

The Role of Patient-Centered Medical Homes In
Reducing State Medicaid Programs' Long-Term
Care Costs

*Serj Mooradian**

I. INTRODUCTION

As Americans live longer, the country's long-term care needs are increasing.¹ Approximately twelve million people in the United States need long-term care; this number is expected to increase to twenty-seven million by 2050.² The cost associated with this dramatic rise is unsustainable, particularly by Medicaid, which pays for forty-three percent of the country's long-term care.³ In 2009, this amount was \$171.8 billion or 47.8% of Medicaid's total cost.⁴ Between retiring baby boomers and the Medicaid expansion under the Patient Protection and Affordable Care Act ("PPACA"), the Congressional Budget Office predicts that Medicaid long-term care costs will increase by an average of 7% per year over the next ten years⁵ - more than doubling over this timeframe.⁶ This highlights the

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2014. Mr. Mooradian is a staff member of *Annals of Health Law*.

1. *See generally* ROBERT WOOD JOHNSON FOUND., CAN CULTURE CHANGE OFFER VIABLE SOLUTIONS TO MEET INCREASED DEMANDS FOR LONG-TERM CARE? 1 (2012) [hereinafter CULTURE CHANGE], available at http://rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401182. Seventy percent of American adults alive today will need long-term care in their lives. *Id.* This will increase as the proportion of the population over sixty-five rises. *Id.* In the next twenty years, the percentage of Americans over sixty-five years old will increase from roughly 13% to 19% of the population, an increase from over forty million to approximately seventy million people. *Id.*

2. *Id.* This dramatic increase is likely to be partly due to an increase in the prevalence of Alzheimer's disease. *See id.*

3. *Id.*

4. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 114 (2012) [hereinafter MACPAC REPORT], available at http://www.macpac.gov/reports/2012-06-15_MACPAC_Report.pdf.

5. CONG. BUDGET OFFICE, SPENDING AND ENROLLMENT DETAIL FOR CBO'S FEBRUARY

urgency with which long-term care costs within Medicaid must be contained.

The federal government and states have a shared interest in Medicaid cost containment. Medicaid is a federal-state program,⁷ in which the federal government funds 57% of its entire cost.⁸ The specific percentage varies from state to state, as the states can increase their share of specific parts of the program by offering additional services.⁹ One of the specific parts that some states supplement is long-term care.¹⁰ In 2010, the states paid for fifty-three percent of total Medicaid long-term care costs.¹¹

Despite predictions that state budgets will improve in 2013,¹² containing Medicaid expenses should remain a top priority to the states. Medicaid consumes twenty-four percent of the states' combined budgets.¹³ Controlling the cost of long-term delivery can therefore help improve the states' budgets generally. Feasibly, the states have two approaches to reducing their long-term-care-related Medicaid costs: they can shift the cost

2013 BASELINE: MEDICAID (2013), *available at* <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43885-Medicaid.pdf>.

6. The author calculated that a 7% increase over ten years results in a total 197% increase. Based on the MEDPAC Report numbers, this would lead to a total long-term care costs of \$338.5 billion by 2019. *See* MACPAC REPORT, *supra* note 4.

7. *See* Ctrs. for Medicare & Medicaid Servs., *Financing and Reimbursement*, MEDICAID.GOV, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Apr. 28, 2013).

8. *Id.*

9. *Id.*

10. *See* Kaiser Family Found., *Distribution of Medicaid Spending on Long Term Care, FY2010*, STATE HEALTH FACTS, <http://www.statehealthfacts.org/comparetable.jsp?typ=4&ind=180&cat=4&sub=47> (last visited Apr. 28, 2013).

11. *See id.* Please note that author added the totals spent by each individual state and compared the sum to the amount spent by the federal government.

12. Pamela M. Prah, *States' Fragile Recovery at Risk*, STATELINE (Jan. 23, 2013), <http://www.pewstates.org/projects/stateline/headlines/states-fragile-recovery-at-risk-85899444612>.

13. *Id.*

of long-term care to consumers¹⁴ or, alternatively, they could reduce the overall cost of long-term care delivery.¹⁵ Both methods would reduce the states' share of long-term care cost. The former is traditionally done through financial incentives, but this option does not solve the rising costs issue.¹⁶ Lowering the cost of long-term care delivery is the most viable way forward. Primary-care reform, through the implementation of Patient-Centered Medical Homes ("PCMHs"), is a better solution. Community Care of North Carolina is an example of a state Medicaid program that has successfully curbed long-term care costs through the implementation of a PCMH model in its Medicaid delivery.¹⁷

II. FAILURE OF STATE ATTEMPTS TO SHIFT THE COSTS OF LONG-TERM CARE TO CONSUMERS

Traditionally, some states have tried to ease their long-term care financing burden by shifting the cost to consumers.¹⁸ States have done so in two ways: through tax incentives for purchasing long-term care insurance¹⁹ and with Long-Term Care Partnership Programs ("partnership programs").²⁰ Twenty-eight states and the District of Columbia offer tax deductions for individuals and/or employers who purchase long-term care insurance.²¹ However, tax deductions have been ineffective at incentivizing consumers to buy long-term care insurance, primarily because the deductions are so small that they do not function as enough of an

14. *See infra* Part II.

15. *See infra* Parts III-V.

16. *See infra* Part II.

17. *See infra* Part V.

18. *See infra* notes 21-29 and accompanying text.

19. *See infra* notes 21-25 and accompanying text.

20. *See infra* notes 26-29 and accompanying text.

21. *Long-Term Care Insurance Tax-Deductibility Rules*, AM. ASS'N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php> (last visited Apr. 28, 2013).

incentive.²² Instead, they merely reward those consumers who would otherwise be purchasing the insurance.²³ Further complicating the problem, individuals who know that Medicaid will cover the cost of their long-term care expenses have little incentive to incur the cost of the insurance, even with a tax break.²⁴ Long-term care insurance is just “too expensive, especially for older individuals who need it the most.”²⁵

Second, many states attempt to incentivize the purchase of long-term care insurance through partnership programs, in which the states relax Medicaid eligibility requirements for individuals who have purchased long-term care insurance policies.²⁶ All but six states and the District of Columbia have partnership programs in place.²⁷ However, the same problems arise with these programs as with tax incentives – long-term care insurance policies are expensive. Partnership programs are “ideally suited [to encourage] *middle-income* Americans” to buy long-term care insurance.²⁸ However, many middle-income Americans would otherwise not be eligible for Medicaid.²⁹ Therefore, while partnership programs do

22. See Karin C. Ottens, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective and Inefficient*, 22 VA. TAX REV. 747, 764 (2003). Although Ottens’s article discusses federal tax deductions, the author applies the premise to state tax deductions.

23. *Id.*

24. *Id.* at 764.

25. *Id.* at 765.

26. See generally Dep’t of Health & Human Servs., *State Partnership Programs*, LONGTERMCARE.GOV, http://www.longtermcare.gov/LTC/Main_Site/Paying/Private_Financing/LTC_Insurance/State_Partnership.aspx (last visited Apr. 28, 2013) (giving an overview of the program).

27. *Long Term Care Insurance Partnership Plans*, AM. ASS’N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved> (last visited Apr. 28, 2013).

28. *Id.* (emphasis added).

29. See KAISER FAMILY FOUND., *WHERE ARE STATES TODAY? MEDICAID AND CHIP ELIGIBILITY LEVELS FOR CHILDREN AND NON-DISABLED ADULTS 3* (2013), available at <http://www.kff.org/medicaid/upload/7993-03.pdf>. In 2013, the upper income limits for Medicaid eligibility among the states range from 160%-400% of the Federal Poverty Line. *Id.* This upper limit is \$37,680-\$94,200 for a family of four. See DEP’T HEALTH & HUMAN SERVS., *2013 POVERTY GUIDELINES 1* (2013), available at

encourage more individuals to buy long-term care insurance generally, they do not comprehensively confront the problem of rising long-term care costs by the people that Medicaid is supposed to cover: those who cannot afford long-term care insurance in the first place.

To address the cost problem associated with long-term care delivery by Medicaid programs, the states need to reform the way they deliver primary care to their Medicaid populations. Long-term care costs are rising too quickly for consumers to be able to absorb them, even with long-term care insurance.³⁰ The states need to disrupt the current model of long-term care delivery in order to effectuate meaningful cost savings. Primary care reform through the implementation of PCMHs will be such a disruption.

III. OVERVIEW OF PATIENT-CENTERED MEDICAL HOMES

PCMHs deliver primary-care through multidisciplinary teams that provide “accessible, comprehensive, coordinated, and continuous patient-centered care.”³¹ In addition to the traditional, fee-for-service type reimbursements, PCMHs receive a capitated monthly management fee from payors, to coordinate patients’ care.³² PCMHs typically have a dedicated care coordinator to work with clinicians and other providers.³³ The extra coordination helps PCMHs optimize their patients’ health outcomes by intervening with preventive measures before the medical issues become more complex.³⁴

Poverty-level-charts.pdf.

30. *See supra* Part I.

31. Mary Takach, *About Half of the States are Implementing Patient-Centered Medical Homes For Their Medicaid Populations*, 31 HEALTH AFF. 2432, 2432 (2012) [hereinafter Takach].

32. *See id.* at 2433-34.

33. *Id.* at 2434.

34. Daniel D. Meang et al., *Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisinger’s Medical Home Model*, 18 AM. J. MANAGED CARE 149, 154 (2012).

Twenty-five states have incorporated PCMHs into their Medicaid programs,³⁵ which is due, in part, to federal funding made available under the PPACA.³⁶ The PPACA funding is specifically for states that designate health teams who operate as health homes for individuals with chronic conditions.³⁷ This suggests that Congress viewed PCMHs as a feasible option for reducing the cost of chronic care.

PPACA does not define PCMH.³⁸ However, the Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, defines it as encompassing five functions and attributes:

- (1) Comprehensive care by a group of multidisciplinary providers to meet the large majority of its patients' physical and mental health needs, including prevention and chronic care;
- (2) Patient-centered orientation, in which providers understand and respect their patients' unique needs, culture, values, and preferences;
- (3) Coordinated care between the providers in all settings, including specialty care, hospitals, home health care, community services, and supports, especially during transitions between sites of care;
- (4) Accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around the clock telephone or electronic access to a member of the care team; and
- (5) A demonstrated commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools.³⁹

These attributes create the ideal conditions for reducing the incidence of chronic disease. As discussed below, the reduction of chronic disease will,

35. *Medical Home & Patient Centered Care*, NAT'L ACAD. FOR ST. HEALTH POL'Y, <http://www.nashp.org/med-home-map> (last visited Apr. 28, 2013).

36. 42 U.S.C. § 1396w-4(c)(1) (2010); *see also* Takach, *supra* note 31.

37. 42 U.S.C. § 1396w-4(c)(1).

38. *See id.*

39. *Defining the PCMH*, AGENCY FOR HEALTHCARE RES. & QUALITY, http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2 (last visited Apr. 28, 2013).

in turn, contribute to significantly containing the costs long-term care among Medicaid beneficiaries.

IV. LINKING PATIENT-CENTERED MEDICAL HOMES WITH DECREASING MEDICAID LONG-TERM CARE COSTS

PCMHs do not offer a silver bullet for Medicaid's long-term care cost crisis. Rather, they offer a way of transforming Medicaid primary-care delivery that specifically targets the population that is susceptible to needing long-term care services.⁴⁰ Implementing PCMH models reduces medical costs in medically complex patients,⁴¹ all while also increasing medical outcomes in this population.⁴²

The states should find it appealing to implement a system of health care delivery that targets vulnerable patients and coordinates these patients' care in a way that reduces their medical costs and their health outcomes.⁴³ If the model works, it will contain the long-term care problem before it is gets worse.

V. COMMUNITY CARE NORTH CAROLINA: A MODEL OF USING PATIENT- CENTERED MEDICAL HOMES TO COMBAT THE COST TO MEDICAID OF LONG-TERM CARE

Since 1998, Community Care North Carolina ("CCNC") has provided some evidence that states who adopt a PCMH model for their Medicaid

40. T.J. Flottemesch et al., *Patient-Centered Medical Home Cost Reductions Limited to Complex Patients*, 18 AM. J. MANAGED CARE 677, 685 (2012).

41. *Id.* ("[A]mong the sickest and most costly patients, improved PMCH related systems appear to have been associated with reduced costs and utilization across multiple categories . . .").

42. See DOUGLAS MCCARTHY & KIMBERLY MUELLER, COMMUNITY CARE OF NORTH CAROLINA: BUILDING COMMUNITY SYSTEMS OF CARE THROUGH STATE AND LOCAL PARTNERSHIPS, 7-8 (2008) [hereinafter MCCARTHY & MUELLER], available at http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jun/1219_McCarthy_CCNC_case_study_624_update.pdf.

43. Vulnerable patients may include those with disabilities, mental illness, and chronic issues. See generally *id.*

programs can lower their long-term care costs in this way.⁴⁴ CCNC is a private-public partnership that brings together regional networks of healthcare delivery professionals to provide cooperative, coordinated care through the PCMH model.⁴⁵ The program is comprised of fourteen networks,⁴⁶ made up of physicians, hospitals, social service agencies, and county health departments.⁴⁷ Each network manages the care of its enrollees⁴⁸ and covers approximately 90% of its region's Medicaid enrollees.⁴⁹ Each covered enrollee is linked to a PCMH, which provides acute, chronic, and preventative care services, and coordinates secondary care on behalf of its patients.⁵⁰

Instrumental in the coordination of care are CCNC's case managers, who identify specific patients who could benefit most from care coordination.⁵¹ Such patients include those who make repeated emergency room visits; patients with asthma, diabetes, or heart failure; and patients with chronic conditions and high service use or complex care needs, including those with mental health conditions.⁵² Case managers ensure continuity of care by working directly with patients to educate them about treatments and ensure that they stay compliant with the treatments.⁵³ The case managers also help

44. *See generally id.*

45. *The Community Care Story: Why a Community-Based System Really Works*, CMTY. CARE OF N.C., <http://www.communitycarenc.org/about-us> (last visited Apr. 28, 2013).

46. *Working Together*, CMTY. CARE OF N.C., <http://www.communitycarenc.org/our-networks> (last visited Apr. 28, 2013).

47. KAISER COMM'N ON MEDICAID & THE UNINSURED, COMMUNITY CARE OF NORTH CAROLINA: PUTTING HEALTH REFORM IDEAS INTO PRACTICE IN MEDICAID 3 (2009) [hereinafter KAISER], available at <http://www.kff.org/Medicaid/upload/7899.pdf>.

48. *Id.*

49. *See* N.C. DEP'T OF HEALTH & HUMAN SERVS., NORTH CAROLINA MEDICAID CCNC/CA MONTHLY ENROLLMENT REPORT (2012), available at <http://www.ncdhhs.gov/dma/ca/enroll/caenr12.pdf>.

50. KAISER, *supra* note 47.

51. MCCARTHY & MUELLER, *supra* note 42.

52. *Id.*

53. *Id.*

clinical care providers assess the patients' care needs and work with the providers to ensure that the patients' needs are met.⁵⁴

CCNC and the individual networks then use data gathered by the case managers to create evidence-based programs that aim to improve health outcomes either statewide (through CCNC) or locally (through the individual networks).⁵⁵ Statewide initiatives have targeted asthma, diabetes, efficient prescribing and use of drugs, and prescription drug management in nursing home patients.⁵⁶ Local initiatives include efforts to improve assessment and treatment of mental health patients and to coordinate care with local safety-net providers and indigent care programs to provide continuity of care to patients who move between Medicaid and being uninsured.⁵⁷ In these initiatives, the state has targeted inefficient parts of the Medicaid population and addressed them in order to prevent costs from spiraling out of control.

Using the PCMH model, CCNC has saved North Carolina at least \$700 million in Medicaid expenditures since 2006.⁵⁸ More aggressive estimates place savings at almost \$1 billion during 2007 to 2010.⁵⁹ While cutting costs, North Carolina has also improved quality outcomes for CCNC patients, as measured by national standards.⁶⁰ By targeting patients that are likely to need long-term care in the future, CCNC has lowered the cost of its future long-term care costs. While the amount has not been quantified, it is likely to be significant. The aggregate effect of such savings between

54. *Id.*

55. *Id.* at 8.

56. *Id.* at 8-9.

57. *Id.* at 9.

58. Powerpoint Presentation, Cmty. Care of N.C., Community Care of North Carolina: 2012 Overview 23 (2012), <https://www.communitycarenc.org/about-us/> (last visited Feb. 17, 2013). The PowerPoint may be found at the bottom right of the webpage.

59. *Id.* at 17.

60. MCCARTHY & MUELLER, *supra* note 42, at 7-8 (discussing improved outcomes in emergency room admissions, asthma and diabetes outcomes, and lower drug expenditures).

several states would make a significant impact on Medicaid's long-term care costs nationwide.

Therefore, CCNC can serve as a model for the other twenty-four states that have committed to incorporating the PCMH model into their Medicaid programs.⁶¹ The model is gaining acceptance across the clinical disciplines: among the many groups that have accepted the PCMH model as a viable way forward are the American Medical Association,⁶² American Hospital Association,⁶³ hospitals and insurance companies,⁶⁴ and safety-net providers.⁶⁵ Many of these organizations are developing their own PCMH programs to take advantage of the potential cost savings they bring.⁶⁶ The general PCHM model is considered by some, including insurance companies, to be the engine that produces cost savings under the Accountable Care Organizations promulgated under the PPACA.⁶⁷ On paper, at least, the goodwill to implement PCMHs exists.

All these stakeholders need to work together to realize the potential savings that exist. By coordinating care, providers can work together to identify and effectively treat patients with both physical and mental health disabilities, avoid negative outcomes associated with transfers in care

61. *See supra* note 35 and accompanying text.

62. AM. MED. ASS'N, REPORT OF THE COUNCIL ON MEDICAL SERVICE 6 (2009), available at <http://www.ama-assn.org/resources/doc/cms/a09-cms-rpt-8.pdf> (last visited Feb. 17, 2013).

63. AM. HOSP. ASS'N, PATIENT-CENTERED MEDICAL HOME: AHA RESEARCH SYNTHESIS REPORT 2 (2012), available at <http://www.aha.org/research/cor/patient-centered/index.shtml>.

64. *E.g.*, BCBSNC and UNC Health Care Open Carolina Advanced Health, BLUECROSS BLUESHIELD OF N.C. (Dec. 7, 2011), <http://www.bcbsnc.com/content/providers/news-and-information/news/dec7a-2011.htm>.

65. *E.g.*, Peter Cunningham et al., *Safety-Net Providers in Some US Communities Have Increasingly Embraced Coordinated Care Models*, 31 HEALTH AFF. 1698, 1698 (2012).

66. DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL HOME 2.0: THE PRESENT, THE FUTURE 6-7 (2010), http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_MedicalHome2_092210.pdf.

67. Lola Butcher, *Medical Homes Prepare the Way For Accountable Care Organizations*, MANAGED CARE (October 2011), <http://www.managedcaremag.com/content/medical-homes-prepare-way-accountable-care-organizations>.

settings, such as discharge from hospitals and lapses in Medicaid coverage. By ensuring that both providers and patients follow through with the best practices, care delivery can become more efficient. As CCNC has shown, addressing factors that lead to long-term care being needed can have a great impact on costs savings.

VI. CONCLUSION

The emergence of PCMHs offers an opportunity for meaningful primary-care reform that could help bring down the quickly rising costs of long-term care. By implementing PCMHs into their Medicaid programs, the states can derive significant savings that will ease what has already become a large burden on their budgets. With the federal government providing funding to implement such changes and an eagerness on the part of all of Medicaid stakeholders to participate, the timing is right for the transition to a PCMH model. The savings that North Carolina has made as a result of implementing CCNC can serve as a model for the states to work toward tackling the issues that lead to significant long-term care costs. If the states are successful in doing so, it will benefit not only Medicaid funding or their general state budgets, but to society as a whole.