INTRODUCTION

Continuing pressures to restrain health care costs have stimulated innovative arrangements for the delivery of health care services. A variety of such arrangements involve use of a so-called "gatekeeper" to monitor and control patient utilization of services. The term "gatekeeper" is frequently used to refer to a person that serves as a case manager, responsible for determining what services are needed and for coordinating the provision of appropriate care. By limiting or replacing patients' freedom to self-select use of health care services, particularly highly expensive services (e.g., hospital and specialist services), this mechanism is seen by some government and private health care payers as a means of assuring that needed health care is provided in a more cost-effective manner than through traditional fee-for-service arrangements. However, in the context of providing for the medical needs of patients, we believe a more appropriate term is "patient care manager."

The patient care manager concept has been around for quite some time. Utilization of family practitioners to screen access to specialists care was recommended in 1932 by President Hoover's Committee on the Costs of Medical Care. In 1966, the AMA's Millis Commission advocated training of primary care physicians who could provide comprehensive medical care and serve as coordinators of all medical resources needed by individual patients. The use of primary care physicians in a managerial role was also recommended in the Institute of Medicine's 1978 Report, A Manpower Policy for Primary Care.

The patient care manager has been most extensively applied in the United States through Health Maintenance Organization (HMO) arrangements. HMOs generally offer "prepaid managed care" in which primary care physicians serve as "gatekeepers" to specialist and hospital care. Fee-for-service charges are replaced by annual premiums determined and paid in advance on a per patient basis. HMOs typically offer a comprehensive package of covered services, but limit coverage only to services provided or authorized by the HMO. Preventive and primary health care are normally encouraged as a means of decreasing subsequent use of more expensive inpatient hospital and specialist care. Patients may obtain care outside the HMO system, but with the exception of emergency care normally must pay for it themselves.
Preferred Provider Organizations (PPO) and Exclusive Provider Organizations (EPO) also utilize physicians as patient care managers. Under these types of arrangements, enrollee coverage is restricted to participating physicians who determine access to specialist and hospital care. In a PPO arrangement, reimbursement may be limited only to the services performed or authorized by physicians from among a list of PPO participants. In the EPO model, the enrollee must choose one physician who is responsible for the provision of covered health care.

Under the Medicaid program, a number of states have applied the patient care manager concept to Medicaid recipients by establishing primary care networks or primary care case management systems. Since these systems pay only for services rendered by participating providers, recipients are limited in their choice of providers. However, most states require the primary physician to make arrangements for 24-hour access, and exclude emergency services from approval requirements. They encompass primary care physicians in a variety of health care settings, including community centers, prepaid group practices, solo practice, as well as in HMOs.

Physicians have long performed the functions of determining patient medical needs, making referrals to specialists, and admitting patients to hospitals. Indeed, patients typically expect their personal physician to perform such functions. As a patient care manager, the personal physician's traditional role has been to provide primary and continuing care and to assure that appropriate care is given in all situations. While the cost of care is an important consideration, the patient's health care needs are the personal physician's greatest concern. Inappropriate and unnecessary care should be avoided regardless of physician practice arrangement.

The American College of Physicians, representing over 60,000 specialists in internal medicine and allied subspecialties who are committed to serving the medical needs of adults and adolescents, believes that the increasingly widespread use by health care delivery systems of physicians as patient care managers of health care services necessitates the examination of the public policy issues involved. The following positions underscore the College's view that physicians can and should play a significant role as patient care managers within these delivery systems.

**SUMMARY OF POSITIONS**

1. Health care delivery systems that use patient care managers to screen medical and institutional services should use primary care physicians in that role.

2. Health care delivery systems that require prior approval for coverage of services must assure that patients are not denied timely access to needed services.
3. Where health care programs utilize patient care managers, enrollment ideally should be voluntary rather than mandatory, because such programs restrict patients' freedom of choice of physician. The College recognizes that under certain circumstances state and local governments may need to utilize mandatory enrollment programs in order to assure the solvency of their health care delivery systems. However, these mandatory enrollment programs should establish mechanisms to assure that enrollees have some initial choice among physicians and that there are reasonable opportunities to change that choice.

4. Medicaid "lock-in" programs must have clear and appropriate criteria for identification of "overutilizers." Physician involvement in the determination process of such programs is essential to assure sensitivity to justifiable medical needs. Medicaid patients should not be subjected to further hardships merely because of the severity or frequency of their illnesses.

5. The increasing utilization of the patient care manager as an approach to the provision of health care services requires that research be undertaken to better analyze its effectiveness in assuring the delivery of appropriate medical care.

POSITION

1. Health care delivery systems that use patient care managers to screen medical and institutional services should use primary care physicians in that role.

RATIONALE

The patient care manager approach involves a medical screening process in which access to medical and other related services is determined by case managers. These managers should be qualified to evaluate patient symptoms, determine needs for medical care, and promptly provide or initiate treatment in an efficient and cost-effective manner. We believe that primary care physicians (internists, family physicians, and pediatricians) are highly qualified to serve in this capacity.

Primary care physicians serving as patient care managers should possess broad clinical competence and be able to interact effectively with specialists and subspecialists in other fields. They should be prepared to recognize those illnesses requiring subspecialty medical, surgical, or psychiatric attention and should be responsible for coordinating the provision of appropriate physician care. They also should be responsible for making appropriate referrals for services rendered by non-physicians such as social services, rehabilitation, nutrition, and respiratory therapy. The primary care physician serving as patient care manager should ensure accessibility to, and comprehensiveness, coordination, continuity and accountability of health care services.
Appropriate training of primary care physicians as patient care managers should be emphasized, as well as broad training in general medicine and/or pediatrics, during the graduate medical education experience. For internal medicine, the residency program should include training in evaluating the benefits, risks, and costs of medical care and medical technology. The resident's educational experience should include exposure to techniques and methodologies that aid in medical decisionmaking and should be applied in the resident's daily practice routine. Exposure to a variety of clinical problems in different practice settings, including hospital, long-term care, and ambulatory facilities would further prepare the new physician for the role of patient care manager. The residency experience must also assure that the physician will become accomplished in the basic skills of primary care so as to effectively and efficiently diagnose and treat the more common ailments many adults and adolescents contact. As part of the training process, the resident should be given some responsibility in selecting and interacting with physician consultants as this will be an important function of a patient care manager. Conversely, the subspecialist resident will need to acquire skills in effectively collaborating with the referring primary care physician who as patient care manager will assume the principal responsibility for the patient (1).

Utilization of primary care physicians as patient care managers may be particularly appropriate for patients suffering from chronic illnesses requiring a range of health care services. For certain patients with serious or complicated diseases, the primary care physician may refer patients to subspecialists for ongoing principal care. Geriatric diagnostic evaluation centers described and recommended in the College's position paper entitled "Long-Term Care of the Elderly" involve the use of primary care physicians in a similar manner.

POSITION

2. Health care delivery systems that require prior approval for coverage of services must assure that patients are not denied timely access to needed services.

RATIONALE

Health care delivery systems should be structured so that patients are assured timely access to needed health care services. Systems that restrict patient access to medical and institutional services through a patient care manager or other mechanism should also assure that needed care is provided in a timely manner.

Organizational barriers to needed services must not result in a delay in diagnosis or a delay in the provision of appropriate therapeutic modalities. Such delays could have an adverse impact on the length and severity of a patient's illness and lead to a worsened medical condition and poorer patient outcomes. Decisions on the prescription of health services should be made on the basis of clinical indications.
In health care systems utilizing patient care managers, patients must be assured that physicians are available and access to them is both timely and reasonable. Reasonable access is difficult to define but may include a variety of arrangements such as 24-hour physician coverage or more limited stand-by coverage, or simply by providing access by telephone outside of normal working hours. Referral mechanisms must be in place for emergency situations but should be structured so that the hospital emergency room is not used to provide primary non-emergency care as a substitute for the patient care manager. A sufficient cadre of physician specialists as well as non-physician providers must also participate in order that appropriate quality medical care can be provided and appropriate referral assured. A variety of institutional services should be available to provide care in appropriate settings.

The College does not believe that these health care delivery systems should exclude their patients from access to institutions such as tertiary or teaching hospitals. Arrangements may need to be developed to assure access to such institutions. Interaction between alternative delivery systems and teaching and research facilities will foster further improvements in cost-effective health care.

POSITION

3. Where health care programs utilize patient care managers, enrollment ideally should be voluntary rather than mandatory, because such programs restrict patients' freedom of choice of physician. The College recognizes that under certain circumstances state and local governments may need to utilize mandatory enrollment programs in order to assure the solvency of their health care delivery systems. However, these mandatory enrollment programs should establish mechanisms to assure that enrollees have some initial choice among physicians and that there are reasonable opportunities to change that choice.

RATIONALE

In the present health care environment, a variety of health care plans and programs compete for subscriber patients. Patients should be able to choose among them to find one that appropriately meets their needs. It is reasonable to advocate that their choice be voluntary and that opportunities exist for them to withdraw from a particular plan and choose another. Increasing efforts at cost control, however, will likely result in further pressure in both the public and private sector to limit patient freedom of choice. This limitation, however, may not be applicable solely to the patient care manager approach but may apply also to other health care delivery systems.

A particular challenge to this principle is the mandatory enrollment of a targeted population in a program that utilizes the patient care manager approach, such as the primary care networks established under some state Medicaid programs. Under these programs, Medicaid recipients are limited in their choice of providers to those who participate in the state program.
Many state Medicaid programs have used primary care networks to help control state health care expenditures, given the state's limited resources and the need to assure the solvency of state health care delivery systems. While recognizing these significant responsibilities, states must still assure that these networks deliver health care services of an appropriate quality to Medicaid recipients. In arrangements where the participating primary care physician actively manages the Medicaid recipient's health care needs, access to appropriate services may be improved. However, when the patient is dissatisfied with either the care given or the care giver, a problem may occur if the patient does not have the opportunity to choose another provider. It would be inappropriate for patients to be forced to accept health care services they find unsatisfactory or to receive no services at all. The College believes that these programs should include mechanisms that assure patients some initial choice of participating providers, and permit the selection of a new provider if there is legitimate dissatisfaction with the provider or with the care received. Finally, these mandated programs should include review mechanisms to help assure the delivery of health care services of an appropriate quality.

POSITION

4. Medicaid "lock-in" programs must have clear and appropriate criteria for identification of "overutilizers." Physician involvement in the determination process of such programs is essential to assure sensitivity to justifiable medical needs. Medicaid patients should not be subjected to further hardships merely because of the severity or frequency of their illnesses.

RATIONALE

Under new statutory language added to Section 1915(b) of the Social Security Act (1981), state Medicaid programs are permitted to establish "lock-in" programs that assign Medicaid recipients who overutilize services to specific providers. By the end of 1982, at least 37 states had established or were in the process of implementing these programs. In fact, 20 states had already established such programs prior to passage of the legislation. These programs were enacted under federal statutory requirements mandating states to provide safeguards against unnecessary utilization. They permitted limits on services based on medical necessity or on utilization control procedures (2).

"Lock-in" programs vary among states; however, most limit provision of all primary care services to a designated physician and require the primary care physician's referral for non-emergency specialty care. In addition to their "lock-in" programs, Michigan and Tennessee require prior authorization for services to overutilizers. California and Nevada do not have programs that have "lock-in" restrictions, but they do require prior approval for certain services to high users. California issues a specially coded red ID card to recipients who exceed normal usage levels for prescription drugs or physician services. The special card alerts providers that prior approval must be obtained before dispensing services. In Nevada, medical professionals determine overutilizers. Recipients so
identified receive medical cards stamped "Valid for Emergency Care Only," and providers must call a control phone number for authorization to provide ambulatory services (except emergency care and diagnostic tests) (2).

At least 14 states operate formal patient education programs in conjunction with "lock-in" programs. In several states overutilizers are first enrolled in the patient care education program. If utilization continues above acceptable levels after completion of the education program, then the patient is entered into the "lock-in" program (2).

By restricting those who overutilize or inappropriately utilize medical and pharmaceutical services, "lock-in" programs may decrease excessive utilization and thereby reduce Medicaid costs. The National Governors' Association estimates that annual expenditures are reduced by $1,000 for each enrollee of a "lock-in" program, and that net annual Medicaid savings from adoption of these programs nationwide could be over $25 million (2).

While legitimate savings in Medicaid programs should be applauded, Medicaid patients should not be inappropriately denied needed health care. "Lock-in" programs need to be structured so that the criteria used to determine an overutilizer are not based solely on the frequency or provider or institutional contacts. In order to ascertain the medical necessity and justification of the use of services, physicians should be involved in the determination process of "lock-in" programs. Overutilization determinations should be made by personnel who are trained and sensitive to the legitimate medical needs of patients. Physician participation in lock-in programs helps to assure that Medicaid recipients are not subjected to hardships merely because of their financial inability to secure health care services.

POSITION

5. The increasing utilization of the patient care manager as an approach to the provision of health care services requires that research be undertaken to better analyze its effectiveness in assuring the delivery of appropriate medical care.

RATIONALE

Because of the changing competitive environment in health care and increasing pressure to identify cost-effective means of delivering health care, better understanding of the effectiveness of the patient care manager approach is necessary. Specifically, research should be focused not only on the cost-effectiveness of the physician patient care manager (e.g., decreased hospitalization, utilization of diagnostic tests and procedures), but also on a variety of patient care outcomes (e.g., wellness upon discharge from hospital, restoration of functional activities, mortality rates, etc.). Research on the patient care manager approach in acute, ambulatory, and long-term care services should include investigations to assess the impact of the incentives and disincentives for providing appropriate care in these delivery systems. Whether the chronically ill or high risk
patient is adversely affected by this approach should also be investigated. Research is also needed on the effectiveness of various types of patient care manager (e.g., primary care physicians and specialists) as well as on the various delivery system models.

In addition, research is needed in a variety of related areas. There should be research on patient satisfaction with access to care, the actual care provided, and the physician-patient relationship. Research should also help establish effective methods of educating physicians for the role of patient care manager, and as well provide physicians data on cost-effective treatment modalities. Research should also focus on the effect the patient care manager approach has on provider behavior and on provider finances, including whether some providers fare better than others.

Information will also be needed on the long term effects of the use of the patient care manager approach. Are patients managed in such a fashion exposed to more health promotion and disease prevention activities? Does improved health status result? Does it result in underuse of specialists' services? What long-term effects do reduced hospitalization rates have on health? The College believes that health care payers should give such research high priority.

REFERENCES
