

# THE LAW AS HEALER: HOW PAYING FOR MEDICAL-LEGAL PARTNERSHIPS SAVES LIVES AND MONEY

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# Executive Summary

Health outcomes are worse in the United States than in other developed nations. Why? One reason is that as a nation, we spend less on ameliorating social problems that often result in poor health. Funding streams for health care are deep but narrow, and are rarely able to cover the cost of non-medical needs such as safe, affordable housing or healthy food. But the best evidence confirms these social determinants of health have a bigger impact on population health outcomes than access to medical care.

Despite the inflexibility of health care funding, the good news is that many of the social needs that influence health are guaranteed by law. The bad news is that these laws are either unenforced, or enforced unequally. Therefore, vulnerable individuals often face an impossible situation when they require legal assistance in order to gain access to social supports essential for healthy living, but cannot find or afford an attorney to represent their cause. Millions of Americans are caught in this trap, with one in six people needing legal assistance in order to be healthy.

Families need help fighting unlawful eviction and compelling landlords to fix building code violations that produce substandard living conditions. Victims of domestic violence need protective orders and advocates to keep themselves and their children safe. Workers, and sometimes entire communities, need help to protect them from toxins or environmental hazards. It is precisely these people and groups with the greatest social needs who are least likely to be able to access the legal services required to address them. For these populations, lawyers, working together with health professionals, are healers.

Innovative Medical-Legal Partnerships (MLPs) are designed to strengthen the social determinants of health among low- and moderate-income patients, using the force of law. Specifically, MLPs integrate civil legal aid lawyers into the primary care clinical setting, allowing doctors and lawyers to work together to secure better health preventively, by strengthening legally-protected social supports.

In this paper, I first review the mounting empirical evidence that MLPs can reduce health care costs and improve the quality of health outcomes. I then make seven policy recommendations for stakeholders to work toward payment models that will sustainably pay for MLPs and other interventions that address health-harming social risks. The first three recommendations relate to the use of existing financing vehicles to pay for MLP services. The next two focus on necessary reforms through CMS and its newly formed Physician-Focused Payment Model Technical Advisory Committee (PTAC). Finally, two recommendations are directed toward state and local governments.

## Recommendations for Using Existing Financial Vehicles

1. More health centers should finance MLPs as an “enabling” or “wrap-around” service under Section 330 of the Public Health Services Act;
2. Medicaid managed care organizations should use the Centers for Medicare & Medicaid Services’ “in lieu of” financing to pay for MLPs; and

3. Established MLPS should expand their use of bundled payment models that a few partnerships already successfully employ.

## CMS Recommendations

4. Physicians should propose episode payment and condition-based payment models to the PTAC to cover MLP services ordered by eligible professionals; and
5. CMS should add new Medicare quality metrics in medical homes, ACO and ACH payment models to incentivize providers to incorporate MLP services in private managed care contracts.

## State Government Recommendations

6. States should invest in long-term public and private financing options; and
7. State and local government agencies should experiment with blending and braiding strategies such as social impact bonds.

MLPs are emerging as an evidence-based intervention that produces quantifiable results on both individual and population levels. The recommendations in this paper aim to make it financially feasible for MLPs to provide an attorney to every patient in this country who has an unresolved civil legal issue standing between them and the opportunity to live a healthy life.

# Introduction

Populations—especially vulnerable ones—need much more than good health care to be healthy. As a policy matter, this fact means that American health care will continue to underperform<sup>1</sup> and outspend other nations<sup>2</sup> unless we expand the current model to include innovations that address the social as well as medical determinants of health.<sup>3</sup> This paper focuses on how to pay for them.

There is no shortage of good ideas. Numerous delivery innovations have been implemented on a small scale to address patients' social risks. However, none of these interventions have been brought to scale despite evidence some could significantly improve population-level health outcomes.<sup>4</sup> This lack is due in large part to the absence of sustainable financing to support long-term social interventions in medical settings. This white paper recommends approaches to sustainably finance one such intervention designed and shown to mitigate several social risks—the medical-legal partnership (MLP).

The MLP is a health care delivery model that integrates civil attorneys into the clinical setting to address legal problems that adversely affect patient health. The MLP is an ideal example of an underutilized health care delivery innovation because it demonstrably improves access to several social determinants of health. Also, the national proliferation of the MLP approach provides a broad evidentiary base of the model's performance in a variety of clinical settings, patient populations, and geographic regions.

The concept is not new. Dr. Jack Geiger formed a precursor to the MLP in 1967 to address Mississippi patients' food and housing problems. In the 1980s, health care institutions began working closely with civil legal aid attorneys to confront the AIDS crisis.<sup>5</sup> Dr. Barry Zuckerman founded the nation's first MLP with the Boston Medical Center in 1993.

Today, MLPs operate in 155 hospitals, 139 health centers, and 34 health schools across the country. Several observational studies outline the MLP's benefits, which include improving patient health and quality of care while reducing healthcare costs. Moreover, the MLP has been shown to meaningfully address a range of social determinants to which vulnerable populations frequently

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1 World Health Organization. (2010). Ranking of the World's Health Systems. Retrieved from:

<http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-health-systems>

2 OECD Health Statistics. (2016). Current expenditure on health, percent of gross domestic product.

Retrieved from: <http://www.oecd.org/els/health-systems/health-data.htm>

3 Bradley, E. H., Elkins, B. R., Herrin, J. & Elbel, B. (2011). Health and social services expenditures: associations with health outcomes. *BMJ Quality & Safety*. <http://qualitysafety.bmj.com/content/early/2011/03/28/bmjqs.2010.048363.short>

4 MLPs have penetrated one provider market: The National Nurse-led Care Consortium (NNCC), a network of primary care clinics run by advance practice nurses (nurse practitioners), runs an MLP initiative to support adoption of the MLP approach in nurse-managed health centers. See, <http://medical-legalpartnership.org/wp-content/uploads/2016/04/Nurse-Led-MLP-Issue-Brief.pdf>.

5 A history of the medical legal partnership movement is available here: <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf>

lack access, including safe, affordable housing, stable income, and high-quality educational opportunities.

However, MLP funding is fragmented and mostly short-term, yet return on investment (ROI) analyses suggests the model's benefits exceed the costs required to run even mature MLPs. Consequently, MLPs have reached a tipping point. The model has demonstrated its potential to improve vulnerable populations' health, at a reasonable cost, by improving the social conditions in which they work, play and live, but MLPs can reach only small fraction of the populations that most benefit from their services, until they are sustainably financed.<sup>6</sup>

This paper proceeds in four parts. Part I describes the MLP approach with a focus on its relationship to the social determinants of health. Part II explains how the social determinants of health affect population health outcomes. Part III describes how MLPs affect the social determinants; here, we review the evidence that MLPs improve health outcomes for each legal service that MLPs provide. Part IV presents the core policy proposals for this paper and their justifications. Our financing proposals can be applied to other innovations that integrate non-medical services as part of primary healthcare delivery in order to better address the social determinants of population health.

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6 Recently, the national center for MLPs issued a report that contained the qualitative responses of over 250 MLP respondents nationally. Among the reports four recommendations, the drafters explained the need to “grow, improve, and sustain MLPs by building out critical infrastructure elements like diverse and stable funding streams.” See, Regenstein, M., Sharac, J. & Trott, J. (2016). The State of the Medical-Legal Partnership Field: Findings from the 2015 National Center for Medical-Legal Partnership Surveys. National Center for Medical-Legal Partnerships. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf>

# I. What is a Medical-Legal Partnership?

Medical-legal partnerships help low income and underserved populations improve their health and health care by addressing legal issues that adversely affect their health. First, MLP attorneys change traditional delivery systems so that health providers routinely screen patients to identify unmet legal needs that harm health. An example is a family living in an apartment with levels of lead in paint, soil, or water that violate federal safety standards. Next, MLPs integrate lawyers as members of the health care delivery team to address legal problems collaboratively with providers. For example, physicians and attorneys work together to compile evidence to support patients in negotiations, as well as in legislative, administrative, or judicial hearings. However, the overwhelming majority of lawyers in MLPs across the country are part of publicly-funded legal aid offices, or are funded by law school or philanthropic grants for work on MLP cases.

Most of the nation's 300 MLPs are unsustainably financed. The MLP approach is founded on the premise that addressing patients' income, housing, education, personal safety, and other legal problems<sup>7</sup> will improve health outcomes.<sup>8</sup> Most often those legal needs concern inequitable access to medical care, or problems with one of the social determinants of health. MLPs are designed to bridge the gap between unaddressed legal issues that exacerbate patients' health problems, and the medical provider who is treating patients' health problems.<sup>9</sup> MLPs train clinicians to screen patients for health-harming legal needs, and work through in-clinic attorneys to address those needs preventively. In contrast, providers in most traditional health care settings discover a patient's social needs only after the patient is in crisis (e.g. evicted, without heat, suffering elevated blood lead levels), if at all. The physician practicing in a traditional setting may refer that patient to an attorney outside the clinic. But because that attorney is unrelated to the clinic, unaware of the health impacts caused by the legal crisis, and likely under-resourced, resolution of the legal issue may be slow, and the associated adverse impacts on patient health may be prolonged.

MLP attorneys provide three core services.<sup>10</sup> First, MLP lawyers provide legal representation to address adverse social conditions for which there are legal remedies, and which have the potential to improve patient health. Examples include requiring landlords to remove lead paint, toxins or mold, appealing wrongful public benefit terminations, and enforcing educational accommodations for disabled children. Second, MLPs transform health and legal institutional practices by training clinical providers to screen for and identify patients' social and legal needs during office visits. The goal is to identify these needs while they may be addressed preventively in the same way

7 The MLP acronym for this list of legal issues MLPs address is "I-HELP." See, <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

8 See, National Center for Medical Legal Partnership, "The Need for Medical-Legal Partnership," here: <http://medical-legalpartnership.org/need/>

9 See, National Center for Medical Legal Partnership, "The MLP Response," here: <http://medical-legalpartnership.org/mlp-response/>

10 See, National Center for Medical Legal Partnership, "How MLP Works: A Utilities Case Study," here: <http://medical-legalpartnership.org/mlp-response/how-medical-legal-partnership-works/>



that physicians seek to provide preventive rather than crisis medical care. Third, MLPs advocate for structural policy changes at an institutional, local, state, and federal level. MLP attorneys bring a “patient-to-policy” perspective, identifying needs in the communities they serve, and then working to improve policies and laws that impact those communities and ultimately, the social determinants of individual and population health.

Some MLPs serve the needs of an identifiable population. LegalHealth in New York City, for example, is an MLP that partners with public hospitals to help veterans maintain stable housing, obtain VA disability benefits and access mental health services to cope with trauma after their return home from battlefield service. In Cincinnati, Ohio, an MLP called Child HeLP addresses substandard housing conditions that thwart children’s recovery from asthma and other chronic conditions. Child HeLP also addresses custody, family violence, special education, and public benefits issues that present upstream barriers to children’s health and well-being. Other MLPs serve a general population, while still others specialize in a particular type of legal problem. The majority of MLPs serve children (59 percent). Three-quarters of the health organizations that partner with MLPs are located in underserved areas; in 2015, 84 percent had at least a quarter of their patients on Medicaid and 47 percent have an uninsured patient population. A substantial number of MLPs also serve immigrants, the elderly, veterans, Native Americans, or adult patients with high-utilization rates.

A few MLPs are known for effective policy advocacy on a specific public health legal issue. However the movement has not succeeded generally at elevating the approach from the individual case-by-case level, to a public health tool that affects population health. A few exceptions stand out. The Health Justice Project (HJP) in Chicago is an example of an MLP that effectively improves population health. HJP received frequent reports of children with elevated blood lead levels in its affiliated clinics. In response, the MLP fought to require the Chicago Housing Authority to lower the level of lead poisoning in children that would trigger a mandatory assessment of the need for lead abatement. Moreover, this MLP partnered with legal aid groups, health experts, and providers to file a petition for rulemaking. The result was that the United States Department of Housing and Urban Development announced amendments to improve protections for children in public housing under the “Lead Based Paint Poisoning Prevention in Certain Residential Structures” regulations.<sup>11</sup>

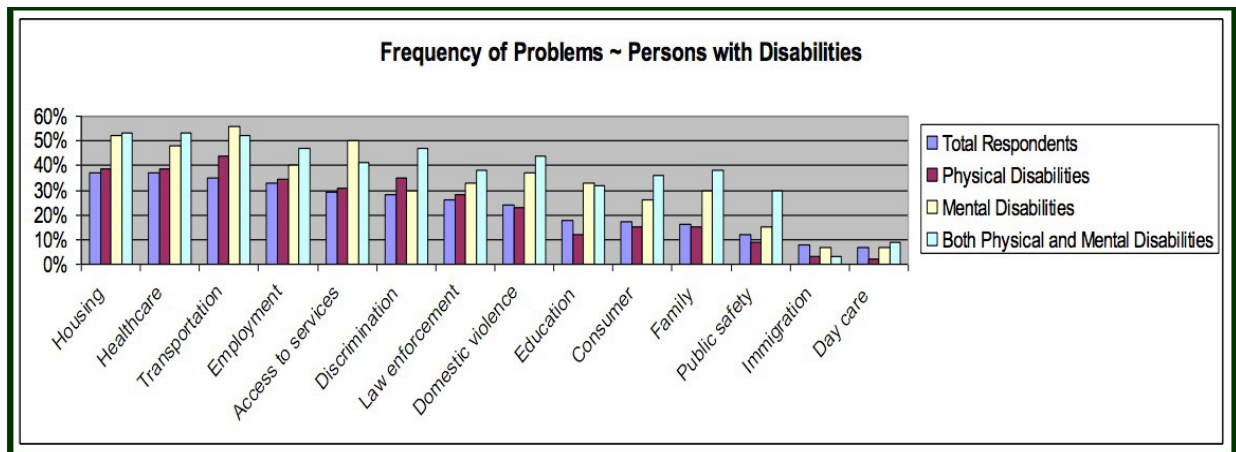
In another case, MLP staff and health care providers responded to the high frequency of patients in their clinic experiencing utility shut-off notices. That MLP included a form letter in the health care center’s electronic medical records for clinicians to access, sign and submit efficiently. Attorneys from this MLP also testified before state regulators based on the medical consequences of utility shut-offs. The outcome was change in regulations that reduced the need for chronic disease re-certification to prevent utility shut-offs and allowed nurses to sign shut-off appeal letters.

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<sup>11</sup> 24 C.F.R. 35.



**Figure 1. Frequency and type of problems identified by low-income Minnesota residents (2014)**



Source: Overcoming Barriers That Prevent Low-Income Persons from Resolving Civil Legal Problems. *Bench & Bar of Minnesota*.

The need for MLP representation is particularly acute among the poor. Studies consistently show that low income people have significantly more unresolved civil legal problems than higher income people, and that low income people are less likely to obtain legal assistance for their problems.<sup>12</sup> As a result, 70 to 90 percent of the legal needs related to housing, family, and consumer issues that low-income families face go unaddressed. In a qualitative study of Minnesota’s low income population, the intersection between physical and mental disability and these unresolved legal issues was clearly shown in data that is representative of populations around the country. As shown in Figure 1 below, housing and healthcare problems were the leading problems that poor people with physical or mental disabilities encountered, and the vast majority of all problems they identified would likely require legal services such as litigation to resolve.<sup>13</sup> For example, lawyers may help address unhealthy employment conditions, inadequate educational accommodations for disabled students, immigration and transportation barriers to accessing health care or environmental claims that traffic routes unfairly expose vulnerable communities to harmful pollution.

Un-represented (or *pro se*) litigants in civil matters suffer much worse outcomes than those with legal representation.<sup>14</sup> Indeed, Secretary of Health and Human Services Sylvia Mathews Burwell has explained, “civil legal aid ensures that more Americans have access to good nutrition, safe housing and other basic human necessities that are essential to overall health and well-being.”<sup>15</sup>

12 Greene, S. S. (2016). Race, Class, and Access to Civil Justice. *Iowa Law Review*, (101): 1263-1321.

13 Lieberman, H. (2011). Overcoming Barriers That Prevent Low-Income Persons from Resolving Civil Legal Problems. *Bench & Bar of Minnesota*. Retrieved from: [http://www.mncourts.gov/Documents/0/Public/administration/Final\\_MN-CABS\\_Study\\_September\\_2011.pdf](http://www.mncourts.gov/Documents/0/Public/administration/Final_MN-CABS_Study_September_2011.pdf)

14 Engler, R. (2009). Connecting Self-Representation to Civil Gideon: What Existing Data Reveal About When Counsel is Most Needed. *Fordham Urban Law Journal*, (37). Retrieved from: <http://ir.lawnet.fordham.edu/ulj/vol37/iss1/2/>

15 White House Legal Aid Interagency Roundtable. (2016). “Expanding Access to Justice, Strengthening Federal Programs.” First Annual Report of the White House Legal Aid Interagency Roundtable.

The unifying concept that underlies the MLP model is that legal intervention provides services to vulnerable patients that address poor health outcomes by mitigating risks known as the social determinants of health.

## II. What Are Social Determinants of Health?

Social determinants are the economic and social conditions that shape individual and population health. While social scientists recognize five factors that may contribute to health outcomes,<sup>16</sup> the social factors which include the social environment (e.g. income, gender, disability, and race discrimination), the physical environment (neighborhood and living conditions), and access to health care have at least as strong an association with poor health outcomes as genetics, biology, or effects of individual behaviors related to diet, smoking, exercise, or alcohol consumption.<sup>17</sup> Therefore, policy interventions that address the social determinants of health are essential to improving population health.

The World Health Organization (WHO) compiled the first comprehensive evidence of the association between social determinants and population health in 1998 based on clear evidence of the inverse relationship between socioeconomic status and poor health.<sup>18</sup> The evidentiary basis for the association WHO spotlighted can be traced to “The Whitehall Studies,” a pair of analyses from the UK that identified an inverse relationship between the social status of British civil servants—all of whom obtained health care through the National Health Service—and their relative risk of morbidity and mortality. The Whitehall studies compiled over 15 years of longitudinal data for a cohort of over 10,000 study participants. The data showed that shorter life expectancy and most diseases occur more commonly further down the social ladder, less commonly in the middle-class, and least among upper-class populations. This relationship, called the “social gradient,” reflects the fact that people with lower socioeconomic status (SES) bear at least twice the risk of shorter life expectancy and disease morbidity than people with higher socioeconomic status (SES).<sup>19</sup> The major contribution of the Whitehall studies was to confirm that psychosocial conditions at work, home, and in communities account for the social gradient.

More recently, researchers have attempted to identify causal mechanisms that link specific social determinants to poor health outcomes. Several studies have linked mortality and poverty,<sup>20</sup> as well as mental health and more specifically income inequality with health disparities.<sup>21</sup>

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16 McGovern, L., Miller, G. & Hughes-Cromwick, P. (2014). The Relative Contribution of Multiple Determinants to Health Outcomes [Policy Brief]. *Health Affairs*. Retrieved from: [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_123.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf)

17 Forchuk, C., Dickins, K. & Corring, D. J. (2016). Social Determinants of Health: Housing and Income. *Healthcare Quarterly*, (18)SE: 27-31. See also, Heiman, H. J. & Artiga, S. (2015). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity [Issue Brief]. Kaiser Family Foundation. Retrieved from: <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

18 Wilkinson, R. & Marmot, M. (Eds.) 2003. *Social Determinants of Health: The Solid Facts* (2nd ed.). World Health Organization: Denmark. Retrieved from: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/98438/e81384.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf)

19 Marmot, M. & Brunner, E. (2005). Cohort Profile: The Whitehall II Study. *International Journal of Epidemiology*, 34(2): 251-256.

20 Brooks-Gunn, J. & Duncan, G.J. (1997). The Effects of Poverty on Children. *Children and Poverty*, 7(2): 55-71.

21 Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, 365(9464): 1099-1104.

Other researchers have identified poor housing conditions,<sup>22</sup> stressful work environment,<sup>23</sup> and educational disparities<sup>24</sup> as social mechanisms that have a deleterious impact on health. Importantly, health behaviors such as smoking, alcohol consumption and drug use have been associated with poor social conditions such as low income<sup>25</sup> and low educational attainment. The causal relationship between these social risks is a matter of debate. However, the association between social risks and inferior health outcomes has been quantified by some researchers who purport to show these risks are a mechanism by which health inequities occur.

Estimating the contribution a social risk factor makes to particular health outcomes is complex. Disease and injury may be linked to multiple potential causal factors. Measuring the impact of social determinants is further complicated by confounding differences in populations being compared, the importance of intergenerational or life-course perspectives, data availability, and the timing of impacts and outcomes measured. Vulnerable patient populations may not readily present themselves for data collection for several reasons including historically informed distrust of medical researchers. Also, causality is bi-directional. While social risk factors can cause poor health, poor health can lead to lower income and educational attainment.

Despite these challenges, several researchers have estimated relative contributions of social risk factors to morbidity and mortality. For example, researchers David Cutler and Adriana Lleras-Muney estimated that, using a three percent discount rate, a year of education raises earnings by approximately 10 percent in the United States, reduces the risk of heart disease by 2.16 percentage points, reduces the risk of diabetes by 1.3 percentage points, and increases life expectancy by 0.18 years. Sandro Galea and colleagues estimate that approximately 245,000 U.S. deaths in 2000 were attributable to low education, 176,000 to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, 119,000 to income inequality, and 39,000 to area-level poverty.<sup>26</sup> While the methods to accurately quantify the impact of each social determinant on adverse health outcomes are still evolving, medical-legal partnerships have been shown to improve the association between each of these upstream social determinants, and downstream patient health outcomes.

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22 Krieger, J. & Higgins, D. L. (2002). Housing and Health: Time Again for Public Health Action. *American Journal of Public Health*, 92(5): 758–768.

23 Siegrist, J. (1996). Adverse health Effects of High-Effort/Low-Reward Conditions. *Journal of Occupational Health Psychology*, 1(1): 27-41.

See also, Robert Wood Johnson Foundation, (March 2013) "How Does Employment, or Unemployment Affect Health?"

24 Zimmerman, E. B., Woolf, S. H. & Haley, A. (2015). Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. *Agency for Healthcare Research and Quality*. Retrieved from: <http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html>

25 Smoking prevalence of blue collar workers is double that of white collar workers. This difference may be explained by the additional psychological stressors low income brings (Sorensen, Barbeau, Hunt, & Emmons, 2004; Barbeau, Krieger, & Soobader, 2004).

26 Galea, S. et al. (2011). Estimated Deaths Attributable to Social Factors in the United States. *American Journal of Public Health*, 101(8): 1456-1465

# III. Medical-Legal Partnerships and the Social Determinants of Health

Low-income Americans report having a broad range of civil legal problems,<sup>27</sup> but limited access to attorneys who can help address them.<sup>28</sup> MLPs selectively screen patients to address legal issues that fit within a list of “health-harming civil legal needs.” These are summarized by the acronym “I-HELP.”<sup>29</sup> The acronym stands for the categories of civil legal problems that MLP attorneys handle: income supports, housing, education and employment, legal status (e.g. immigration, divorce, custody), and personal safety. This section summarizes the type and extent of the health harm represented by each type of need or social determinant, the legal services that MLPs provide, and evidence of the impact that medical-legal partnerships have on health.

Economic hardship adversely affects health. Moreover, the health effects of economic insecurity are mediated by economic policies.<sup>30</sup> Factors that contribute to economic insecurity include unemployment, working conditions at an undesirable job, income loss due to structural economic changes, and low wage rates that result in being unable to pay one’s bills. These economic risk factors are associated particularly strongly with adverse mental health outcomes. Moreover, low-income people who experience economic insecurity are more likely to have high blood pressure, high cholesterol, diabetes, and obesity. In short, the association between income instability and poor health is clear and well-documented.

## 1. Income and Insurance

Income insecurity is also associated with increases in the incidence of poor health behaviors such as smoking, excessive alcohol consumption, and drug use. Admittedly, there is some evidence that individual and community characteristics may contribute to the ability to experience positive health outcomes despite economic disadvantage,<sup>31</sup> particularly within immigrant populations.<sup>32</sup>

However, the interaction among low-socioeconomic status, health behaviors, and health outcomes is complex and only partly understood by researchers.<sup>33</sup> It has been shown, for example, that

27 Legal Services Corporation. (2009). Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans. Retrieved from: [http://www.americanbar.org/content/dam/aba/migrated/marketresearch/PublicDocuments/JusticeGainAmerica2009\\_authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/migrated/marketresearch/PublicDocuments/JusticeGainAmerica2009_authcheckdam.pdf)

28 National Center for Access to Justice. (2016). The Justice Index, 2016. Fordham Law School. Retrieved from: <http://justiceindex.org/2016-findings/attorney-access/>

29 National Center for Medical Legal Partnership. (n.d.) How Civil Legal Aid Helps Health Care Address SDOH. Retrieved from: <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

30 Catalano, R. (1991). The health effects of economic insecurity. *American Journal of Public Health*, 81(9): 1148-1152.

31 Mechanic, D. & Tanner, J. (2007). Vulnerable People, Groups, and Populations: Societal View. *Health Affairs*, 26(5): 1220-1230.

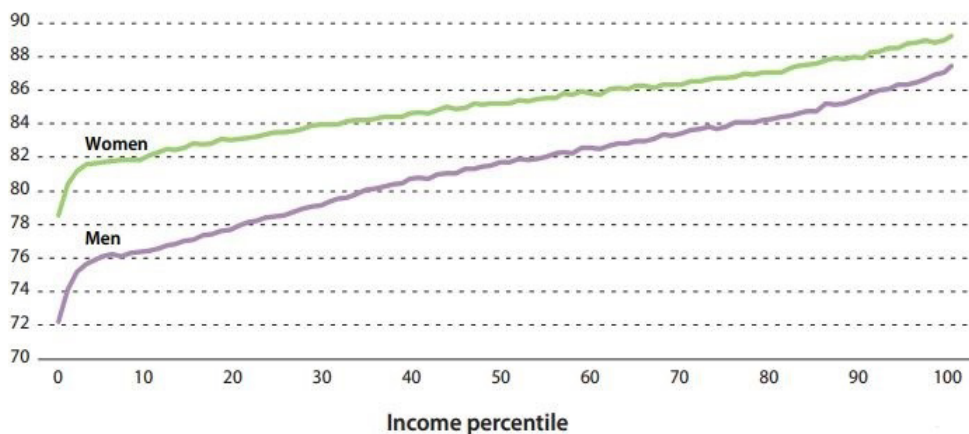
32 Franzini, L. & Fernandez-Esquer, M. E. (2004). Socioeconomic, Cultural, and Personal Influences on Health Outcomes in Low Income Mexican-Origin Individuals in Texas. *Social Science & Medicine*, 59(8): 1629-1646.

33 Adler, N. E. & Newman, K. (2002). Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*, 21(2): 60-76.

income insecurity increases stress,<sup>34</sup> which can lead to poor health behaviors. Also, environment and social context influence have an effect on health behaviors. Therefore, policy solutions must take the social circumstances of target audiences into account.<sup>35</sup>

Income insecurity threatens all aspects of life from the families' ability to buy healthy food to their mental health.<sup>36</sup> The American Academy of Pediatrics has noted that the health effects of poverty on U.S. children include direct impacts from the inability to meet basic food and housing needs leading to malnutrition, chronic infection, and mental health problems. The financially insecure are more likely to have obese children. Income insecurity is also associated with indirect harms such as domestic abuse or neglect that can arise as a byproduct of increased family stress. The long-term consequences on children and adults, of one year of child maltreatment in the United States, are estimated to increase direct health care costs by \$150 billion.<sup>37</sup> The most telling data summarizing these various health effects of income insecurity is the well-documented association between income and life expectancy.<sup>38</sup>

**Figure 2. Expected age of death for 40-year-olds, by gender and household income percentile**



Source: Chetty et al. 2016.

Note: Sample pools individuals who turn 40 during the period 2001–14.

Source: Schanzenbach, D. W., Nunn, R. & Bauer, L. (June 2016). The Changing Landscape of American Life Expectancy. *The Hamilton Project*. Brookings Institution. Retrieved from: [http://www.hamiltonproject.org/assets/files/changing\\_landscape\\_american\\_life\\_expectancy.pdf](http://www.hamiltonproject.org/assets/files/changing_landscape_american_life_expectancy.pdf); Chetty, R. et al. (2016). The association between income and life expectancy in the United States, 2001-2014. *Journal of the American Medical Association*, 315(16): 1750-1766.

34 Mani, A., Mullainathan, S. et al., (2013). Poverty Impedes Cognitive Function. *Science*, 341(6149): 976-980.

35 Adler and Newman, *Id.* at 69.

36 Rose, D. (1999). Economic Determinants and Dietary Consequences of Food Insecurity in the United States. *Journal of Nutrition*, 129(2S Suppl): 517S-520S.

37 Fang, X. et al. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, 36(2): 156-165.

38 Chetty, R. et al. (2016). The association between income and life expectancy in the United States, 2001-2014. *Journal of the American Medical Association*, 315(16): 1750-1766.



Beyond economic insecurity, researchers have also found that income inequality appears to be bad for health outcomes. A study by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation concluded that people in income unequal communities are more likely to die before age five than people in more equal communities even if the average incomes were the same in both communities.<sup>39</sup> Indeed, sociologist Nancy Krieger argues that public health interventions may exacerbate health inequalities if they are not accessible and acceptable to economically and politically disadvantaged groups.<sup>40</sup>

There is evidence that when MLPs advocate for improved access to insurance, benefits, and fair employment conditions, these attorneys also address economic inequality for low-income populations. Research has shown that when MLP attorneys address legal barriers to improved income and income supports, their low-income clients experience better health outcomes. In a randomized clinical trial to analyze the effect of providing MLP-led support to newborn infants and their families, Robert Sege found that the MLP intervention was associated with improved access to income supports for low-income families, as well as a better quality of preventative care.<sup>41</sup> The Sege study involved 330 families from an urban safety-net hospital serving a large Medicaid patient population. Families were randomly assigned to receive either assistance through a family specialist trained and supported by a Boston medical-legal partnership, or an unrelated safety intervention.

At the outset, 73 percent of families reported economic hardships. More than half (61 percent) reported food insecurity, 28 percent reported they were unable to pay rent or mortgage during the previous 12-months, 42 percent reported missing a payment for gas, electricity or water utilities, twelve percent reported a utility shut-off for failure to pay, and almost half (44 percent) reported their telephone service had been disconnected for failure to pay sometime during the previous year. The MLP intervention accelerated access to concrete income supports for newborn babies and their families. At six- and twelve-month post-intervention surveys, significantly more patients in the MLP group had obtained income, utility, housing, and food assistance than patients in the control group. For example, twelve months after the birth of their children, 21.1 percent of families had obtained income assistance compared to 18.8 percent of control families (p value = .029). Because prior research confirms that concrete support in early months of a child's life may protect against child neglect and abuse by reducing parental stress, and may improve primary health care, the results from this study point out the impact that MLP income supports can have on child health outcomes.

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39 Sanger-Katz, M. (2015, March 30). Income Inequality: It's Also Bad for Your Health. *The New York Times*. Retrieved from: [http://www.nytimes.com/2015/03/31/upshot/income-inequality-its-also-bad-for-your-health.html?\\_r=0](http://www.nytimes.com/2015/03/31/upshot/income-inequality-its-also-bad-for-your-health.html?_r=0)

40 Krieger, N. (2001). Theories for social epidemiology in the 21st century: an ecosocial perspective. *International Journal of Epidemiology*, 30(4): 668-677.

41 Sege, R. et al. (2015) Medical-Legal Strategies to Improve Infant Health Care: A Randomized Clinical Trial. *Pediatrics*, 136(1): 97-106.



In another study, Stewart Fleishman and colleagues surveyed New York cancer patients before and after they received legal assistance from a medical legal partnership. The pilot survey found that 75 percent of the patients interviewed said the MLP services reduced stress, 30 percent said the services helped them maintain their cancer treatment regimen, and 45 percent said the services had a positive effect on their financial situation.<sup>42</sup> The Fleishman pilot study included case studies to describe the mechanisms by which legal responses to patients' financial problems could help patient health outcomes. For example, MLP lawyers intervened on behalf of one patient to address creditors' illegal collection practices and help the patient avoid bankruptcy. As a result, the patient and family were better able to budget and pay for food and medical services; they also reported better rest and medical adherence.

A 36-month prospective cohort study of medical legal partnership impacts by Dana Weintraub and colleagues demonstrated the association between MLP services that improve income supports and health behaviors.<sup>43</sup> Weintraub completed baseline and six-month follow-up assessments of families in a Stanford affiliated hospital MLP. The results demonstrated that after the MLP intervention, a significant proportion of families better utilized food and income supports available to them to relieve financial insecurity, and a significant number reported they no longer avoided seeking health care due to lack of insurance or cost concerns. Moreover, the Weintraub group found a significant reduction in the proportion of children with recent hospitalizations after the MLP intervention. Taken together, these three studies provide examples of the primary mechanisms by which medical-legal partnerships address income insecurity that adversely impacts health.

## 2. Housing and Neighborhood

MLP attorneys have addressed three types of housing issues: substandard housing, housing affordability, and discrimination by landlords, lenders, and real estate brokers against legally protected populations. MLPs indirectly address health-harming impacts at the neighborhood level as well. This section includes examples of each type of housing issue the MLP intervention addresses, and evidence of the health impacts that these MLPs have had.

### *Substandard Housing*

Housing is an important direct and indirect determinant of health that MLPs address. Numerous studies associate poor housing conditions with a broad range of health problems including asthma, lead poisoning, developmental delays, heart disease, and neurological disorders.<sup>44</sup>

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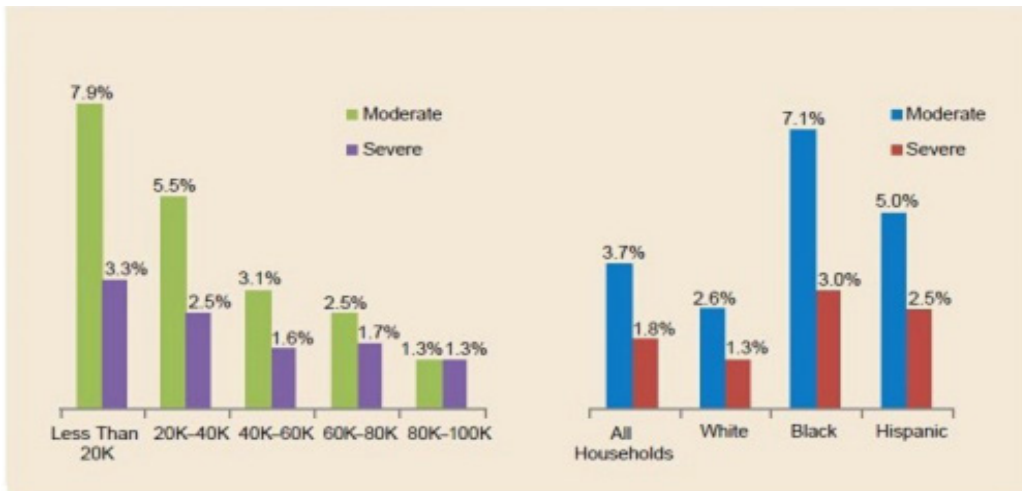
42 Fleishman, S. B., et al (2006). The Attorney As the Newest Member of the Cancer Treatment Team. *Journal of Clinical Oncology*, 24(13): 2123-2126.

43 Weintraub, D. et al. (2010). Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients. *Journal of Health Care for the Poor and Underserved*, 21: 157-168.

44 Desmond, M. & Bell, M. (2015). Housing, Poverty, and the Law. *Annual Review of Law and Social Science*, (11): 15-35.

More than one researcher has called the state of inadequate housing in poor American communities a “public health crisis.”<sup>45</sup> Two million people nationally occupy homes with severe physical problems, while 4.8 million occupy homes with moderate physical problems.<sup>46</sup> Annually, 13.5 million non-fatal injuries occur in and around U.S. homes; 2,900 people die in house fires, and two million people visit the emergency room for asthma related illness. One million children in the U.S. have blood lead levels higher enough to adversely affect their intelligence, development, and behavior. Failure to address the public health threat that lead represents to children’s health is a financially shortsighted decision.<sup>47</sup>

**Figure 3. Inadequate housing among households with children, by race and annual income<sup>48</sup>**



Source: United States Census Bureau, 2011. American Housing Survey National and Metropolitan Public Use File.

The National Center for Healthy Housing reports that 35 million metropolitan homes in the United States have one or more health and safety hazards such as lack of safe drinking water, ineffective waste disposal, and pest infestation, which leads to infectious disease.<sup>49</sup> Damp, cold, mold, toxins and allergens lodged in old carpets and structural housing defects such as leaking pipes have been epidemiologically associated with asthma and chronic respiratory symptoms, even after controlling for confounding factors such as income, smoking, and crowding.

45 Bashir, S. A. (2002). Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis. *American Journal of Public Health*, 92(5): 733–738.

46 Krieger & Higgins. *Housing and Health: Time Again for Public Health Action*.

47 Gould, E. (2009). Childhood Lead Poisoning: Conservative Estimates of the Social and Economic Benefits of Lead Hazard Control. *Environmental Health Perspectives*, 117(7): 1162-1167.

48 United States Department of Housing and Urban Development, Office of Policy Development and Research. (Fall 2014). Housing’s and Neighborhoods’ Role in Shaping Children’s Future. *Evidence Matters*. Retrieved from: <https://www.huduser.gov/portal/periodicals/em/fall14/highlight1.html>

49 National Center for Healthy Housing. (2013). 2013 State of Healthy Housing. Retrieved from: the NCHH website: <http://www.nchh.org/policy/2013stateofhealthyhousing.aspx>

The American Housing Survey reports that in 2011, 10 percent of renters reported being “uncomfortably cold for 24 hours or more” because of broken heating systems. Poor rural populations are particularly susceptible to living conditions that lack basic plumbing; 30 percent of the nation’s rural housing stock lacks piped hot and cold water in rural areas.<sup>50</sup>

Communities living along the U.S.-Mexico border and on Native American lands bear a disproportionate share of this burden of substandard housing. In a 2007 report, the CDC estimated that 14 million children below age six live in housing built before 1960, containing lead-based paint hazards; 35 percent of units occupied by low income families have lead-based paint and 19 percent of modest income housing is affected by lead.<sup>51</sup>

Laws that regulate these housing and safety situations tend to be under-enforced in low-income communities. For example, the data describing prevalent housing problems cited here prevails despite the fact that all states except Arkansas have legislatively recognized that an implied warranty of habitability protects tenants. Some scholars have argued that improving building code enforcement will increase the cost of housing and harm poor tenants;<sup>52</sup> however, the empirical evidence for this position is weak.<sup>53</sup> In contrast, substantial evidence shows that legal representation improves housing code enforcement,<sup>54</sup> and further that code enforcement can improve health. The majority of tenants in housing courts nationally do not have legal representation, while most landlords have attorneys.<sup>55</sup>

Diana Hernández compared qualitative data for 72 families to examine the mechanisms through which MLPs work to resolve housing problems that fell into three categories: affordability, substandard conditions, and stability. Hernández’ study found that the interaction of physicians and lawyers in a patient centered medical home allowed MLP participants to resolve housing affordability (e.g. averting utility shut-off), adequacy (e.g. substandard conditions) and stability (e.g. eviction) problems more successfully than families without MLP assistance.<sup>56</sup>

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50 Housing Assistance Council. (2012). Taking Stock: Rural People, Poverty and Housing in the 21st Century. Retrieved from: [http://www.ruralhome.org/storage/documents/ts2010/ts\\_full\\_report.pdf](http://www.ruralhome.org/storage/documents/ts2010/ts_full_report.pdf)

51 Brown, M. J. (2002). Costs and Benefits of Enforcing Housing Policies to Prevent Childhood Lead Poisoning. *Medical Decision Making*, 22(6): 482-492.

52 Komesar, N. K. (1973). Return to Slumville: A Critique of the Ackerman Analysis of Housing Code Enforcement and the Poor. *The Yale Law Journal*, 82(6): 1175-1193.

53 Brower, M. A. (2011). The “Backlash” of the Implied Warranty of Habitability: Theory vs. Analysis. *DePaul Law Review*, 60(3): 849-894. Retrieved from: <http://via.library.depaul.edu/law-review/vol60/iss3/6>

54 Ortiz, P.C. (2014). How a Civil Right to Counsel Can Help Dismantle Concentrated Poverty in America’s Inner Cities. *Stanford Law & Policy Review*, 25(1): 163-191.

(The majority of tenants in housing courts nationally do not have legal representation, while most landlords have attorneys. Tenants’ vulnerability in housing court is exacerbated by the fact that as a group, unrepresented tenants are most often poor, female, and members of racial or ethnic minority groups. However, substantial evidence shows that when lawyers are present, tenants fare better in housing cases, with some reporting tenants are as much as nineteen times as likely to win if they are represented by counsel, in comparison to unrepresented tenants. Moreover, other studies show that represented tenants obtain more favorable settlements, fewer defaults, and more trial victories.)

55 R. Engler. Connecting Self-Representation to Civil Gideon: What Existing Data Reveal About When Counsel is Most Needed.

56 Hernández, D. (2016). ‘Extra oomph:’ addressing housing disparities through Medical Legal Partnership interventions. *Housing Studies*, 31(7): 871-890.

The Hernández study provides the best insight into MLPs' impact on housing improvements to date. This research team conducted interviews with low-income families who participated in MLPs and with a control group of families. Before the MLP intervention, 53 percent of these families reported living in inadequate housing, 33 percent were struggling to afford rent or utilities, and 14 percent reported housing instability because they were at risk of eviction and homelessness. An overwhelming majority—83 percent of families in this study who received the MLP services improved their housing conditions. Legal services helped reinstate or prevent utility shut-off, retain or regain housing subsidies, relocate to better residential environments, and appeal a rent hike. In contrast, the patients in the control group were less likely to resolve their need for safe, affordable housing; 64 percent of the control group patients and 17 percent of MLP patients did not resolve their housing problem during the study period.<sup>57</sup>

Andrew Beck and collaborators showed the density of housing code violations in census tracts is associated with population-level asthma morbidity and predicted hospitalized patients' risk of subsequent morbidity.<sup>58</sup> Moreover, Beck found that an MLP in Cincinnati, Ohio successfully intervened to enforce building ordinances requiring a landlord to make improvements in a large cluster of pest-infested apartments.<sup>59</sup> Mary O'Sullivan et al. linked an MLP's work compelling New York landlords to provide better living conditions with improved medical outcomes for a small cohort of adult patients with poorly controlled asthma.<sup>60</sup> In addition to improved breathing and reduced dependence on steroids, O'Sullivan measured a 91 percent reduction in ED visits and hospital admissions for inner city New York asthmatic adults after an MLP intervention. Finally, researchers estimated the financial value of public, education, health care, and housing benefits that an MLP in Georgia obtained for 313 pediatric asthma patients, over a seven-year period, equaled \$501,209.<sup>61</sup>

### *Housing Discrimination*

Residential segregation remains a fundamental cause of racial disparities in health and represents an opportunity for MLP intervention.<sup>62</sup> Segregation is defined as the geographical separation of people, primarily unrelated to personal preferences, based on ethnicity or race.

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57 National Low Income Housing Coalition (2016). Medical Legal Partnership Interventions Improve Access to Safe, Decent, Affordable Housing. Retrieved from: <http://nlihc.org/article/medical-legal-partnership-interventions-improve-access-safe-decent-affordable-housing>

58 Beck, A. F. et al. (2014). "Housing Code Violation Density Associated with Emergency Department and Hospital use by Children with Asthma." *Health Affairs*, 33(11): 1993-2002.

59 Beck, A. F. et al. (2012). Identifying and Treating a Substandard Housing Cluster Using a Medical-Legal Partnership. *Pediatrics*, 130(5): 831-838.

60 O'Sullivan, M. et al. (2012). Environmental improvements brought by the legal interventions in the homes of poorly controlled inner-city adult asthmatic patients: A proof of concept study. *Journal of Asthma*, 49(9): 911-917.

61 Pettigagno, R. et al. (2013). Can access to a medical-legal partnership benefit patients with asthma who live in an urban community? *Journal of Health Care for the Poor and Underserved*, 24(2): 706-717.

62 Williams, D. R. & Collins, C. (2011). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Report*, 116(5): 404-416.

Residential segregation is detrimental to health outcomes for minority populations.<sup>63</sup> This is because when black and Latino populations live in segregated neighborhoods, they are isolated from the resources white populations can access to protect and improve their health. Residential segregation relegates black and Latino populations to areas of lower quality housing, schools, food, employment, and recreational spaces as well as increased exposure to violence, environmental hazards, and disparate law enforcement practices.<sup>64</sup> Residential segregation is also associated with inferior access to health care providers and access to lower quality providers such as pharmacies with lower-quality inventories, clinicians with inferior training and experience, and hospitals with worse outcomes, older physical plants, and less medical equipment.<sup>65</sup> <sup>66</sup> Higher rates of racial segregation are associated with higher rates of adult and infant mortality,<sup>67</sup> coronary heart disease,<sup>68</sup> infectious disease such as tuberculosis,<sup>69</sup> and with poorer mental health,<sup>70</sup> even when researchers control for poverty rates. Residential segregation is also associated with higher homicide rates, one of the key drivers of the gap in black-white life expectancy.

Residential segregation is not merely an historic scar from America's past; blacks and Latinos today still live in highly segregated neighborhoods.<sup>71</sup> Modern segregation of blacks and whites is most pronounced in the Northeast and Great Lakes regions, and along the Southeastern seaboard.<sup>72</sup> It is important to note that controlling for socioeconomic status does not explain residential segregation. Affluent as well as low-income black families live in residentially-segregated neighborhoods. In large metropolitan areas, black families with annual incomes of \$100,000 or more are more likely to live in disadvantaged neighborhoods than white households making less than \$25,000 per year.<sup>73</sup> Although in absolute terms, there are more poor whites than blacks in the United States, most poor white people reside in close proximity to non-poor people, while most poor African Americans live in areas where the concentration of poverty is high. An

63 Sudano, J. J. et al. (2013). Neighborhood racial residential segregation and changes in health or death among older adults. *Health Place*, (19): 80-88.

64 Smith, M. R. & Petrocelli, M. (2001). Racial Profiling? A Multivariate Analysis of Police Traffic Stop Data. *Police Quarterly*, 4(1): 4-27. See also, Briggs, S. J. & Keimig, K. A. (2016). The Impact of Police Deployment on Racial Disparities in Discretionary Searches. *Race and Justice*, doi: 10.1177/2153368716646163

65 Skinner, J. et al. (2005). Mortality after acute myocardial infarction in hospitals that disproportionately treat black patients. *Circulation*, 112(17): 2634-2641.

66 Bach, P. B. et al. (2004). Primary Care Physicians Who Treat Blacks and Whites. *New England Journal of Medicine*, 351: 575-584.

67 LaVeist, T. (1993). Segregation, Poverty, and Empowerment: Health Consequences for African Americans. *The Milbank Quarterly*, 71(1), 41-64. See also, LaVeist, T. (2003). Racial Segregation and Longevity among African Americans: An Individual-Level Analysis. *Health Services Research* 38(6 Pt 2): 1719-1734.

68 Diez Roux, A. V. et al. (2001). Neighborhood of Residence and Incidence of Coronary Heart Disease. *New England Journal of Medicine*, 345: 99-106. See also, Fang, J. et al. (1998). Residential segregation and mortality in New York City. *Social Science & Medicine*, 47(4): 469-476.

69 Acevedo-Garcia, D. (2001). Zip code-level risk factors for tuberculosis: neighborhood environment and residential segregation in New Jersey, 1985-1992. *American Journal of Public Health*, 91(5): 734-741; Acevedo-Garcia, D. (2000). Residential segregation and the epidemiology of infectious diseases. *Social Science & Medicine*, 51(8): 1143-1161.

70 Aneshensel, C. S. & Sucoff, C. A. (1996). The neighborhood context of adolescent mental health. *Journal of Health and Social Behavior*, 37(4): 293-310.

71 Massey, D. S. (2016). Residential Segregation is the linchpin of racial stratification. *City and Community*, 15(1): 4-7.

72 Schwartz, D. F. (2016, March 16). What's the Connection Between Residential Segregation and Health? [Blog Post]. *Robert Wood Johnson Foundation*. Retrieved from: [http://www.rwjf.org/en/culture-of-health/2016/03/what\\_s\\_the\\_connectio.html](http://www.rwjf.org/en/culture-of-health/2016/03/what_s_the_connectio.html)

73 Eligon, J. & Gebeloff, R. (2016, August 20). Affluent and Black, and Still Trapped by Segregation. *The New York Times*. Retrieved from: [http://www.nytimes.com/2016/08/21/us/milwaukee-segregation-wealthy-black-families.html?\\_r=0](http://www.nytimes.com/2016/08/21/us/milwaukee-segregation-wealthy-black-families.html?_r=0)



analysis of the 171 largest U.S. cities showed that in not one of the cities studied did white people live in comparable ecological conditions to blacks in terms of poverty rates and the number of single-parent households.<sup>74</sup> These conditions include a disproportionate burden of pollution from hazards such as landfills, power plants, incinerators and interstate highways that are disparately proximate to poor and minority communities.

African Americans and Hispanics face discrimination in housing and mortgage markets, even after controlling for income.<sup>75</sup> Black and Latino borrowers face higher rejection rates and discrimination from lenders, and these rejections have been shown to be founded on differences related to race not income. Rather, studies show that modern practices continue the redlining practices that originated nearly a century ago, responding less often to minority loan inquiries, and providing less information when responses are sent. For example, in one study participants posing as borrowers were given white or black sounding names. The researchers found that 1.9 percent of loan officers declined to respond to black inquiries while responding to white clients. The study found white borrowers were given more information and treated with more friendliness so that the effect on black borrowers was approximately equal to the effect of having a credit score 71 points lower.<sup>76</sup>

Given the strong legal prohibitions against racial and ethnic discrimination, and the evidence that prohibited discrimination is a primary driver of residential segregation and its health-harming effects, MLP activity on these legal issues could be more robust. MLPs are active, however, protecting against non-racial forms of discrimination. For example, the Work & Family Medical Legal Partnership serves patients at San Francisco General Hospital's Women Health Center and the San Francisco Department of Public Health. This MLP ensures that low-income pregnant women can access employment-related legal protections such as disability leave, pregnancy and lactation accommodation, and paid time off for prenatal care appointments.<sup>77</sup> The Whitman-Walker MLP in Washington, D.C. helps transgender patients change names on their state-issued forms of identification as an entry back into regular primary care services, which this patient population had previously avoided because of discrimination concerns.<sup>78</sup> The Legal Clinic for the Disabled is an MLP that reports winning ADA accommodations for thousands of disabled patients in Philadelphia.<sup>79</sup>

74 Williams, D. R. & Collins, C. (2011). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Report* 116(5): 404-416.

75 Yinger J. (1997). *Closed Doors, Opportunities Lost: The Continuing Costs of Housing Discrimination*. New York, NY: Russell Sage Foundation.

76 Love, D. (2016, January 31). Study: Racial Discrimination In Mortgage Lending Continues To Impact African Americans, With A 'Black' Name Lowering One's Credit Score By 71 Points. *Atlanta Black Star*. Retrieved from: <http://atlantablackstar.com/2016/01/31/study-racial-discrimination-in-mortgage-lending-continues-to-impact-african-americans-with-a-black-name-lowering-ones-credit-score-by-71-points/>

77 See <http://las-elc.org/medical-legal-partnership>

78 Marple, K. (2014). Health + Legal Care: An Rx for Better Health Outcomes. Community Health Forum, *National Association of Community Health Centers*: 16-18. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-Health-Legal-Care-An-Rx-for-Better-Health-Outcomes.pdf>

79 Available at [https://www.paautism.org/desktopmodules/asert-api/api/item/ItemDetailFileDownload/3628/LCD\\_Talking\\_percent20Points\\_percent202015\\_percent20Intake\\_percent20Line.pdf](https://www.paautism.org/desktopmodules/asert-api/api/item/ItemDetailFileDownload/3628/LCD_Talking_percent20Points_percent202015_percent20Intake_percent20Line.pdf)

In all these examples, MLP health and legal partners are motivated to relieve housing discrimination in order to improve patient health. However, unlike other MLP services, empirical research does not yet show an association exists between these services and better patient health, despite the reasonable assumption the association does exist.

### *Housing Affordability and Homelessness*

Affordable housing improves MLP clients' health by alleviating crowding, freeing financial resources to pay for health care and food, and limiting exposure to environmental toxins. Also, increasing patients' household stability is associated with improved mental health.<sup>80</sup> A significant body of research supports these associations between affordable housing and health.

Adults living in housing they regard as unaffordable are more likely to say their health is fair or poor compared to similar people living in affordable housing. Cost-burdened adults or adults facing foreclosure are less likely to fill prescriptions or adhere to health treatments. Vulnerable populations such as children, the elderly, and racial minorities are most likely to be adversely affected. Frequent moves are associated with higher rates of behavioral and mental health issues among children.<sup>81</sup> Increases in housing costs have been associated positively with increased food insecurity among children.<sup>82</sup> Children with unstable housing are more likely to use emergency department services; children who move more have lower weight for their age, and adolescents are more likely to use drugs.

Seniors are more likely to have depression and adolescents are more likely to have anxiety/aggression when access to affordable housing is limited. The U.S. Department of Housing and Urban Development estimates that in 2015, approximately 500,000 people were unsheltered homeless; 40.4 percent of that population was black and 18.2 percent were over 61.

A Pennsylvania hospital conducted a pilot study in 2011-2012 and found that 95 percent of the "super-utilizers" had two or more civil legal problems responsible for their frequent use of emergency department and hospital inpatient services. The most common were substandard housing, impaired access to public income benefits, and domestic violence. In 2015, the U.S. Department of Veteran's Affairs collected survey data showing that five of the top ten unmet

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80 Maqbool, N., Viveiros, J. & Ault, M. (2015). The Impacts of Affordable Housing on Health: A Research Summary. *Insights from Housing Policy Research*. Retrieved from: [http://www2.nhc.org/HSGandHealthLitRev\\_2015\\_final.pdf](http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf)

81 Weiss, I. et al. (2012). Safe, Stable Homes Lead to Healthier Children and Families for Baltimore. *Children's HealthWatch*. Retrieved from: [http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing\\_brief\\_October2012.pdf](http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing_brief_October2012.pdf)

82 Fletcher, J. M., Andreyava, T. & Busch, S. H. (2009). Assessing the effect of changes in housing costs on food insecurity. *Journal of Children and Poverty*, 15(2): 79-93. See also, Kirkpatrick, S. I. & Tarasuk, V. (2011). Housing circumstances are associated with household food access among low-income urban families. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 88(2): 284-296.



needs that homeless male veterans face, and four of the top ten unmet needs faced by female veterans who are homeless require civil legal assistance.<sup>83</sup>

### 3. Education

Inferior educational opportunities produce poor health outcomes by decreasing human capital and cognitive skills, limiting employment and economic resources, and decreasing social networks.<sup>84</sup> Better educated people have lower morbidity rates from common acute and chronic illnesses, even after controlling for demographic and labor market differences.<sup>85</sup> While life expectancy is improving for all Americans, the gap between life expectancy for those with and without college education has widened.<sup>86</sup> In fact, when race and education are combined, the disparities in life expectancy are not only worsening but according to analysis “many may not catch up.”<sup>87</sup> Based on this and other evidence, medical legal partnerships represent an important intervention to address legal aspects of disparate educational opportunities that affect the health of young children and their families.”

MLP attorneys could use anti-discrimination laws to address educational inequality that results from disproportionate disciplinary practices which place black and Latino children at an early disadvantage. The U.S. Department of Education, Office of Civil Rights reported in 2016 that black pre-school children are 3.6 times more likely to receive out of school suspension than white preschoolers. Black children equal only 19 percent of enrollment but 47 percent of the children who receive one or more out of school suspension.

Students who suffer disabilities have been successfully helped by medical legal partnerships. MLP attorneys help to obtain individual education plans (IEPs) for students who qualify to receive academic accommodations but do not get them for a variety of reasons. In many cases, parents are unable to leave work to represent themselves at hearings, or navigate application requirements. In 2007, a study of children with parent-reported autism spectrum disorder diagnosis showed that between 12 percent and 20 percent of children with this diagnosis do not but are entitled by law to receive special services through IEPs. Foster children represent a vulnerable population that MLP attorneys have helped to gain access to educational accommodations required by law. In 2002, a half-million children were in foster care nationwide. A study found that over 6 percent of those children had special education needs, as compared to 2 percent of the population

83 United States Veteran’s Administration. (2015). Project CHALENG – Community Homelessness Assessment, Local Education and Networking Groups. Retrieved from: [http://www.va.gov/homeless/docs/chaleng/52015\\_CHALENG\\_2015\\_Fact\\_Sheet.pdf](http://www.va.gov/homeless/docs/chaleng/52015_CHALENG_2015_Fact_Sheet.pdf)

84 Zimmerman, E. B. et al. Understanding the Relationship Between Education and Health.

85 Cutler, D. M. & Lleras-Muney, A. (2006). Education and Health: Evaluating Theories and Evidence. (NBER Working Paper No. 12352). Cambridge, MA: *National Bureau of Economic Research*. See also, Pincus, T. & Callahan, L. F. (1994). Associations of low formal education level and poor health status: behavioral, in addition to demographic and medical, explanations? *Journal of Clinical Epidemiology*, 47(4): 355-361.

86 Cutler, D. M. & Lleras-Muney, A. (2007). Education and Health [Policy Brief #9]. *National Poverty Center*. Retrieved from: [http://www.npc.umich.edu/publications/policy\\_briefs/brief9/policy\\_brief9.pdf](http://www.npc.umich.edu/publications/policy_briefs/brief9/policy_brief9.pdf)

87 Olshansky, S. J. et al. (2011). Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up. *Health Affairs*, 31(8): 1803-1813.

generally. Foster parents, school staff, and even medical providers may have little awareness of the history and circumstances foster children have experienced, especially if the child has moved frequently.<sup>88</sup> Foster parents, as well as other low-income parents hoping to improve educational equality, may be significantly helped by MLP attorneys. Another area of educational inequity that significantly impacts health outcomes is disparate school financing practices. Since 1973 when the U.S. Supreme Court ruled that public education is primarily a state responsibility, states have been busy with litigation<sup>89</sup> and legislation<sup>90</sup> concerning educational equity.

Yet, to date, MLP attorneys have not been active in the pursuit of equitable school financing. School districts with the highest concentration of poverty receive approximately 10 percent less in funding per student. In 23 states, wealthier school districts receive more local funding than poorer school districts. While only 14 states have structured funding to target greater resources in high-poverty districts, 14 states have ‘flat’ systems with no difference between high- and low-poverty districts, and 20 have funding systems that can be called “regressive” because those districts provide high-poverty districts with less state and local revenue than they provide to low-poverty districts. These funding disparities result in wage disparities that place the most inexperienced teachers in schools where predominately minority students attend.<sup>91</sup> The U.S. Department of Education reported in 2012 that black and Latino students are 38 percent of the study body in schools with Advanced Placement courses, but only 29 percent of those enrolled in advanced classes.

The health impacts of educational disparities are multi-generational and racially disproportionate. In 2008, white American men and women with 16 years or more of education had life expectancies between 10.3 and 14.2 years longer than for black men and women with fewer than 12 years of education. MLP attorneys could provide educational access to break these trends toward “two separate Americas.”<sup>92</sup> This could be a growth area for the MLP movement. While some MLPs like those at Whitman-Walker Health in Washington, D.C. and the Crossroads Medical Clinic in Mississippi focus on removing discriminatory barriers that impact HIV/AIDS patients and the LGBTQ community, currently, no MLP in the nation focuses on reducing health disparities by broadly addressing racial and ethnic discrimination in education or any other social determinant of health.

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88 Foster children in California attend an average of nine different schools before age 18.

89 Recent issues of law journals have been dedicated to current legal remedies for school inequality. See Nance, J. P. (2016). School Inequality: Challenges and Solutions. *University of Richmond Law Review* 50 and Bilan, A. (2016). The Runaway Wagon: How Past School Discrimination, Finance, and Adequacy Case Law Warrants a Political Question Approach to Education Reform Litigation. *Notre Dame Law Review* 91(3): 1225-1252.

90 State Role in Education Finance. (n.d.) National Conference of State Legislatures. Retrieved from: <http://www.ncsl.org/research/education/state-role-in-education-finance.aspx>

91 United States Department of Education. (2012). New Data from U.S. Department of Education Highlights Educational Inequities Around Teacher Experience, Discipline and High School Rigor. [Press release]. Retrieved from: <https://www.ed.gov/news/press-releases/new-data-us-department-education-highlights-educational-inequities-around-teache>

92 Olshansky et al. Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up.

## 4. Employment

MLPs seek to improve patients' health by addressing legal issues that pertain to loss of employment, employment conditions, or employment discrimination. Several studies have shown that being employed has a positive protective effect on mental health. Certainly, having a steady job provides income to buy healthy food, obtain health care, and access other determinants of health. However, low-income populations are often vulnerable to health harming working conditions, or can be subjected to unfair labor practices. The Robert Wood Johnson foundation classifies 10.5 million Americans as “working poor,” a status associated with health risks due to workplace injuries or depression. Moreover, unemployment is a health hazard. People who are unemployed are 54 percent more likely than those continuously employed to have poor health. They are 83 percent more likely to develop stress-related conditions such as stroke, heart attack, heart disease, arthritis or depression. At the same time, people who are ill are more likely to lose their jobs.

Conditions at work can contribute to adverse health outcomes for the employed. Work stress is a factor for hypertension, diabetes, musculoskeletal back problems, and cardiovascular disease. Jobs that place high demands on workers physically, but afford low decision control, have negative health impacts for low and high wage earners. Gender and racial discrimination or harassment on the job has also been linked to poor health outcomes. As noted above, studies document an inverse relationship between discrimination and good health.<sup>93</sup>

MLPs such as the one serving Salud Para La Gente in Watsonville, California regularly help low-wage workers resolve worker compensation matters in order to improve access to medical care and lost income. An MLP between legal advocates called “Friends of Farmworkers” and a community health center called “Puentes de Salud (Bridges of Health)” is an example of an MLP serving the employment issues commonly faced by immigrant populations. This Philadelphia-area MLP resolves issues of workplace health and safety, worker exploitation and wage theft, interpersonal violence, and others, all of which affect physical and mental health and well-being.

## 5. Legal Status

The three legal status issues that MLPs typically address relate to citizenship, marital status, and discrimination due to minority status. Conflict and uncertainty with respect to each of these issues are associated with negative health outcomes. As a vulnerable population, immigrants to the U.S. have an intersectional group of potential issues that limit access to healthcare: socioeconomic background, immigration status, English proficiency, federal and state laws regarding publicly funded healthcare, residential area limitations, and feelings of stigma or marginalization.

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93 Williams, D. R. & Mohammed, S. A. (2009). Discrimination and Racial Disparities in Health: Evidence and Needed Research. *Journal of Behavioral Medicine*, 32(1), 20-47.

Compared to the U.S.-born population, immigrants are 2.5 times less likely to have health insurance. They also use healthcare services less frequently and receive lower-quality care.<sup>94</sup> Additionally, immigrants face language barriers, receive fewer preventative services, and are more likely to not understand the directions for prescriptions and follow-up appointments. Over 20 percent of non-English speaking patients altogether avoid seeking medical help because of language barriers. MLP attorneys can help resolve immigration challenges, clear criminal or credit histories, and assist with asylum applications, thereby allowing immigrants consistent access to care and potential benefits.<sup>95</sup>

Studies show that legal representation improves outcomes in family law cases. Maccoby and Mnookin found that parents were more likely to request and receive joint legal custody when both parties were represented.<sup>96</sup> Legal representation also correlated with improved financial awards in domestic law cases. Women received alimony in 18 percent of cases in which both parties had legal representation, but in only 2 to 4 percent of cases where one or both parties appeared *pro se*. MLP Philadelphia, the nation's first and only nurse-led health center and MLP, reports that the largest share of its legal caseload (35 percent) is divorce, child custody, and support cases.<sup>97</sup>

MLP attorneys have represented clients in immigration hearings, a setting in which traditional legal aid offices cannot practice; the MLP can address a range of health related immigration issues ranging from advocacy for victims of human trafficking, obtaining work permits, and helping individuals and families eligible for status adjustments that can lead not only to citizenship, but also to the freedom to seek regular access to preventive care.

A 2013 study of transgender and gender non-conforming people in Massachusetts revealed that due to discrimination, 13.9 percent of respondents postponed medical care when needed, resulting in emergency care, 24.8 percent postponed needed medical when sick or injured, and 30.2 percent postponed preventative care.<sup>98</sup> Racial and ethnic minorities all report significantly more perceived provider discrimination, with black Americans reporting the greatest perceived discrimination. Combined with unsatisfying provider interaction, those factors are significantly correlated to having an unmet need for health care utilization. Perceived provider discrimination is also an indicator of poor health status.<sup>99</sup> Whitman-Walker Health, one of the first health centers

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94 Derose, K. P., Escarce, J. J. & Lurie, N. (2007). Immigrants And Health Care: Sources Of Vulnerability. *Health Affairs*, 26(5): 1258-1268.

95 Regenstein, M. et al. (2015). Medical-Legal Partnership and Health Centers: Addressing Patients' Health-Harming Civil Legal Needs as Part of Primary Care. *National Center for Medical-Legal Partnerships*. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2015/08/Medical-Legal-Partnership-and-Health-Centers.pdf>

96 Murphy, C. J. (2003). Engaging With The State: The Growing Reliance on Lawyers and Judges To Protect Battered Women. *Journal of Gender, Social Policy & the Law*, 11(2): 499-521.

97 Lawton, E., Coon, B. B. & Fung, A. (2010). Medical-legal partnership | Philadelphia: Meeting basic needs and reducing health disparities by integrating legal services into the healthcare setting. *Philadelphia Social Innovations Journal*, 3.

98 Reisner, S. L. et al. (2015). Legal Protections in Public Accommodations Settings: A Critical Public Health Issue for Transgender and Gender-Nonconforming People. *The Milbank Quarterly*, 93(3): 484-515.

99 Lee, C., Ayers, S. L. & Kronenfeld, J. J. (2009). The Association between Perceived Provider Discrimination, Health Care Utilization, and Health Status in Racial and Ethnic Minorities. *Ethnicity & Disease*, 19(3): 330-337.

focused on HIV/AIDS, has had a long-standing medical legal partnership. The center's lawyers have helped over 1,800 people enroll in the Medicare prescription drug (Part D) program. They also work with clients who qualify for SSDI or whose SSDI benefits are wrongly terminated and assist LGBTQ foreign nationals with their asylum applications.<sup>100</sup>

## 6. Personal Safety

The CDC has called intimate partner violence (IPV) “a serious, preventable public health problem that affects millions of Americans.” MLPs can address the adverse effects of IPV on health, employment, and economic stability.

Abuse causes both immediate and long-term injuries or health conditions, including anxiety and post-traumatic stress disorder, which may require long-term mental health care. IPV constrains employment opportunity. Victims of IPV are often fired as a result of their abuse—between 21 and 60 percent lose their jobs from reasons stemming from the abuse, including time off from work to obtain medical, legal, or counseling services.<sup>101</sup> Low income women who experienced IPV had a 30 percent lower likelihood of maintaining a 30-hour work week for six or more months when compared to women who did not experience violence.

IPV is associated with homelessness and housing instability, both of which are risk factors for poor health outcomes. Between 22 percent and 57 percent of all homeless women report IPV as the immediate cause of their homelessness. However, it is not only the poor who suffer the health impacts of IPV. Affluent victims of abuse lose access to finances. Abusive husbands may have the resources to create expert legal teams or manipulate the legal system.<sup>102</sup> IPV victims have a lifetime incidence of homelessness at 38 percent. Between 22 and 57 percent of homeless women report that domestic violence was the immediate cause of their homelessness and over 90 percent have experienced severe physical or sexual abuse.<sup>103</sup> Furthermore, a 2005 Congressional inquiry found, in the year previous, almost 150 documented cases of IPV eviction due to domestic violence crimes and almost 100 people who were denied housing because of their IPV victim status.<sup>104</sup>

Due to reporting issues, accurate statistics about the incidence of domestic or intimate partner violence (IPV) are difficult to obtain. A 2011 study by the Centers for Disease Control and Prevention

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100 Whitman-Walker Health. (2014, July). Legal Services Program. Retrieved from: Whitman-Walker Health website: [http://www.aidswalkwashington.org/assets/whitmanwalker/files/\\$cms\\$/100/1253.doc](http://www.aidswalkwashington.org/assets/whitmanwalker/files/$cms$/100/1253.doc)

101 Rothman, E. F., Hathaway, J., Stidsen, A. & de Vries, H. F. (2007). How Employment Helps Female Victims of Intimate Partner Violence: A Qualitative Study. *Journal of Occupational Health Psychology*, 12(2): 136-143.

102 Shapiro, E. (2013, February 28). Domestic Violence Among the Wealthy Hides Behind 'Veil of Silence.' *The Daily Beast*. Retrieved from: <http://www.thedailybeast.com/articles/2013/02/28/domestic-violence-among-the-wealthy-hides-behind-veil-of-silence.html>

103 National Network to End Domestic Violence. (2013). Domestic Violence, Housing, and Homelessness [Fact sheet]. Retrieved from: [http://nnedv.org/downloads/Policy/NNEDV\\_DVHousing\\_factsheet.pdf](http://nnedv.org/downloads/Policy/NNEDV_DVHousing_factsheet.pdf)

104 National Network to End Domestic Violence. Domestic Violence, Housing, and Homelessness [Fact sheet].

found that 15.8 percent of women experience sexual violence (excluding rape) by an intimate partner in their lifetimes. Another 22.3 percent experience at least one severe physical violent attack by an intimate partner and 47.1 percent experience at least one form of psychological aggression by an intimate partner in their lifetimes.<sup>105</sup> Low income and minority populations are more likely to experience intimate partner violence. Black women and men experience it at a 35 percent and 62 percent higher rate than white women and men, respectively, and American Indian/ Alaska Native women also experience significantly higher rates of physical abuse compared to other racial groups.<sup>106</sup> In addition, women with family incomes under \$7,500 are five times more likely to be IPV victims than women with family incomes between \$50,000 and \$74,000.<sup>107</sup> A study of women receiving welfare found that 34 to 65 percent experience some form of relationship violence during their lives.<sup>108</sup>

Having an attorney substantially increases the chance of receiving a protection order against a violent partner. One study showed that 83 percent of women seeking protection from domestic violence successfully obtained a protective order, while only 32 percent of unrepresented women succeeded.<sup>109</sup> MLPs have helped IPV victims receive cash assistance, food stamps, change their welfare benefits, and negotiate child support arrangements. However, obtaining legal and social services is more difficult for underserved groups. A 2002 study of low-income, mostly black women in Baltimore revealed that about a third of the sample did not know of social services, hotlines, or shelters for abused women; 70 percent did not seek assistance, and those who did turned to family and friends instead of formal assistance.<sup>110</sup> MLPs work collaboratively with healthcare professionals to support survivors and reduce the risk of re-traumatization by the abuser and as part of the legal process, as well as provide clinical evidence to support housing, healthcare, and other legal claims.<sup>111</sup> MLPs can also help address the issues that may arise in conjunction with IPV: unsafe living conditions, evictions, mortgage foreclosure, debt, loss of benefits, and child custody.

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105 Breiding, M. J. et al. (2014). Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization — National Intimate Partner and Sexual Violence Survey, United States, 2011. *The Centers for Disease Control and Prevention*. Retrieved from: [http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm?cid=ss6308a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm?cid=ss6308a1_e)

106 Sampson, R. (2006). Domestic Violence. The Center for Problem-Oriented Policing. Retrieved from: [http://www.popcenter.org/problems/domestic\\_violence/2](http://www.popcenter.org/problems/domestic_violence/2)

107 Sampson. Domestic Violence.

108 Hill, T. D., Mossakowski, K. N. & Angel, R. J. (2007). Relationship Violence and Psychological Distress Among Low-income Urban Women. *Journal of Urban Health*, 84(4): 537-551.

109 Murphy. Engaging With The State: The Growing Reliance on Lawyers and Judges To Protect Battered Women.

110 Johns Hopkins Bloomberg School of Public Health. (2002). School Researchers Find Domestic Violence Services Are Not Reaching Low-Income Women [Press release]. Retrieved from: <http://www.jhsph.edu/news/news-releases/2002/abused-women-ocampo.html>

111 Edouard, L. (2010). Empowering Families Impacted by Domestic Violence: Optimizing Financial Stability through Medical-Legal Partnerships. *The Congressional Hunger Center*. Retrieved from: <http://www.hungercenter.org/community/domestic-violence-survivors/>



## 7. The Emerging Business Case for Medical-Legal Partnerships

The range of legal issues that MLPs are able to address argues in favor of the medical-legal partnership approach. However, based on the evidence of MLPs health impacts, at least three further theoretical and financial arguments also favor financing social interventions like the MLP. We highlight them briefly below.

### *MLPs Can Cost-Effectively Leverage Civil Legal Aid Attorneys' Expertise and Infrastructure*

Most medical-legal partnerships are staffed through subcontracts with health providers, by civil attorneys from state and federal legal aid agencies.<sup>112</sup> The federal legal aid infrastructure employs 4,592 attorneys and 1,559 paralegals through the Legal Services Corporation (LSC). LSC is a nonprofit corporation through which Congress has provided funding for the single largest provider of civil legal aid services since 1974.<sup>113</sup> LSC legal aid attorneys represent an existing and ready source of experts who understand the legal issues that poor families face. However, legal aid offices have been chronically under-funded and over-extended.<sup>114</sup> The evidence reviewed here that connects legal representation with improved health and lower health care costs argues in favor of leveraging the legal aid workforce to deliver more services preventatively, in primary care clinics, as part of the MLP approach.

### *MLPs Represent a Favorable Return on Investment*

Although the literature is not robust, several studies suggest that the benefits that MLPs confer substantially exceed the cost to implement and operate an MLP. Financial impact studies typically analyze the return-on-investment that MLPs provide when the cost of volunteered services is measured against the savings to institutions or patients. Obviously, volunteerism is not a sustainable way to bring the MLP model to scale nationally. Nevertheless, these studies are useful to estimate the financial viability of MLPs by focusing on a traditional cost-benefit analysis. For example, a longitudinal study of an MLP in rural Illinois compared the financial benefit as compared to the initial investment to calculate a financial return on investment (ROI) for the initial period of the MLP's operation from 2002-2006, as compared to the relative benefit of the MLP during 2007-2009.<sup>115</sup> Researchers reported the MLP program produced a 149 percent return on investment (ROI) of \$115,438 for the hospital partner during the first period, and the hospital's Medicaid ROI increased to 319 percent based on an investment of \$116,250 during the second period.

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112 See, <http://medical-legalpartnership.org/partnerships/>

113 See, <http://www.lsc.gov/what-legal-aid/how-we-work>

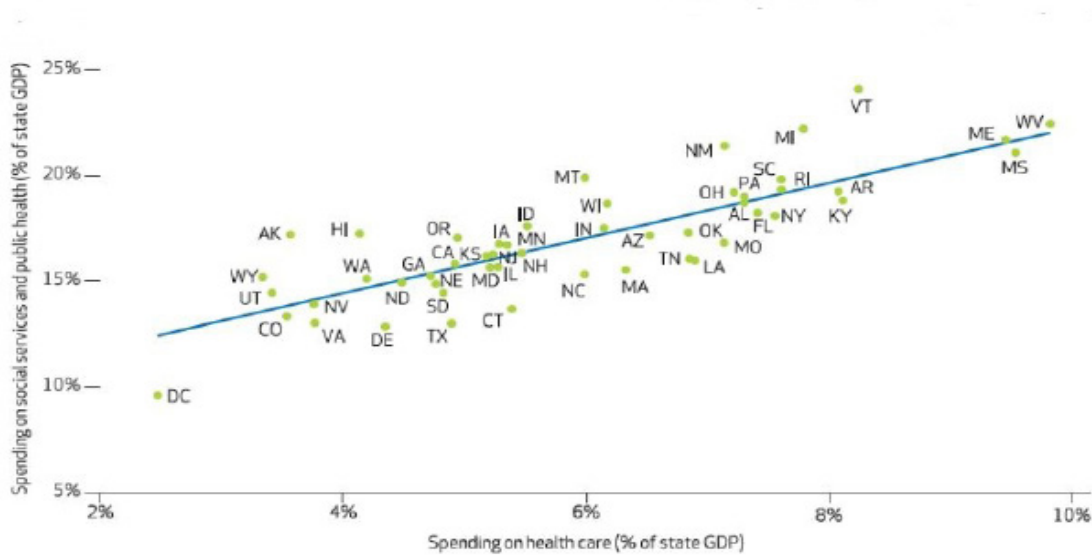
114 See, <http://www.lsc.gov/what-legal-aid/unmet-need-legal-aid>

115 Teufel, J. A. et al., (2012). Rural Medical-Legal Partnership and Advocacy: A Three Year Follow-up Study. *Journal of Health Care for the Poor and Underserved*, 23(2): 705-714.



Another researcher analyzed the return on investment hospitals received from MLP programs that resolve previously denied benefit claims. Kerry Rodabaugh and colleagues reported on an MLP that worked with cancer patients and generated nearly \$1 million in benefits by resolving denied benefit claims.<sup>116</sup> In a retrospective study of 71 parents or guardians of 76 children diagnosed with sickle cell disease, researchers measured patients' gains in benefits due to the MLP intervention.<sup>117</sup> This MLP, formed between a Children's Hospital and Georgia Law School, measured the monthly amount of public benefits obtained or retained including housing, education, and health insurance benefits, as well as the number of patients who received end of life care following MLP legal counsel. MLP services returned the greatest net benefits in education (\$720,000), but also helped patients reverse public benefit denials, restore wrongfully terminated employment and reinstate health insurance benefits. In still another approach, researchers at Johns Hopkins conducted a longitudinal study to determine that an Illinois MLP relieved patients of over \$4 million in health care debt, and obtained a total of \$1 million in social security benefits.<sup>118</sup> To date, no MLP study has considered the return on investments from a societal level, which would involve valuing the health improvements the MLPs achieved.

**Figure 4. US state spending on social services and public health and on health care (Medicare and Medicaid) as percentage of state GDP, 2009**



**SOURCE** Authors' analysis of data from Exhibits 1 and 2. **NOTES** States (the fifty states and the District of Columbia) above the line have greater-than-average ratios of social to health spending; states below the line have lower-than-average ratios. GDP is gross domestic product.

Source: Bradley, E.H. et al. (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09. *Health Affairs*, 35(5): 760-768.

116 Rodabaugh, K. J. et al. (2010). A Medical–Legal Partnership as a Component of a Palliative Care Model. *Journal of Palliative Medicine*, 13(1): 15-18.

117 Pettigagno, R., Caley, S. B. & Bliss, L. R. (2011). Medical-Legal Partnership: Impact on Patients With Sickle Cell Disease. *Pediatrics*, 128(6): 1482-1488.

118 Id., Teufel.

*MLPs Can Contribute to Improved Public Health Outcomes Associated with Increased Social Service Spending*

The ratio of social spending to health spending is correlated with the quality of health outcomes in OECD countries. Overall, higher levels of spending on social factors are associated with better health outcomes in western countries.<sup>119</sup> However, the United States does not fare well by this measure, compared with its global counterparts.

A recent study published by the RAND Corporation importantly confirmed not only that countries with greater social expenditures have better health outcomes, but also that public expenditures by governments have the strongest influence on health. That is, public social spending has a stronger positive influence on health outcomes than private spending.<sup>120</sup> This finding is particularly important given the current funding structure of the MLP intervention.

**Figure 5. Adjusted associations between the rate of social to health spending with a one-year lag and health outcomes across the fifty states and the District of Columbia, 2000-2009**

Health outcome	Estimated coefficient <sup>c</sup>	p value	Estimated coefficient <sup>c</sup>	p value
<b>PERCENT OF ADULTS WHO:</b>				
Were obese (body mass index $\geq 30$ )	-0.33	0.014	-0.16	0.101
Had asthma	-0.11	0.041	-0.12	0.012
Reported 14+ days in past 30 days as mentally unhealthy days	-0.43	0.007	-0.24	0.035
Reported 14+ days in past 30 days with activity limitations	-0.37	<0.001	-0.25	0.002
<b>MORTALITY RATE FOR:</b>				
Acute myocardial infarction (per 100,000 population)	-4.02	0.032	-0.64	0.649
Lung cancer (per 100,000 population)	-2.72	0.001	-2.35	0.002
Type 2 diabetes (per 100,000 population)	-0.45	0.004	-0.51	<0.001
Postneonatal infants <sup>d</sup> (per 100,000 live births)	-4.15	0.325	-6.56	0.037

Source: Bradley, E.H. et al. (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09. *Health Affairs*, 35(5): 760-768.

The RAND study revealed that the association between higher social spending and better health outcomes holds across all American states. This was confirmed in another study by Elizabeth Bradley and colleagues. As shown in Figure 5 above, Bradley found that states with a higher ratio of social and public health to healthcare spending (Medicare and Medicaid), had significantly

119 Bradley, E. H. & Taylor, L. A. (2013). *The American Health Care Paradox: Why Spending More Is Getting Us Less*. New York, NY: Public Affairs.

120 Rubin, J. et al. (2016). Are better health outcomes related to social expenditure? A cross-national empirical analysis of social expenditure and population health measures. Santa Monica, CA: RAND Corporation. Retrieved from: [http://www.rand.org/pubs/research\\_reports/RR1252.html](http://www.rand.org/pubs/research_reports/RR1252.html)

better health outcomes for adult obesity, asthma, mentally unhealthy days, days with activity limitations, and mortality rates for lung cancer, heart attack, and Type 2 diabetes.<sup>121</sup>

MLPs that address the social determinants of health have been shown to improve health quality, decrease disparities, and contribute to health care cost savings. Thus, the increased investment required to provide access to MLP services for America's 97.3 million low-income people and the additional 29 percent of the population who earn modest incomes<sup>122</sup> may fairly be considered the type of social spending that is associated with better health outcomes.

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121 Bradley, E.H. et al. (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09. *Health Affairs*, 35(5): 760-768.

122 Kaiser Family Foundation. (2015). State Health Facts 2015, Distribution of Total Population by Federal Poverty Level 2015. Retrieved from: <http://kff.org/other/state-indicator/distribution-by-fpl/?currentTimeframe=0>

## IV. Proposals to Sustainably Pay for Medical-Legal Partnerships that Improve Health Outcomes

Despite their record of success, existing MLPs address only a fraction of the patient population whose health outcomes could be improved by access to legal representation. That is because funding remains a substantial challenge to developing, sustaining, and growing MLPs. Direct support of lawyers and paralegals generally comes from sources outside of the health center, with the lion's share contributed from federal, state or locally funded civil legal aid agencies or law school clinics. Therefore, funding sources do not account for or align with populations' need for those legal services that could address health-related problems. This section proposes approaches to enlarging the scale and scope of approaches to financing medical legal partnerships.

There are 6,415 people living in poverty for every one civil legal aid attorney in the United States.<sup>123</sup> Beyond those who qualify for free legal representation because of poverty, the Legal Services Corporation and the American Bar Association estimate that of the approximately 50 million low-income individuals in this country, each has at least one health-harming civil legal need.<sup>124</sup> Thus, patient and provider populations will benefit directly from broadening use of the MLP intervention.

MLPs add a modest amount to the health care delivery team budget, often because underpaid and over-worked civil legal aid attorneys are publicly funded through federal and state legal aid networks. However, this payment model is neither sustainable nor scalable. According to the results of a recent national survey that included approximately two-thirds of the nation's 300 MLPs, these entities operate with a median annual budget of \$80,415; MLPs in health centers represent the lowest end of the cost spectrum with a median budget of \$55,000; MLPs partnered with hospitals/health centers = \$65,000; and MLPs in other health organizations operate at \$95,000.<sup>125</sup>

On the higher end of the spectrum, MLPs that have operated for five or more years, have a median annual budget of \$132,000 because they have established staffs, processes, and track records. Clearly, these are small absolute numbers when compared to providers' total health care delivery budgets but their impact on value depends on information about outcomes and the number of patients served that is still not collected or reported on any systematic basis.<sup>126</sup> However,

123 Legal Services Corporation. Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans.

124 *Id.*

125 Regenstein, M., Sharac, J. & Trott, J. (2016). The State of the Medical-Legal Partnership Field: Findings from the 2015 National Center for Medical-Legal Partnership Surveys. National Center for Medical-Legal Partnerships. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf>

126 Provider operating budgets are not readily available however some data points are illustrative: Ge Bai and Gerard F. Anderson, (2016). A More Detailed Understanding of Factors Associated with Hospital Profitability, *Health Affairs* 35(5):889-897 (reported that the nation's ten most profitable hospitals earned more than \$163 million in total profits from patient care services but

in light of evidence that the number of deaths in the United States attributable to low education, poor housing, and income inequality is comparable with the number of deaths attributable to heart attack, strokes, and lung cancer, respectively, the case for financing MLP services broadly is strong, though the question of who bears responsibility to address the legal problems MLP attorneys take on is unresolved.

The earliest adopters of the MLP model financed legal services largely through philanthropy and *pro bono* service. Stronger programs have grown to rely upon multiple streams of revenue which may include academic research grants, managed care demonstration or pilot contracts, or even social impact bond funding. Programs that have fully integrated their legal and medical services share financial support from host health care institutions and partnering legal aid programs, law schools, or foundations. Increasingly, institutions are using same funding streams as used for community health workers, case managers, and patient navigators to pay for legal services. However, even the most recent payment reforms announced, in part, to facilitate expansion of social determinants treatment are currently underutilized so that only a small segment of the demonstrated need for MLP services has been satisfied. The following seven recommendations could to improve the long term financial stability of MLPs and other interventions that address the social determinants of health:

- 1) Health centers that serve medically underserved populations should finance MLPs as an “enabling” or “wrap-around” service under Section 330 of the Public Health Service Act.**
- 2) Managed care organization should expand use of “in lieu of” Medicaid financing.**
- 3) Established medical-legal partnerships should expand use of value-based alternative payment models (APMs).**
- 4) Medicare clinicians should propose episode payment and condition based payment models to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that include coverage for MLP services ordered by eligible professionals.**

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showed that only 45 percent of hospitals were profitable in 2013); Becker’s Hospital CFO reported in 2012 that the 5,000 nonfederal general community hospitals in the U.S. posted a cumulative profit of \$64.4 billion, based on total gross revenue of \$2.43 trillion that year. (Available here: <http://www.beckershospitalreview.com/finance/12-statistics-on-hospital-profit-and-revenue-in-2012.html>); In 2011, the average revenue for Federally Qualified Health Centers in California, for example, was \$17.3 million. Blue Shield of California Foundation, Financial findings from California Community Health Centers, (August 2013) (available here: [http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/BSCF\\_IssueBrief\\_Capital percent20Links\\_September.pdf](http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/BSCF_IssueBrief_Capital%20percent20Links_September.pdf))

- 5) **CMS should incorporate quality metrics in medical homes, ACO and ACH payment models to incentivize providers to incorporate MLP services into private managed care contracts.**
- 6) **States should invest in long-term public and private financing alternatives.**
- 7) **State and local government agencies should experiment with blending and braiding strategies such as Social Impact Bonds (SIBs).**

**Recommendation #1 — Health centers that serve medically underserved populations should finance MLPs as “enabling” or “wrap-around” services under Section 330 of the Public Health Service Act.**

Seventy-seven<sup>127</sup> MLPs receive funding under Section 330 of the Public Health Service Act; health centers should expand their use of this source of federal grant funding to include all health centers hosting MLPs nationwide.

Section 330 of the Public Health Services Act is the federal law through which the federal government authorizes funds to federally qualified health centers (FQHCs). FQHCs provide comprehensive primary care services to medically underserved populations. They accept all patients regardless of their ability to pay, setting fees on a sliding fee scale, and therefore receive enhanced reimbursement from Medicaid and Medicare, as well as Health Resources & Services Administration (HRSA) grants under Section 330. Section 330 authorizes health centers to provide “enabling services” including transportation, interpreters, and environmental services. In 2014, HRSA issued a policy guidance to clarify that “enabling services” may also be used to pay for on-site civil legal aid that helps meet primary health needs.<sup>128</sup>

HRSA has strongly signaled its support of MLP financing. In July 2015, HRSA published a funding opportunity announcement that extended access to enabling services funding. Existing health center grantees could apply for funds to cover civil legal aid services. The awards were made available to expand health services such as expanding dental facilities or improving substandard abuse treatment. However, up to 20 percent of the award could be used to increase availability of enabling services if the grantee could demonstrate an increase in patient access to care would result.

In September 2015, HRSA announced that its expanded services supplemental funding awards of \$350 million was available to enable collaborations between healthcare and legal services.

127 As of the date of this paper’s publication.

128 See <http://medical-legalpartnership.org/enabling-services/>



As a result, health centers such as the Waimanalo Health Center in O’ahu, Hawaii received a \$20,000 award to expand its MLP for children by adding a part time law fellow and supervising attorney. That particular MLP partners with the University of Hawaii Law School and a FQHC to provide civil legal aid to advocate for youth. In another instance, a health center in Manchester, New Hampshire that operates four sites and serves 13,000 children and adults annually living at or below 200 percent of the federal poverty level will reopen an MLP that had closed due to lack of funding. The \$50,000 HRSA award will allow the organization to immediately build out the first-year of the MLP that had closed, by now hiring two paralegals to staff the site twice weekly at its clinic locations.

These centers are examples of funding that will expand MLP availability. Although HRSA supplemental grant funding shows laudable leadership in making MLP financing available, this form of funding will not sustain long-term MLP operation unless other, permanent funding is established, as demonstrated by the Manchester, New Hampshire center’s experience; services were interrupted when funding ran out and although the clinic sites are open again serving poor patients, they may close again in the future without permanent funding. Nevertheless, more of the 300 MLPs nationwide should take advantage of HRSA funding for enabling services.

## **Recommendation #2 — Managed Care Organizations should expand use of “in lieu of” Medicaid financing**

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) released its first major update to the Medicaid and CHIP managed care regulations in more than a decade.<sup>129</sup> The new Final Rule creates new authority for Medicaid MCOs to offer alternative services, or services in alternative settings, from those traditionally covered under Medicaid state plans. These services are called “in lieu of services.” MLPs should use this source of funding to cover legal services that reduce costs and improve health outcomes.

The Rule grants Medicaid managed care organizations (MCOs) the ability to develop rates for services designated as “in lieu of services” that are included in MCO capitation contracts as covered services. This provision attracted considerable attention because it revised the IMD exclusion, granting authority for the first time in Medicaid’s history for state plans to receive federal matching funds for inpatient psychiatric or substance abuse treatments in institutions for mental diseases. However, the “in lieu of services” provision also represents an opportunity for states to cover MLP services that are medically necessary to improve patient health.

The rule allows states to reimburse for services covered by an MCO, Prepaid Inpatient Health Plan, or Prepaid Ambulatory Health Plan even though those services are not explicitly covered as a part of the state plan. In accordance with the rule, an enrollee cannot be required to use

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129 81 Federal Register 27497-27901 (May 6, 2016)



the “in lieu of services.” The rule imposes four criteria for in lieu of services. First, the state determines that the alternative service or setting is a “medically appropriate and cost effective substitute for the covered service or setting” under the state plan. This determination must be made as a general matter, not based on enrollee-specific criteria. Second, the authorization must be expressly written in the contract, along with a list of the “in lieu of services” approved. Third, the enrollee cannot be required to use the alternative service or setting. They are offered at the MCOs discretion. And fourth, the utilization and cost of the in lieu of services should be taken into account when developing the capitation rates for the covered state plan services. This means “the base data capturing the cost and utilization of the in lieu of services are used in the rate setting process.”

Under this final rule, states have express authority to increase or decrease payments to a Medicaid MCO by 1.5 percent without submitting a new certification to CMS. Of course, the managed care rates for these services must be “actuarially sound”—that is projected to provide for all reasonable, appropriate, and attainable costs under the contract. The rates and services must be appropriate for specific populations covered and the services must be adequate to meet the network adequacy, access, and coordination of care requirements. The rates must be reasonably likely to allow the managed care plan to achieve an 85 percent medical loss ratio.

This rule affects the 39 states and the District of Columbia that outsource their Medicaid programs by paying capitated monthly sums totaling \$123.6 billion annually, to 267 private MCOs. The MCOs earn an estimated \$115 billion in revenue and \$2.4 billion in operating profits to cover approximately 46 million enrollees or 73 percent of all regular Medicaid beneficiaries now enrolled in managed care plans. Cost containment is the primary reason that states are expanding use of managed care plans. This rule presents an opportunity for programs seeking to cover social services such as MLP attorneys that reduce costs and improve health outcomes for Medicaid patients.

**Recommendation #3 — Established medical-legal partnerships should expand use of existing value-based alternative payment models (APMs).**

The National Center for Medical Legal Partnerships recently highlighted two examples of MLPs that have integrated the cost of legal services into managed care contracts between health systems or providers, and payers.<sup>130</sup> More health centers and MLPs should adopt this internal financing model through value-based contracting with insurance companies and other payers. In order to incentivize integrating MLP costs into payment models, providers should expand the use of alternative payment models (APMs) such as the medical home (advanced primary care

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130 Theiss, J., Sandel, M., Teitelbaum, J. & Marple, K. (2016). Applying the Medical-Legal Partnership Approach to Population Health, Pain Points and Payment Reform. *The National Center for Medical-Legal Partnerships*. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2016/10/Applying-the-MLP-Approach-to-Population-Health-October-2016.pdf>

practice), accountable care organizations, and accountable health communities models that have demonstrated cost savings and quality improvements.

At the University of Nebraska Medical Center, MLP attorneys from the Legal Aid of Nebraska help address social needs of high-need, high-cost patients. Under a bundled payment agreement, the Medical Center bears the risk of its costs exceeding the contract amount. However, the MLP helped reduce emergency department visits of high-need, high-cost patients and thus were an important part of the strategy to keep the cost of caring for these patients below the contract amount. In Indiana, a mental health clinic incorporates MLP services to help identify and address social and legal issues that might harm patients and the facility's bottom line. In this example, cost savings were incentivized under a value-based MCO contract that penalized the provider for excessive institutionalizations but rewarded outpatient treatment of mentally ill patients in a community setting.

The value-based contracting model is particularly suited to providers in network care organizations such as Accountable Care Organizations, Accountable Health communities, Coordinated Care Organizations or other integrated entities. The model can take one of two forms. Incentive-based contracts reward providers for satisfying quality standards built into the reimbursement contract while risk-based payment models set expected costs in advance for treating a patient population and providers bear the risk of exceeding that estimate. Bundled payments designed to reimburse an episode of care might include legal MLP services for appropriate patients in either of these two models.

The Kaiser Family Foundation reviewed the most recent data on APMs that CMS is currently testing within Medicare. That data based on early performance results, showed most models are meeting quality targets and some models are showing modest cost savings.<sup>131</sup> Although the Comprehensive Primary Care (CPC) and Advanced Primary Care Practice (APCP)<sup>132</sup> models showed mixed results, MLPs and their affiliated health providers should join the new Comprehensive Primary Care Plus Model (CPC+) that will be available in January 2017. Under CPC+, up to 5,000 participants in 20 regions will receive prospective Medicare care management fees as well as a pre-paid incentive for meeting quality and utilization benchmarks that provide incentive for care management outside the face-to-face clinical encounter such as MLPs require.

Alternatively, physicians and other providers participating in ACOs could negotiate reimbursement for services based on evidence that the MLP could improve shared savings overall. Currently, the ACO models' performance is based on 34 quality measures used to assess performance and

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131 Baseman, S. et al. (2016). Payment and Delivery System Reform in Medicare: A Primer on Medical Homes, Accountable Care Organizations and Bundled Payments. *The Kaiser Family Foundation & American Institutes for Research*. Retrieved from: <http://files.kff.org/attachment/Report-Payment-and-Delivery-System-Reform-in-Medicare.pdf>

132 The FQHC/APCP model ended in 2014.

shared savings or losses.<sup>133</sup> These measures include access to specialists and health promotion and education, but do not include screening for or access to social services. As a long-term and sustainable incentive to integrate MLP services financially, CMS should add a quality measure specifically to incentivize collaboration with ancillary social services such as MLPs that can demonstrate they will likely have a positive impact on quality and cost savings.

Finally, MLPs can negotiate to participate in bundled payment models that establish an overall budget for services a patient receives through an episode-of-care. The Bundled Payment Care Improvement Initiative (BPCI) includes a new and ongoing bundled payment model for post-acute care services (BPCI Model 3) which could be used to cover the costs of providers directing patients to provider partners such as MLP attorneys.

Perhaps the most promising of the APMs for MLP services is the Accountable Health Communities (AHC) model that CMS announced in January 2016. This model recognizes “social comorbidities”<sup>134</sup> and specifically seeks to fund clinical and community partnerships. To date, CMS has announced only a Track 1 funding opportunity designed to increase patients’ awareness of available community services through information dissemination and referral. However, over a five-year period, CMS will test two additional tracks designed to assist patients with accessing services through screening, and to encourage community partners to provide services responsive to patient needs.<sup>135</sup> Together these AHC models invite MLP and provider collaboration to improve patient health outcomes through legal services.

**Recommendation #4 — Medicare clinicians should propose episode payment and condition-based payment models to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that include coverage for MLP services ordered by eligible professionals.**

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) created new ways for Medicare to pay physicians. MACRA also included incentives for physicians and other eligible clinicians to develop new physician-focused payment models (PFPMs).<sup>136</sup> Medicare clinicians that serve vulnerable populations should submit proposals for new PFPMs that pay for addressing social needs. While the proposals must meet the Secretary’s ten criteria,<sup>137</sup> Medicare providers should help develop appropriate PFPMs to cover MLP services and submit them to the newly formed Physician-Focused Payment Model Technical Advisory Committee (PTAC).

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133 Centers for Medicare & Medicaid Services. (2016). Quality Measures, Reporting and Performance Standards. Retrieved from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html>

134 Perla, R. & Onie, R. (2016, March 2). Accountable Health Communities And Expanding Our Definition Of Health Care [Blog]. *Health Affairs*. Retrieved from:

<http://healthaffairs.org/blog/2016/03/02/accountable-health-communities-and-expanding-our-definition-of-health-care/>

135 CMS, Accountable Health Communities Model, available here: <https://innovation.cms.gov/initiatives/ahcm>

136 See Section 101(e)(1) of MACRA.

137 42 CFR §414.1465.

The American Medical Association (AMA) has provided guidance for developing such PFPMs for clinicians to consider. The AMA published a guide to physician-focused alternative payment models to outline the range of APMs that could be structured to address the most common barriers to physician innovation in health care delivery. The guide presents seven models that are PFPMs to address lack of payment for high valued services that hinder physicians from delivering a mix of services that departs from traditional fee-for-service care. Two of the AMA's proposed models could make it possible to include MLP's in the mix of services.

Episode payment models are designed for medical treatment that is delivered collaboratively with other service providers. As proposed, the AMA's recommendation involves a single bundled payment for multiple services delivered by multiple providers over a period of time. The services include follow-up services that are related to the initial procedure. The episode treatment could be treated as a prospective payment, or as a budget against which providers bill retrospectively. However, the AMA's proposal for episode payment is narrowly focused on clinical "procedures," making no allowance for episodes of care that might require non-medical services for patients to recover optimally. This focus is inconsistent with the recognition that most physicians have acknowledged that social as well as medical services are important to patient health. Here is one example of how this PFPM could integrate MLP services: If the episode payment model were enlarged to include MLP services, providers could comprehensively address the medical and social needs of patients who receive procedures after they have been victims of domestic violence.

A second example is the AMA's condition-based payment model. This is a PFPM designed to give physicians and other providers the flexibility and accountability to deliver the most appropriate treatment to address the whole spectrum of patient needs in a coordinated and flexible manner. The condition-based payment is based on the patient's health condition—say, chronic childhood asthma—and ties payment to the management of care for the condition rather than to the delivery of specific procedures or treatments. This model is ideally suited to cover MLPs. MLP services could be reimbursed under this model because they are related to treating asthma, for example, where housing and school conditions are important to a child's health.

PTAC will review and recommend to the HHS Secretary proposals that will control health care spending and/or improve health care quality. The episode and condition based PFPMs modified to include MLP costs, would meet the HHS criteria for "payments designed to improve the efficiency of care and/or outcomes for patients receiving both services delivered by physicians or other eligible professionals *and related services ordered by eligible professionals that are delivered by other providers.*" (italics added) Other requirements and guidance for providers submitting proposals [are found here: https://aspe.hhs.gov/sites/default/files/pdf/226776/PTACRFP.pdf](https://aspe.hhs.gov/sites/default/files/pdf/226776/PTACRFP.pdf). In short, once an MLP payment model that conforms to the PFPM criteria is developed, a Medicare

clinician may submit a two-page, a non-binding letter of intent<sup>138</sup> to PTAC for its review any time after December 1, 2016.

**Recommendation #5 — CMS should incorporate specific quality metrics in medical homes, ACO and ACH Health payment models to incentivize providers to incorporate MLP services into private managed care contracts.**

As Medicare and other payers move toward rewarding high quality care rather than volume, providers will develop innovative delivery systems in response to the quality and cost measures that payers use calculate value-based reimbursement. This year, CMS published a list of 97 quality and cost measures that are under consideration for Medicare quality and value-based purchasing programs;<sup>139</sup> but none of these measures focus on social risk factors. CMS should include measures that specifically address the social factors that contribute to health.

The Department of Health and Human Services will use these quality and efficiency measures to assess provider performance. Thus, they have the potential to drive improvement and innovation in delivery of care across numerous settings that affect nearly 54 million patients each year. Social measures would be relevant to all CMS programs, but especially to the following programs:

- Hospital Inpatient Quality Reporting
- Hospital Outpatient Quality Reporting
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Medicaid and Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals
- Medicare Shared Savings Program
- Merit-Based Incentive Payment System

CMS should consider adding three new types of social measures: a process measure, a patient self-reported outcome measure, and an outcome measure. The first is a social screening measure. Just as the current measures list includes screening for tobacco and alcohol use, CMS should include a single quality measure that assesses whether providers have screened for the basic social needs of their patients. This measure should include follow-up as with the ACO Adult Weight

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138 PTAC provides a template for the letter of intent here: <https://aspe.hhs.gov/sites/default/files/pdf/226771/LetterofIntentTemplate.pdf>

139 Centers for Medicare & Medicaid Services. (2016). List of Measures Under Consideration for December 1, 2016. Retrieved from: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Measures-under-Consideration-List-for-2016.pdf>

Screening quality measure in order to ensure identified needs are linked with appropriate social service providers. Second, a specific screen should ask patients to report whether they have an unresolved legal concern that affects their health. Invariably, an affirmative response to this question will point to a deficient social determinant of health, and could result in an appropriate referral. Third, an outcome measure should focus on measuring the extent to which patients have access to the social determinants shown to have the largest impact on health. Similar to an outcome measure currently under consideration that would describe the percentage of adults that currently smoke, CMS should develop a social outcome metric that measures the percentage of patients who were continuously housed at the same address during the six months immediately prior to the clinical visit.

**Recommendation #6 — States should invest in long-term public and private financing alternatives.**

In addition to the opportunity for more immediate changes that providers and MLP entities can pursue on their own, other commenters have observed there are longer term options that would require state officials to join in seeking payment alternatives that are worth considering here. The important point to remember, however, is that these options have been available to states for some time—they are not new in the way that Medicaid “in lieu of services” or HRSA “enabling services” authority is newly expanded. Therefore, there must be consideration given to ways to incentivize states in ways that are not currently available, to get states to use these tools to pay for MLP services.

- *Submit State Plan Amendments (SPAs) to Cover MLP Services.* Targeted case management services under Section 1095(b) and 1915(g)(1) are optional benefits that could be used by states to help gain access to MLP services.
- *Seek MLP coverage as preventive and rehabilitative services or Section 1945 Health Home Services.* States currently have broad flexibility to establish alternative benefit plans (ABPs) for targeted groups of beneficiaries that might include MLPs directed to specific population groups such as the elderly or the mentally disabled.
- *Apply for Medicaid waivers.* Maryland and Vermont both operate innovative “all payer waivers” that incentivize public (and in Vermont’s case, private) payers to tie reimbursements to quality rather than to quantity. Such delivery reforms represent opportunities to include MLPs into reimbursement structures. For example, Delivery System Reform Incentive Payment Program Waivers (DSRIP) and Section 1115 demonstration program waivers can be used to expand covered populations or benefits. These waivers are available from the DHHS to tie performance metrics and projects that include collaboration with MLPs. Similarly, Home and Community-Based



Service Waivers (HCBS) under Section 1915(i) state plan amendments could include MLP coverage.

- *Value-added services.* These are services that are not included in the state plan or list of covered managed care contract services but an MCO can, with state approval, elect to provide them to improve the quality of care or reduce costs as a medical not administrative cost for MLP purposes.
- *Optional social support services.* Under current Medicaid provisions, states can cover 1) linkages to non-covered social services; 2) housing services; 3) employment services; and 4) peer support services. These are all categories that could be adapted to cover MLPs.

**Recommendation #7 — States and local government agencies should experiment with blending and braiding strategies such as social impact bonds.**

States and local government agencies should encourage experimentation with new forms of blended public and private funding such as social impact bonds (SIBs). SIBs are innovated financing agreements under which a government agency sets a specific, measureable social outcome to achieve within a well-defined population over a period of time, and private investors pay the upfront costs for providing the social services to achieve those outcomes. The government agency repays investors over time, a specified return, if and only if a third-party evaluator determines that the services achieve the outcomes agreed upon. Potential investors include individuals, trusts, and foundations, as well as Community Development Financial Institutions (CDFIs), which are investment firms dedicated to impact investments in underserved communities.<sup>140</sup>

South Carolina, for example, tapped SIBs to reduce the state’s high rate of premature births among Medicaid beneficiaries. The SIB agreement, also called a “pay-for-success contract” has also been used by the city of Fresno, California to fund programs aimed at reducing childhood asthma hospitalizations and emergency room visits; the District of Columbia turned to private investors to fund a teen pregnancy prevention program. SIBs make financial sense when a multi-year project is likely to help a state or municipality avoid paying for more expensive health services down the road.<sup>141</sup> However, while SIBs have the potential to improve and scale-up successful social models such as the MLP, they do not work well if quantitative metrics are unclear or otherwise flawed.

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140 Costa, K. (2014, March 3). Investing for Success: Policy Questions Raised by Social Investors. *Center for American Progress Report*. Retrieved from: <https://www.americanprogress.org/issues/general/reports/2014/03/03/85099/investing-for-success/>

141 Ollove, M. (2015, October 29). ‘Social Impact Bonds’ Tap Private Money for Public Health. *PEW Charitable Trusts Research & Analysis – Stateline* [Blog Post]. Retrieved from: <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/10/29/social-impact-bonds-tap-private-money-for-public-health>

SIBs impose administrative costs and require a return that should be justified by the project.<sup>142</sup> SIBs represent one viable example of combining and coordinating public and private financing streams. Others are also possible and promising.<sup>143</sup>

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142 Barajas, A. et al. (2014). Social Impact Bonds: A New Tool for Social Financing. Princeton University Public Policy and International Affairs Fellowship. Retrieved from: <https://www.princeton.edu/sites/default/files/content/Social%20Impact%20Bonds%202014%20Final%20Report.pdf>

143 E. H. Bradley et al. (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09. *Health Affairs* 35(5), 760-768.

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