

Medicaid Health Plans of America Patient-Centered Medical Home Policy Statement



September 2010

Given the scope of Medicaid health plans - their experience in care coordination, financial management, and quality improvement, and their mature data infrastructures that support reporting on quality and cost for primary, specialty and hospital care - MHPA believes that effective implementation of the PCMH for Medicaid beneficiaries requires the expertise and support of Medicaid Health Plans.

Approximately 47% of Medicaid beneficiaries are enrolled in a Medicaid health plan, with other beneficiaries receiving fee for service or primary care case management services. Medicaid health plans have a long track record of providing quality care to beneficiaries and being accountable for access, cost and quality.

State policy-makers are increasingly interested in use of patient-centered medical homes (PCMH) to improve access, care management and patient outcomes. Recent health reform legislation included funding incentives for states to promote medical homes for the chronically ill in Medicaid. MHPA believes that effective implementation of the PCMH for Medicaid beneficiaries requires the expertise and support of Medicaid Health Plans because:

- Medicaid health plan activities support and facilitate all of the Joint Principles of the Patient-Centered Medical Home.*
- Medicaid health plans are accountable and at-risk for the total cost of care, including inpatient, outpatient and ancillary services, allowing states to implement predictable budgeting processes.
- Medicaid health plans have demonstrated capacity to support high needs Medicaid populations, including transportation, care coordination, and translation services.
- Medicaid health plans operate under regulation and oversight that is far more comprehensive than oversight of fee-for-service Medicaid or primary care case management programs. They are accountable for quality and use standard, public quality metrics reported to states, CMS, and accrediting organizations.
- Medicaid health plans have a mature infrastructure to integrate and aggregate data and analyze it for cost and quality insights that can be translated into actionable improvement strategies by plans and providers.
- Medicaid health plans are adaptable: they can bring value-based payment innovations to providers and deploy care management and quality improvement support more quickly than state agencies.

Provider organizations alone do not have data and operational management systems to evaluate total cost, fully manage financial risk or assess quality across the continuum of services. Partnerships between health plans, physicians, and other providers such as nurses, advance practice nurses, care coordinators and other providers are essential to effective transformation of the health care system. States should promote collaborations with Medicaid health plans and providers to develop and maximize the effectiveness of PCMH models, and should explicitly include Medicaid health plans in state strategies to implement PCMHs. MHPA also believes it essential for states to establish performance and evaluation metrics to assess effectiveness of the PCMH in improving health outcomes of Medicaid beneficiaries.

About MHPA

Medicaid Health Plans of America is the leading national organization solely dedicated to representing health plans participating in Medicaid managed care. MHPA provides effective policy solutions to promote and enhance the delivery of quality healthcare to Medicaid beneficiaries.

* See the reverse side of this page for the Joint Principles and a crosswalk of capabilities.

Alignment of Medicaid Health Plan Capability with Joint Principles of the Patient-Centered Medical Home

Element of the Patient-Centered Medical Home	<i>Description from Joint Principles</i>	Medicaid Plan Activities that Align With PCMH
Personal physician	<i>Patient has ongoing relationship for comprehensive care</i>	Medicaid plans require members to have a personal physician and assist them in choosing one.
Physician directed medical practice	<i>Team care with collective responsibility</i>	Medicaid plans provide a team to support the primary care practice including physicians, pharmacists, nurses, informatics experts, education specialists and outreach workers. Services include dental and vision care.
Whole person orientation	<i>Health care team is responsible for providing or arranging care</i>	Health plans address the total health of plan members through risk assessment, prevention, health education and outreach and by coordinating care through case managers.
Care is coordinated and / or integrated	<i>Physician and other care (home health, hospital) is coordinated through information technology and information exchange</i>	Medicaid plan case managers support members with complex health needs and coordinate medical and ancillary providers and benefits across all settings.
Quality and safety	<i>Practices use evidence based medicine and decision support, care quality is evaluated and continuously improved</i>	Medicaid plans assess and report HEDIS quality indicators and CAHPS patient experience measures; plans are accredited by NCQA and comply with state and federal quality mandates. Health plan data systems identify quality and safety concerns such as duplicate medications.
Enhanced access	<i>Expanded hours, technologically supported visits (email, web)</i>	Medicaid plans are required by federal regulations and NCQA standards to ensure access. They offer nurse support lines, assist members in accessing urgent care and contract with physicians who will meet specific accessibility standards
Payment	<i>Payment method recognizes added value services, new modes of delivering care and need for infrastructure development, and should reflect shared savings resulting from care improvement</i>	Medicaid plans are accountable to states for managing all costs of comprehensive care including inpatient and outpatient. Plans manage capitated payments from state and administer payments to providers and can innovate payment to reward value added services such as the PCMH, when permitted by states.

The Joint Statement is from: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). March 2007. Available at: <http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>