DESIGN OF ENHANCED PRIMARY CARE CASE MANAGEMENT PROGRAMS OPERATING IN RURAL COMMUNITIES: LESSONS LEARNED FROM THREE STATES

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EXECUTIVE SUMMARY

States are beginning to develop alternative managed care strategies for their Medicaid populations, including enhanced primary care case management (PCCM) programs that incorporate features originally developed for fully capitated managed care programs, such as care coordination and quality improvement efforts. Such alternative approaches have proven to be especially useful in rural communities, where it is more difficult to attract and maintain fully capitated managed care contracts. This findings brief highlights lessons learned from three states: Florida, North Carolina and Oklahoma, which provide enhanced benefits to Medicaid beneficiaries.[1] We find that:

- Recipients in more isolated communities seem to benefit greatly from the additional clinicians and individualized care associated with case and disease management programs.
- Face-to-face care management is more difficult to implement and maintain in rural areas because of the geographic dispersion of enrollees and the limited number of recipients in a given service area, causing increased use of management by telephone.
- Disease management programs that rely on telephone case management are problematic, as some Medicaid recipients do not have consistent access to telephones.
- Rural care managers may have more responsibilities due to the lack of other available community resources to provide patient education or address psychosocial problems.
- Partially capitated systems can ensure the viability of rural primary care providers by guaranteeing a stream of revenue with minimal financial risk.

BACKGROUND

Between 1997 and 2001, the number of rural counties covered by Medicaid managed care programs increased by almost 30%.[2] PCCM continues to be the most prevalent form of Medicaid managed care, but the number of rural counties with fully capitated plans also increased. Although Medicaid managed care programs have grown steadily, states continue to report problems with health plan withdrawals. This instability of Medicaid health maintenance organizations has motivated some states to consider new strategies for covering their Medicaid populations that do not rely exculsively on fully capitated managed care systems.

[1] Complete case studies can be found at: http://www.shepscenter.unc.edu/research_programs/rural_program/papers.html

[2] Silberman P, Poley S, James K, Slifkin R. Tracking Medicaid Managed Care in Rural Communities: A Fifty-State Follow-Up. Health Affairs. July/August 2002;21(4):255-263.

Between January and April of 2002, we visited North Carolina, Florida, and Oklahoma to interview key individuals involved in enhanced PCCM programs. Respondents included Medicaid staff, case managers, providers, and when appropriate, representatives of health departments, social services, and private organizations that contracted with states to provide disease management or nurse triage lines. Questions focused on program design, including eligibility, enrollment, benefit and referral policies, provider reimbursement, PCP and care manager responsibilities, administrative systems, disease and/or care management processes, quality assurance and improvement, health status goals, program effectiveness, and access problems.

PROGRAM DESIGN

All three states have taken unique approaches in designing their Medicaid managed care programs, but share some commonalities. All are employing case management techniques in their Medicaid managed care programs, and Florida and North Carolina have gone a step further and invested heavily in disease management, although through different mechanisms. Oklahoma relies more on other strategies to improve access and quality, including partial capitation payments to rural primary care providers, a centralized nurse triage line and capitated transportation system to serve rural communities. Each of these approaches has significant implications for rural practice.

CASE MANAGEMENT

Case management, a central feature of all three states, can be especially beneficial to rural enrollees as it can increase the resources available to small rural practices and provide needed social services that might otherwise be unavailable. Care coordinators (or case managers) in all three states help coordinate the clients' medical care, and help link clients to other available services in the community. In Florida and North Carolina, the care coordinators also help with disease management, by providing more intensive patient education, monitoring the patient's condition, and providing follow-up. Despite similarities across the three states, there are significant differences in how these programs operate, and each model has rural implications that states should consider.

In Florida, the state contracts with multiple Disease Management Organizations (DMOs) to monitor patients' conditions, and provide education and follow-up directly to beneficiaries. The DMO case managers typically coordinate the care of beneficiaries in multiple rural counties. Because rural enrollees are geographically dispersed, there is an incentive to conduct case management by telephone rather than in person, as is often the case in urban areas. This can create problems for some rural beneficiaries who lack access to regular telephone service. To address this inequality, states could consider higher case management fees for rural enrollees, with requirements regarding the provision of in-person services.

The Florida model also has implications for rural practitioners. The use of multiple DMOs, each handling different conditions, may be difficult for small rural practices with limited administrative staff. This problem is being partially addressed through a new initiative which streamlines the number of case mangers working with providers.

Case management in North Carolina is provided through provider-led community networks that participate in statewide disease management initiatives. Networks hire their own case managers, with funding from a per-member per-month management fee. There is at least one case manager in every participating rural county (and in some counties, multiple case managers), but any given practice is usually assigned a single case manager. Case managers work closely with the local physicians, sometimes working directly out of the physicians' offices or spending time each week with the physicians. While the telephone is still a primary method of reaching clients, case managers have greater ability to provide case management services to the clients, in either the beneficiaries' homes or in the doctors' office. Nonetheless, there are still disadvantages in rural communities. Case managers have to travel farther and spend more time to reach the homes of some rural beneficiaries. Further, in rural areas, case managers may have more responsibilities because of the lack of other available community resources to provide patient education or address psychosocial problems.

In North Carolina, respondents noted that the case management fee might not generate the necessary level of funding to support program expansion into some of the smaller communities with limited population bases. Unlike more urbanized areas where thousands of recipients combine to create a substantial pool of money to hire staff and create program infrastructure, some rural communities may have too few enrollees to create the necessary funding base. This is a potential barrier to enrolling some of the most remote and sparsely populated rural areas. To address this, North Carolina is beginning to create regional networks, linking smaller rural areas to urban hubs.

Oklahoma has a centralized staff of exceptional needs coordinators that work directly for the Medicaid agency. In addition to traditional case management functions, these individuals help primary care providers with specialty referrals and with managing patients who are perceived to abuse the health care system. Because of the centralized structure of the current case management system and a lack of resources, Oklahoma relies solely on the telephone for case management services. While the case management and provider relations staff appears to be doing a good job interfacing with rural physicians, they have less capacity to work intensively in meeting the health and psychosocial needs of rural beneficiaries.

OTHER INNOVATIONS

Oklahoma has developed a Medicaid managed care program exclusively for its rural areas, which uses a partial capitation financial model. Unlike the fully capitated program operating in urban parts of the state, the partial capitated program places rural providers at risk for only a limited range of primary care services. In addition, these providers receive a steady stream of income. This regular source of revenue is particularly important in rural areas, where limited populations can make it challenging for providers to remain financially viable. Oklahoma's Medicaid managed care program also features a nurse triage line and a capitated transportation system to serve rural communities, both of which improve access to services for rural beneficiaries. Through the transportation system, recipients may call a toll-free number to arrange non-emergency transportation Monday through Saturday in the form of a taxi or van service, bus vouchers or mileage reimbursement. Finally, Oklahoma's provider relations and case management staff also have assisted rural providers in obtaining specialty referrals, when local specialists are unavailable.

LESSONS LEARNED

As states redesign their Medicaid managed care programs, it is useful for them to consider factors that are unique to rural areas. Case management, disease management, and/or other systems to improve access and quality are of significant value in rural areas; however, implementing such programs may be more challenging in rural areas. Some of the factors that should be considered include:

Small number of enrollees in geographic service areas. Rural counties typically have fewer Medicaid beneficiaries than urban communities. Providing in-home services to a rural community often requires additional costs (in both travel and time). Further, per-member per-month payments may generate insufficient funds to support the program in some rural communities. States may need to adjust the case management fees to address these problems, and may want to add requirements to ensure in-person case management when medically necessary.

Fewer resources in rural communities. In many rural communities, there are fewer resources available to address the health, psychosocial and other needs of rural residents. Rural recipients may have to travel out of the community for specialty care or for other needed services. Care coordinators can help link patients to needed resources. This may be easier for locally based care coordinators than those in regional or centralized locations, as locally based staff are likely to have a better understanding of the available resources in the immediate or surrounding counties.

Ongoing transportation barriers. Transportation barriers are common in both urban and rural areas, but appear to be a bigger issue in rural communities. Federal Medicaid laws require states to assure transportation so that Medicaid recipients can access necessary medical services; however, these state transportation systems are not always effective. Oklahoma appears to have had some success with its capitated transportation model that may be worth exploring in other states.

Smaller practices with fewer administrative staff. Some rural practices are small, with few administrative staff. Requiring small rural practices to interface with multiple case managers or different disease management organizations can create administrative barriers. On the other hand, trained care managers can serve as care extenders for rural practitioners, helping to arrange transportation, link the patient to available social services, or assist in patient education. Other systems can be established to reduce barriers for rural practitioners, for example, by helping to facilitate referrals to specialists. These services – provided at either the state or local level – can assist rural practitioners who may be a sole source of care for large populations.

Regional approaches. Regional approaches that link small communities to larger urban centers to create referral networks have the promise to improve care. But, if states rely on networking as part of their case management strategy, they need to develop strategies to address the potential distrust that some rural providers feel towards the larger urban providers.

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