct module to be completed by state agencies with PCCM programs. Questions about the PCCM program paralleled those about the HMO program. Both the PCCM and HMO modules inquired about a common set of clinical quality indicators, primarily from the Health Plan Employer Data and Information Set (HEDIS), including measures of patient satisfaction, access to care, and quality of care. For each clinical quality indicator and type of program, the instrument asked whether the agency collected data on the indicator and whether the agency "fed back" the results to the public. For agencies with HMO programs, the survey asked if the agency fed back results to health plans. For agencies with PCCM programs, the survey asked if the agency fed back the results to primary care providers (PCPs) or medical groups.

The survey asked whether the PCCM program developed interventions to im-

prove performance in the clinical area assessed by each indicator and whether improvement was demonstrated. It asked about special programs to improve clinical care, such as disease or case management programs using protocols, guidelines, or care paths for high-risk pregnancy, asthma, or diabetes. The survey asked whether the PCCM program offered bonus payments for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pap smears. It also included questions on traditional quality assurance activities such as verification of training, licensing, and certification of PCPs; review of their malpractice history; review of the adequacy of PCPs' office hours; and on-site review of the PCP office. Finally, the survey ascertained whether the PCCM program collected and fed back to PCPs data on rates of specialist referrals, emergency department (ED) visits, use of prescription drugs, hospitalization, and well-child visits.

■ **Analysis.** The analyses were primarily descriptive. We stratified and compared the responses of three categories of state agencies: those with PCCM programs only, those with both PCCM and HMO programs, and those without PCCM programs (HMO only). Because our sample was a nearly complete census of the relevant state Medicaid agencies (only two states, Nebraska and South Dakota, declined to respond), we do not report statistical significance or confidence limits.

Study Results

■ **Programs and enrollment.** We received responses from all but two of the forty-nine state agencies (and the District of Columbia) that had eligible prepaid HMO or PCCM programs (response rate, 96 percent).[9] Among these agencies, nine offered a PCCM program only, sixteen offered both PCCM and HMO programs, and twenty-two offered an HMO program only (Exhibit 1). Enrollment of Temporary Assistance for Needy Families (TANF), disabled, and elderly beneficiaries in PCCM and HMO programs varied. Overall, TANF beneficiaries and the disabled were more likely than elderly beneficiaries to be enrolled in managed care, reflecting policies that exclude Medicare "dual eligibles" and institutionalized beneficiaries from managed care programs. In states offering both PCCM and HMO programs, the median percentages of TANF, disabled, and elderly enrolled in each type of program were relatively similar (Exhibit 1). HMO programs tended to have been in operation longer than PCCM programs (mean of 11.7 years versus 8.0 years).

■ **Performance data collection and reporting.** State agencies were much less likely to collect performance data from their PCCM programs than from HMO programs (Exhibit 2). Satisfaction data were the most commonly collected data (64 percent of PCCM programs) followed by data on availability of translators (24 percent of PCCM programs), office waiting times and childhood immunization rates (16 percent of PCCM programs), and cervical cancer screening (12 percent of PCCM programs). No PCCM program reported collecting data on mental health measures. State agencies with both HMO and PCCM programs were much more likely to collect performance data within the HMO program than the PCCM

EXHIBIT 1
Numbers Of State Medicaid Agencies Enrolling Beneficiaries And Median Enrollment Percentage In Primary Care Case Management (PCCM) And Health Maintenance Organization (HMO) Programs

	PCCM only (n = 9)		PCCM and HMO (n = 16)		No PCCM (HMO only) (n = 22)	
Category of enrollment	N	Median enrollment (%)[a]	N	Median enrollment (%)[a]	N	Median enrollment (%)[a]
Enrolls beneficiaries in the PCCM program						
TANF	9	80	16	29	–	–
Disabled	5	48	11	24	–	–
Elderly	2	6	4	15	–	–
Enrolls beneficiaries in the HMO program						
TANF	–	–	16	42	22	77
Disabled	–	–	10	32	12	26
Elderly	–	–	7	15	9	6

SOURCE: Survey of Medicaid State Agencies, 2002.
NOTE: TANF is Temporary Assistance for Needy Families.
[a] Percentage among states enrolling beneficiaries in the category.

program.

Feedback of performance results to either of the relevant target audiences was infrequent and was less frequent in PCCM programs than in HMO programs (Exhibit 3). For the most commonly collected indicator (satisfaction with care), 66 percent of states provided HMO performance results to the public, but only 12 percent provided PCCM performance results to the public. State agencies were much less likely to feed performance results back to individual physicians and physician groups in PCCM programs than to health plans in HMO programs.

In contrast to the infrequent data collection on quality measures, PCCM programs collected data on use of services much more frequently. The type of data (and the percentage of PCCM programs collecting them) included ED use (60 percent of programs), prescription drug use (36 percent), well-child visits (36 percent), hospitalization rates (32 percent), and referrals to specialists (32 percent). All PCCM programs that collected utilization data also disseminated these data to PCPs with the exception of well-child visits (six of nine programs disseminating) and referrals to specialists (five of eight programs disseminating).

■ **Other quality management approaches.** In addition to collecting and reporting performance data, state agencies can act to improve quality by conducting outreach to providers or members, initiating disease or case management programs, and paying bonuses to promote valuable services such as EPSDT or Pap smears. In PCCM programs, the clinical areas most commonly targeted for improvement were childhood immunizations, diabetes, and asthma (each 28 percent of programs), followed by satisfaction with care (24 percent). Five state PCCM programs (20 per-

EXHIBIT 2
Comparison Of State Medicaid Agencies' Collection Of Performance Data On Quality, By Type Of State And Type Of Program, 2002

	PCCM only (n = 9)		PCCM and HMO (n = 16)				HMO only (n = 22)	
	PCCM		PCCM		HMO		HMO	
Quality domain and indicator	N	%	N	%	N	%	N	%
Satisfaction								
Satisfaction with care	6	67	10	63	15	94	19	86
Access								
Translators	2	22	4	25	5	31	14	64
Kept waiting in office	1	11	3	19	7	44	11	50
Clinical quality								
Early prenatal care	1	11	1	6	13	81	18	82
Cervical cancer screening	2	22	1	6	10	63	14	64
Diabetic glycohemoglobin	2	22	0	0	10	63	12	55
Child immunizations	3	33	1	6	12	75	20	91
Appropriate medications for asthma	2	22	0	0	9	56	10	45
Mental health/substance abuse (MH/SA)								
Proportion of MH/SA admissions who receive a follow-up visit within 30 days	0	0	0	0	4	25	8	36
Proportion with new episode of depression who receive an antidepressant medication	0	0	0	0	3	19	7	32

SOURCE: Survey of Medicaid State Agencies, 2002.
NOTES: PCCM is primary care case management. HMO is health maintenance organization. Performance data were collected in 25 agencies with PCCM programs and 38 agencies with HMO programs.

cent) reported that they were able to demonstrate improvements in satisfaction with care, and another five reported improvement in childhood immunizations. Two states reported that they demonstrated improvement in translator services and asthma medication use, respectively. Of twenty-five PCCM programs, few reported disease or case management programs for specific medical conditions. Four states (16 percent) reported a program for high-risk pregnancy, five states (20 percent) reported programs for asthma, and three states (12 percent) reported programs for diabetes. Five states (20 percent) reported bonus payments for EPSDT or Pap smears.

Traditional quality assurance functions such as credentialing and selection or deselection of PCPs would seem to constitute a minimal quality standard. However, only 68 percent of programs verified the training, licensing, and certification of PCPs; 60 percent reviewed the adequacy of PCPs' office hours; and 56 percent reviewed PCPs' malpractice history. Only eight states (32 percent) conducted an on-site review of PCPs' offices. Ten states (40 percent) reported that they dropped PCPs from the PCCM program. Reasons cited included licensure issues, contract noncompliance, and criminal convictions. Only two agencies mentioned "quality" as the primary reason for dropping PCPs.

EXHIBIT 3
State Medicaid Agencies' Provision Of Performance Results On Quality To The Public And Providers, 2001

	Provided to public				Provided to PCPs (if PCCM program) or HMOs (if HMO program)			
	PCCM		HMO		PCCM		HMO	
Quality domain and indicator	N	%	N	%	N	%	N	%
Satisfaction								
Satisfaction with care	3	12	25	66	1	4	6	16
Access								
Translators	2	8	10	26	1	4	24	63
Kept waiting in office	2	8	7	18	0	0	19	50
Clinical quality								
Early prenatal care	0	0	19	50	1	4	13	34
Cervical cancer screening	0	0	18	47	1	4	18	47
Diabetic glycohemoglobin	0	0	12	32	1	4	20	53
Child immunizations	1	4	20	53	1	4	9	24
Appropriate medications for asthma	0	0	13	34	1	4	21	55
Mental health/substance abuse (MH/SA)								
Proportion of MH/SA admissions who receive a follow-up visit within 30 days	0	0	8	21	0	0	10	26
Proportion with new episode of depression who receive an antidepressant medication	0	0	5	13	0	0	6	16

SOURCE: Survey of Medicaid State Agencies, 2002.
NOTES: PCCM is primary care case management. HMO is health maintenance organization. PCP is primary care provider. Performance data were collected from 25 agencies with PCCM programs and 38 agencies with HMO programs.

Discussion

Today more than half of state Medicaid agencies operate primary care case management programs. Recently, PCCM has seen increasing enrollment, especially as commercial HMOs have abandoned Medicaid contracts.[10] By designating accountable PCPs for defined panels of enrollees, PCCM can improve access compared to traditional FFS Medicaid and also create a platform for quality monitoring and quality improvement activities of the type undertaken by many HMOs.[11]

In this study we sought evidence that rising enrollment in PCCM programs would motivate Medicaid agencies to assume an active portfolio of quality management activities. Instead, we found evidence that the large majority of Medicaid PCCM programs are not yet using the quality measurement, feedback, and improvement strategies that are often required of HMOs. The contrast between data collection and reporting in the two types of programs is striking. Even states that operate both PCCM and HMO programs seemed to have fewer expectations of the PCCM program than of the HMO program.

■ **Patterns of data collection.** The patterns of quality-measure collection and reporting are instructive. Data on satisfaction are collected more commonly than data on clinical quality, even though such data may be more difficult to use as a

guide to quality improvement. PCCM programs do not seem to monitor the quality of mental health services in primary care. Although many states rely on behavioral health carve-outs for care of serious chronic mental illness, the omission of a HEDIS measure of medication management for new episodes of depression (frequently the province of primary care) may be a particularly salient missed opportunity.[12]

PCCM programs are more likely to collect and report utilization data than data on clinical quality, but PCCM programs are also less likely than Medicaid HMOs to collect utilization data. According to our survey, fewer than half of PCCM programs collect utilization data, in contrast to more than 80 percent of Medicaid HMOs collecting such data.[13] This emphasis may reflect the availability of data generated by FFS claims and a continuing focus on cost containment. Traditional forms of quality assurance are also more common in Medicaid HMOs than in PCCM programs. More than 80 percent of Medicaid HMOs reviewed office facilities, but only 32 percent of PCCM programs did so in our survey.[14]

In states with HMO programs, Medicaid agencies play the role of purchaser in a marketplace of competing health plans, delegating quality management while maintaining some degree of oversight. In contrast, a PCCM program is designed as an "agency-run HMO" that should internalize the role of quality manager. To the extent that state agencies play this role aggressively, they can create advantages over traditional Medicaid. Like a health plan, a PCCM program could designate a network manager responsible for selecting and maintaining a network of PCPs with demonstrated effectiveness based on cost and quality data. This manager might collect and feed back performance data, institute performance-based financial incentives, initiate focused quality improvement programs, and conduct disease management outreach. The manager might be an agency staff member or an external contractor. California is, to our knowledge, the only state that has delegated oversight of its PCCM program using the latter approach.

■ **Factors limiting data collection.** Several factors could limit collection and reporting of clinical performance data in PCCM programs. First, states may lack the budgetary resources to implement effective PCCM programs; resources may instead be diverted to expanding eligibility to beneficiaries who might otherwise lack coverage altogether. Second, state agency PCCM programs lack a national quality oversight organization, like the National Committee for Quality Assurance (NCQA), which could standardize and motivate data collection and reporting on quality.[15] Third, PCCM programs may lack needed expertise. Our results show that PCCM programs are younger on average than their HMO counterparts. With greater experience, these organizations may become more active in the quality monitoring role.

■ **Study strengths and weaknesses.** To our knowledge, ours is the first systematic assessment of quality measurement and management activities among PCCM programs nationally. We achieved a high response rate on a survey covering a wide range of topics. The parallel construction of the survey enabled us to make direct comparisons of the strategies of PCCM and HMO programs. Limitations in-

cluded a lack of detailed information about specific quality improvement efforts. Also, respondents were asked to recall details about programs in place during the previous year, which could introduce bias. We were not able to verify the accuracy of these reports.

WE FOUND THAT few Medicaid PCCM programs collect performance data, and those that do so rarely disseminate the results. With more than six million Medicaid beneficiaries, many of them subject to mandatory enrollment in programs in rural states that lack competing options or programs in states where commercial health plans have abandoned contracts, quality management of PCCM programs is especially important. If PCCM becomes more common and enrollment grows, Medicaid agencies will want to increase efforts to monitor and improve the quality of care it provides.

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NOTES

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