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The Tools at Hand: Medicaid Payment Reform for People with Complex Medical Needs

*John V. Jacobi**

I. INTRODUCTION

Medicaid reform occurs in a sprawling landscape, encompassing efforts to expand the number of states taking advantage of the Affordable Care Act's (ACA) opportunity for state eligibility expansion, to place increasingly onerous conditions (including work requirements and ramped-up documentation requirements) on Medicaid participation, and to create beneficiary-controlled health savings accounts.¹ Analysis of these and other efforts is vital to charting the future of Medicaid. This article limits itself to one small, but important, corner of the reform landscape: the use of alternative payment models (APMs) to improve care for Medicaid beneficiaries with complex medical needs. The health status of Medicaid's most vulnerable beneficiaries tends to be quite poor. Improvements to Medicaid will require extending beneficiaries' access to innovative models of coordinated care, which emphasize addressing social determinants of health. Promising care models are emerging, and states are beginning to use the power of Medicaid to increase care value and enhance efficiency in the care of a small, vulnerable, and expensive subset of beneficiaries.²

This article argues that expanding the substantive range of Medicaid services to include social services, as well as more traditional health services, for a subset of high-needs Medicaid beneficiaries is both wise and lawful.

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1. Rachel Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*, HENRY J KAISER FAM. FOUND. (June 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>; Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, HENRY J KAISER FAM. FOUND. (Mar. 21, 2019), <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid>; Randy Pate, *Person-Centered Strategies: Health Savings Accounts*, CMS.GOV (Aug. 23, 2018), <https://www.cms.gov/blog/person-centered-strategies-health-savings-accounts>.

2. Julia C. Martinez et al., *Improving the Health Care System: Seven State Strategies*, NAT'L CONF. ST. LEGISLATURES 1, 1 (July 2016), <http://www.ncsl.org/Portals/1/Documents/Health/ImprovingHealthSystemsBrief16.pdf>.

Part I describes the characteristics of the target population of medically complex patients. It also describes the health care and finance innovations that seek to reverse the historic and harmful fragmentation of services by targeting them for improved health status through integration of medical and social services. Lastly, Part I describes two health systems and finance responses to the target population's needs, one medical and one social. Part II discusses a larger integration effort in Medicaid by which "health" services are broadly construed, with delivery and finance innovations addressing social determinants of health through whole-person services.

Part III then describes the legal authority that states can draw upon to use these innovative integrated care models in their Medicaid programs. States have authority directly under the Medicaid statute, as amended by the ACA.³ Specifically, states have broad experimental powers under Section 1115 waivers, which, with the approval of the Secretary of the Department of Health and Human Services, allows them to implement delivery and finance systems capable of bridging the gap between medical and social services for beneficiaries with complex needs.⁴ Furthermore, states have newly-codified power to require managed care organizations that contract with state Medicaid agencies to engage in broadly integrative methods, including partnering with community organizations, to achieve positive results for vulnerable populations.⁵ Finally, Part IV discusses some of the potential pitfalls of embracing private agencies' aggregation of the means to affect the social and medical well-being of vulnerable populations and communities. While adopting methods of broad integrative care promises tremendous benefits for individuals and vulnerable populations, it is important to consider the pitfalls that may stand in the way of success.

II. COMPLEX PATIENTS, THE MEDICAL RESPONSE, AND MEDICAID CARE MANAGEMENT

The distribution of care needs among patients is heterogeneous.[¶] One

3. *Section 1115 Demonstrations*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/index.html> (last visited Apr. 1, 2019).

4. Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, HENRY J KAISER FAM. FOUND. (Feb. 12, 2019), <http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers>.

5. Kathleen Gifford et al., *States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019*, HENRY J KAISER FAM. FOUND. (Oct. 25, 2018), <https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-managed-care-initiatives/>.

6. Robin Rudowitz et al., *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAMILY FOUNDATION (Mar. 6, 2019), <http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight>.

percent of Americans account for over twenty percent of health care costs per year, with five percent accounting for over half of the annual health expenditures.⁷ Many people use little to no healthcare resources in a year, while others are heavy users.⁸ Although many people move in and out of the highest-spender categories from year to year, others consistently fall within the most complex and expensive patients.⁹ Researchers have identified the following as indicators for high-needs patients: high medical costs, use of intensive medical interventions, and limitations on functional abilities.¹⁰ The skewed nature of health care needs significantly impacts health care delivery and finance.

Health systems researchers who examine means to improve quality and increase efficiency in health care delivery and finance have focused on high-utilizing patients for two reasons.¹¹ First, high-utilizing patients are, by definition, key drivers of health care costs.¹² Attention to relatively discrete groups that are responsible for out-sized proportions of national and programmatic health expenditures is a sensible strategy for those seeking insight into the causes of increasing health costs. Second, high-utilizers' health conditions often require innovative care, close coordination of care, and, therefore, coordinated care plans.¹³ Fragmentation of health care delivery and finance is considered partially responsible for the high costs of care of medically complex patients. Thus, reducing that fragmentation has been a robust area of research and innovation.¹⁴

7. Emily M. Mitchell & Steven R. Machlin, *Concentration of Health Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2015*, AGENCY FOR HEALTHCARE RES. & QUALITY (Dec. 2017), https://meps.ahrq.gov/data_files/publications/st506/stat506.pdf.

8. See Peter Long et al., *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health*, NAT'L ACAD. MEDICINE 1, 1 (2017), <https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf> (discussing multiple studies reporting that approximately 50 percent of Americans account for approximately three percent of health care utilization while one percent of Americans account for about 20 percent, and five percent account for about 50 percent of utilization).

9. William C. Johnson et al., *Consistently High Turnover in the Group of Top Health Care Spenders*, NEJM CATALYST (Feb. 1, 2018), <https://catalyst.nejm.org/high-turnover-top-health-care-spenders/>; Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, AGENCY FOR HEALTHCARE RES. & QUALITY 1, 2 (June 2006), https://meps.ahrq.gov/data_files/publications/ra19/ra19.pdf.

10. Long, *supra* note 8, at 5.

11. Long, *supra* note 8, at 5.

12. David Blumenthal & Melinda Abrams, *Tailoring Care Management for High-Need, High-Cost Patients*, 316 J. AM. MEDICAL ASS'N 1657, 1657 (2016).

13. *Id.* at 1657-58; Long et al., *supra* note 8.

14. See generally Donald M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFF. 759, 759-69; EINER ELHAUGE, THE FRAGMENTATION OF U.S. HEALTHCARE: CAUSES AND SOLUTIONS 1-2 (Einer Elhauge ed., 2010); see generally Alain C. Enthoven, *Integrated Delivery Systems: The Cure for Fragmentation*, 15 AM. J. MANAGED CARE 284,

Recognition of the skewed distribution of costs and needs impels a reform focus on high-cost and medically complex patients. The cost of health care is consequential to everyone responsible for paying for services, including Federal and State Governments, plan sponsors, and individual consumers.¹⁵ Effective cost containment reflects awareness of skewed distribution of costs toward the needs of complex patients. Likewise, efforts to improve the quality of care require payors and plan administrators to focus energies on those patients for whom care coordination has the greatest health payoff.

The skewed distribution of costs has been a catalyst for innovative alternative payment models.¹⁶ These models, which share the feature of moving away from disjointed fee-for-service payment and toward coordinated care models in which payment is tied to outcomes and quality, are becoming more prevalent in private and public insurance programs.¹⁷ Health delivery and finance responses to high-cost patients can generally be divided into two categories. First are those responses premised on improving coordination among medical care providers through care management techniques. The second category goes beyond management of medical care and includes non-medical services, shifting the focus from the remediation of illness and injury to interventions directly addressing needs that arise from the effects of social determinants of health.

The medical system's primary response to high-cost patients focuses on care coordination – a means of organizing care to ameliorate the effects of

284-290 (2009); INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 3 (Linda T. Kohn et al. eds., 2000).

15. See Ezekiel Emanuel, *The Real Cost of the US Health Care System*, 319 J. AM. MEDICAL ASS'N 983, 984 (2018) (explaining that increasing health costs has a tendency to crowd out other socially desirable expenditures).

16. J. Michael McWilliams et al., *Early Performance of Accountable Care Organizations in Medicare*, 374 NEW ENG. J. MED. 2357 (2016); Sylvia Burwell, *Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care*, 372 NEW ENG. J. MED. 897 (2015); Zirui Song et al., *Changes in Health Care Spending and Quality 4 Years into Global Payment*, 371 NEW ENG. J. MED. 1704 (2014).

17. See, e.g., Mark McClellan et al., *Payment Reform for Better Value and Medical Innovation*, NAT'L ACAD. MED. (Mar. 17, 2017), <https://nam.edu/wp-content/uploads/2017/03/Payment-Reform-for-Better-Value-and-Medical-Innovation.pdf> (describing private insurers' innovative payment methods directed to improved care coordination); Michael E. Porter & Robert S. Kaplan, *How to Pay for Health Care*, HARV. BUS. REV. (2016), <https://hbr.org/2016/07/how-to-pay-for-health-care> (discussing private payors and insurers moving to alternative payment models); see Randall S. Brown et al., *Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients*, 31 HEALTH AFF. 1156 (2012) (discussing Medicare Coordinated Care Demonstration program); Patrick H. Casey et al., *Effect of Hospital-Based Comprehensive Care Clinic on Health Costs for Medicaid-Insured Medically Complex Children*, 165 ARCHIVES PEDIATRICS & ADOLESCENT MED. 392 (2011) (discussing Medicaid's coordinated care program for children with complex needs).

health care fragmentation.¹⁸ “Fragmentation” in this context connotes the siloed structure of traditional health care delivery and finance.¹⁹ This fragmentation results in uneven or absent consultation among physicians and other caregivers, leading to inconsistent and contradictory courses of care.²⁰ This discord affects quality and cost, and is fueled in part by the traditional form of insurance payment.²¹ In the traditional form of insurance payment, fee-for-service payments compensate on the basis of piece-work, not on the basis of outcomes or coordinated treatment plans. As a result, the fee-for-service model provides little or no incentive for coordination or consultation on patient care.²² Almost twenty years ago, the Institute of Medicine noted as a central problem in the American health delivery system the quality and cost effects of this fragmentation:

The decentralized and fragmented nature of the health care delivery system (some would say “nonsystem”) . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. * * * The provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information. Unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability. * * * The context in which health care is purchased further exacerbates these problems. * * * Most third party payment systems provide little incentive for a health care organization to improve safety, nor do they recognize and reward safety or quality.²³

The problems of fragmentation are exacerbated for complex patients, for whom coordination is most beneficial.²⁴ These patients share several characteristics. For example, they often require intense medical care, experience functional limitations that interfere with their self-care or access to services, and they accrue substantial health care costs.²⁵ Furthermore, complex patients often experience multiple chronic illnesses, which further adds to their need for care coordination.²⁶

Additionally, Medicaid disproportionately covers these complex patients.

18. Dennis Z. Kuo et al., *Care Coordination for Children With Medical Complexity: Whose Care Is It, Anyway?*, 141 *PEDIATRICS* 224, 224-232 (2017).

19. *Id.*

20. Elhauge, *supra* note 14, at 2.

21. Berwick et al., *supra* note 14, at 9.

22. Kuo et al., *supra* note 18, at 229.

23. INST. OF MED., *supra* note 14, at 3.

24. Long et al., *supra* note 8, at 42.

25. Long et al., *supra* note 8, at 104.

26. Ken Thorpe et al., *Prevalence And Spending Associated With Patients Who Have A Behavioral Health Disorder And Other Conditions*, 36 *HEALTH AFF.* 124 (2017).

Almost half of all children with special healthcare needs and nonelderly adults with disabilities – including many with behavioral health conditions that are highly correlated with complex care – obtain insurance through Medicaid.²⁷ From the perspective of these complex patients with multiple chronic illnesses, our fragmented medical care system is inefficient due to its,

[M]yopic focus on isolated symptoms rather than the whole person: “Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, (i.e., treat the disease in the patient rather than treat the patient with the disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.”²⁸

The broadly accepted prescription for the fragmentation of care for complex and high-cost patients is coordination of care through reforms to primary care delivery.²⁹ The movement toward coordination-driven reforms in primary care originated from two observations: (1) primary care forms the foundation of a well-functioning health care system, and (2) primary care in the United States is fragmented in nature.³⁰ Many versions of patient-centered primary care exist, but the various models share certain features.³¹ First, the models comprise practices that genuinely adopt the “four pillars” of primary care, which are “first-contact care, coordinated care,

27. See generally Cynthia Boyd et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, CTR. FOR HEALTH CARE STRATEGIES (Dec. 2010),

https://www.chcs.org/media/clarifying_multimorbidity_patterns.pdf; see also, Rudowitz et al., *supra* note 6; see also, John V. Jacobi, *Medicaid, Managed Care, and the Mission for the Poor*, 9 ST. LOUIS. U.J. HEALTH L. & POL’Y 187, 195-96 (2016) (describing higher rates of disability and chronic illness in Medicaid population) [hereinafter *Mission for the Poor*].

28. John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL’Y, L., & ETHICS 89, 105 (2015) (quoting Robert L. Kane et al., *MEETING THE CHALLENGE OF CHRONIC ILLNESS* 50 (2005)) [hereinafter *Multiple Medicaid Missions*].

29. See Christopher G. Wise et al., *Journey Toward A Patient-Centered Medical Home: Readiness For Change In Primary Care Practices*, 89 MILBANK Q. 399, 400 (2011) (“The patient-centered medical home . . . has become a widely proposed model to address [fragmentation] in primary care”).

30. See *Id.* at 400 (illustrating the observations that primary care forms the foundation of a well-functioning health care system and the existing primary care in the United States is fragmented has been discussed since as early as 2001).

31. Karen Davis et al., *A 2020 Vision of Patient-Centered Primary Care*, 20 J. GEN. INTERNAL MED. 953, 953 (2005).

comprehensive care, and sustained personal relationships.”³² Second, many models adopt a particular form of patient-centered primary care, the Chronic Care Model,³³ which is a heavily-studied form of primary care practice.³⁴ Third, the practices encourage and rely on “activated patients,” that is, patients who engage in the direction and management of their care.³⁵ Fourth, the practices have the technical means to coordinate care through electronic health records and other information technologies.³⁶

Team-based care is a central component of the professional practice within these coordinated care settings.³⁷ The needs of people with chronic illnesses often entail care within various medical specialties, as well as care from those trained in nursing, social work, and food sciences.³⁸ For this reason, the team in a coordinated, primary care setting must include both a variety of competencies as well as protocols for coordination among the professionals.³⁹ Ongoing research tests the capacity of these team-based chronic care models to counter historic care fragmentation by improving quality of care without increasing costs.⁴⁰ Analysis of the clinical effects are

32. Paul A. Nutting et al., *Transforming Physician Practices To Patient-Centered Medical Homes: Lessons From The National Demonstration Project*, 30 HEALTH AFF. 439, 439 (2011).

33. *Id.* at 439.

34. See Katie Coleman et al., *Evidence On The Chronic Care Model In The New Millennium*, 28 HEALTH AFF. 75, 76 (2009) (illustrating the depth of study on The Chronic Care Model).

35. Nutting et al., *supra* note 32.

36. Nutting et al., *supra* note 32.

37. Lisa Schottenfeld et al., *CREATING PATIENT-CENTERED TEAM-BASED PRIMARY CARE* 1, 2 (2016) (explaining that team-based delivery of care is an integral part of moving to patient-centered primary care).

38. See Kane et al., *supra* note 28, at 92 (“Patients with chronic illness will be cared for by a wide range of health care professionals, including general internists, family practitioners, and other physicians; advanced practice nurses, nurses, and nursing aids; and social workers, occupational and physical therapists, and other practitioners”).

39. See Kane et al., *supra* note 28, at 91-93 (detailing the numerous variety of health care professionals that must work together in a coordinated primary care setting and the coordination necessary for practitioners to competently provide care, communicate effectively, coordinate patient care, reconfigure the roles and responsibilities of clinicians who care for patients with chronic conditions, and avoid burnout); see also Edward H. Wagner, *The Role of Patient Care Teams In Chronic Disease Management*, 320 BMJ 569, 570-71 (2000) (illustrating further the diverse team composition for effective chronic disease management).

40. See Hanneke W. Drewes et al., *The Effectiveness of Chronic Care Management for Heart Failure: Meta-Regression Analyses to Explain the Heterogeneity in Outcomes*, 47 HEALTH SERVS. RES. 1926 (2012) (detailing a research study on the effectiveness of team-based chronic patient-care); see also Wayne Katon et al., *Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial*, 69 ARCHIVES GEN. PSYCHIATRY 506 (2012) (demonstrating significant clinical improvements in care with little or no added cost).

promising, although preliminary.⁴¹ Cost studies are similarly underway, and some promising results have been reported.⁴²

States have supported patient-centered care models with enhanced Medicaid reimbursements, including: start-up costs, performance bonuses, enhanced per-member per-month fees to recognize additional costs of care management,⁴³ and enhanced federal matching payment granted by the ACA.⁴⁴ In sum, substantive improvements to primary care coordination created by patient-centered care and state Medicaid payment enhancements have shown the way in enhancing care for complex medical conditions.⁴⁵ However, for present purposes, two observations are necessary.

First, the development of practice models advancing chronic care

41. See Drewes et al., *supra* note 40 (detailing a meta-analysis of chronic care management in heart disease cases which showed reductions in average mortality and hospital usage, however there were uneven results among the programs); see also Michael Stollefson, et al., *The Chronic Care Model and Diabetes Management in US Primary Care Settings: A Systematic Review*, 10 PREVENTING CHRONIC DISEASE (2013) (reporting positive outcomes in diabetes management in primary care settings using chronic case management); see also Carol Davy et al., *Effectiveness of Chronic Care Models: Opportunities For Improving Healthcare Practice And Health Outcomes: A Systematic Review*, 15 BMC HEALTH SERVS. RES. (2015) (reporting positive clinical results in a meta-analysis of studies conducted in several countries).

42. See Katon et al., *supra* note 40 (reporting patients with diabetes and/or coronary heart disease that showed significant clinical improvements with chronic case management with little or no added cost to care); see also Robert J. Reid et al., *The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers*, 29 HEALTH AFF. 835 (2010) (reporting that a patient-centered medical home for chronically ill patients had an estimated “total savings of \$10.30 per patient per month twenty-one months into the pilot program”).

43. Mary Takach, *About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations*, 31 HEALTH AFF. 2432, 2432-38 (2012); see *Frequently Asked Questions: Patient Centered Medical Homes*, N.Y. STATE DEP’T OF HEALTH, https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/faqs.htm (last revised Feb. 2018) (describing add-ons to fees and per-member per-month payments by New York Medicaid under an incentive program known as the New York Statewide Medicaid PCMH Incentive Payment Program that provides additional reimbursement to high-level National Committee for Quality Assurance’s Patient Centered Medical Home recognized practices); see also Robert L. Phillips Jr. et al., *Cost, Utilization, and Quality of Care: An Evaluation of Illinois’ Medicaid Primary Care Case Management Program*, 12 ANNALS FAM. MED. 408 (2014) (describing the primary care case management program, Illinois Health Connect, in which Illinois Medicaid paid per-member per-month fees and performance bonuses in addition to fee-for-service payments).

44. See *infra* Part IV; see also Robin Rudowitz, *Understanding How States Access the ACA Enhanced Medicaid Match Rates*, HENRY J KAISER FAM. FOUND. (Sep. 29, 2014) <http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief> (describing the role the ACA plays in Medicaid funding).

45. See Davy et al., *supra* note 41 (reporting positive clinical results in a meta-analysis of studies conducted in several countries); see also Takach, *supra* note 43 (noting that new payment systems under Medicaid have led to better alignment of payments with performance metrics that emphasize health outcomes, patient satisfaction, and cost containment).

coordination is an evolution of primary care, which can improve the delivery of medical care to people with complex care needs and chronic conditions.⁴⁶ These developments are welcome responses to the observations that fragmentation of the health care delivery system harms patients, particularly those with chronic illness.⁴⁷

Second, these coordinated care developments add a great deal to the coherence and potential efficacy of the primary care delivery system.⁴⁸ However, little in the literature on these programs suggests that they will, or are intended to, go beyond the delivery of medical care toward the integration of non-medical social services, such as housing, vocational, and educational services. It is these broader programs that break the boundaries of traditional health care delivery that raise concerns of mission creep and the pathologizing of Medicaid beneficiaries. The next Part examines these broader programs.

III. BEYOND MEDICAL CARE: SOCIAL DETERMINANTS OF HEALTH

What if coordination of medical care is not enough to achieve integrated health care – that is, what if there were reason to widen the lens through which we regard “health care” and “health insurance”? As this section describes, medical and public health research illustrates that there are many explanatory factors of a person’s health status.⁴⁹ The delivery of medical care can be extremely important at times in any person’s life. Attention to factors other than the medical interventions can have a greater effect on individual and population health than improvements in health care delivery.⁵⁰

“Upstream” factors – circumstances in the lives of patients before they

46. MATHEMATICA POL RESEARCH, COORDINATING CARE FOR ADULTS WITH COMPLEX CARE NEEDS IN THE PATIENT-CENTERED MEDICAL HOME: CHALLENGES AND SOLUTIONS 1 (2012).

47. See Brigham R. Frandsen et al., *Care Fragmentation, Quality, and Costs Among Chronically Ill Patients*, 21 AM. J. MANAGED CARE 355 (2015) (illustrating that patients with fragmentation of care had a higher chance of having a departure from clinical best practice, higher rates of preventable hospitalizations, and higher health care spending).

48. See INST. OF MED. (US) COMMITTEE ON ASSURING THE HEALTH OF THE PUB. IN THE 21ST CENTURY, THE FUTURE OF THE PUBLIC’S HEALTH IN THE 21ST CENTURY (2002) (explaining that “since the collapse of health care reform efforts in the early 1990s, the health care delivery system often does not interact effectively with the other components of the public health system . . .”).

49. See David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health As The Business Of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012) (detailing bodies of research that show multiple explanatory factors).

50. Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It’s Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. 19, 20 (2014) (explaining that the impacts of socioeconomic and other social factors have an overwhelming impact on health outcomes).

manifest illness or injury – can immensely affect their health status.⁵¹ Commentators on health finance structures have noted that “[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them.”⁵² These social circumstances include housing quality, employment and vocational opportunities, stresses related to social and racial inequality, the availability of healthy fresh food, and opportunities for recreation and exercise.⁵³

Health commentators recognize that effective health care and health payment practices must broaden their scope to contemplate services beyond traditional health care by including social determinants of health.⁵⁴ David Blumenthal and Melinda Abrams of the Commonwealth Fund have described these developments in the following terms:

Many HNHC [that is, high-need, high cost] patients have nonmedical needs that compromise their care and increase its costs. Attending to these needs is a core component of care for HNHC patients. The evidence suggests that meeting the housing, nutritional, and personal care needs of HNHC individuals can improve their health and reduce their health care expenses. . . . Achieving the care efficiencies and effectiveness necessary will require flexibility to use evidence-based nonmedical services within VBP [that is, value-based payment] arrangements in which clinicians and health care organizations are accountable for the total costs of care.⁵⁵

Other researchers observing similar effects of the social determinants advanced by Blumenthal and Abrams have noted that increased attention to “upstream” effects of poor health offers the promise of increased health equity, in addition to the effects on individual health status and system equity.⁵⁶ These researchers suggest that attention to upstream causes of poor

51. Nazleen Bharmal et al., *Working Paper: Understanding the Upstream Social Determinants of Health* (2015) (defining “upstream” factors to include “social disadvantage, risk exposure, and social inequalities that play a fundamental causal role in poor health outcomes”).

52. Asch & Volpp, *supra* note 49 at 888.

53. See Clare Bamba et al., *Tackling the Wider Social Determinants of Health and Health Equalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 284, 284 (2010) (explaining that housing quality, access to health care, and quality of work are social determinants of health); see also *Mission for the Poor*, *supra* note 27, at 187 (noting that social determinants of health also include housing, nutrition, and employment training services).

54. LAUREN A. TAYLOR ET AL., *LEVERAGING THE SOCIAL DETERMINANTS OF HEALTH: WHAT WORKS?* 3 (2015) (indicating that greater attention to social determinants of health may both improve Americans’ health and reduce health care costs).

55. David Blumenthal & Melinda K. Abrams, *Tailoring Complex Care Management for High-Need, High-Cost Patients*, 316 J. AM. MED. ASS’N 1657, 1657 (2016).

56. Nancy E. Adler et al., *Addressing Social Determinants of Health and Health Inequalities*, 316 J. AM. MED. ASS’N 1641, 1641 (2016).

health helps to address some of the causes of health inequities, including disparate effects of race, sex, social status, and educational achievement.⁵⁷

Moreover, Blumenthal and Abrams point out that APMs can redirect the attention of caregivers from narrow immediate issues to the, sometimes more fruitful, source of illness and poor health: upstream social determinants.⁵⁸ The use of the term “APM” presupposes a continuum of relationships between payor and clinician that range from “traditional” through degrees of “alternative.”⁵⁹ One useful taxonomy suggests four stages of the payor-clinical relationship as mediated through the payment arrangement: fee-for-service with no quality component, fee-for-service with a payment component linked to quality or value, model “built on fee-for-service architecture” but with extensive value/quality evaluations and payment adjustments, and population-based payment in which payment is premised on addressing social and medical causes of illness.⁶⁰ Progression through this continuum of payment models results in effects on the delivery system of these incentives by which care providers are “increasingly accountable for both quality and total cost of care” and their attention is more focused “on population health management as opposed to payment for specific services.”⁶¹

The medical care management programs described above in Part I draw on the benefits of APMs built on a fee-for-service base.⁶² The necessary next step in care delivery and Medicaid financing for beneficiaries with complex medical conditions is programs premised on population-based payment and/or focused on addressing the social determinants of health.⁶³ At this point, it should be emphasized that the dichotomy between “medical” integration (the subject of Part I) and broader integration between medical and social service systems should not be overstated. One of the federal models for chronic care management, Medicaid Health Home,⁶⁴ as

57. *Id.*

58. See Blumenthal & Abrams, *supra* note 55, at 1658.

59. See HEALTH CARE PAYMENT LEARNING & ACTION NETWORK, ALTERNATIVE PAYMENT MODEL APM FRAMEWORK, MITRE CORP. (2017).

60. Rahul Rajkumar et al., *CMS—Engaging Multiple Payers in Payment Reform*, 311 J. AM. MED. ASS’N 1967, 1967 (2014).

61. *Id.*

62. See Blumenthal & Abrams, *supra* note 55, at 1658; Matthew Fiedler et al., *Congress Should Replace Medicare’s Merit-Based Incentive Payment System*, HEALTH AFF. (Feb. 26, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180222.35120/full/>.

63. See *The State Innovation Models (SIM) Program: A Look at Round 2 Grantees*, HENRY J KAISER FAM. FOUND. (Sept. 25, 2015), <http://files.kff.org/attachment/fact-sheet-the-state-innovation-models-sim-program-a-look-at-round-2-grantees> (discussing states that have taken the initiative to address social determinants of health in Medicare and Medicaid patients).

64. Patient Protection and Affordable Care Act, 42 U.S.C. § 1396w-4 (2018). This section of the ACA is addressed further *infra* at Part IV.

authorized by the ACA,⁶⁵ includes a requirement for these Health Homes to provide “referral to community and social support services, if relevant.”⁶⁶ Whatever the model employed, attention to referral or provision of social services to address the effects of social determinants of health can improve health outcomes for complex patients.⁶⁷

Some forms of care delivery already go beyond adding social service referrals to primary care models.⁶⁸ Compensation models that include quality and outcomes measures as triggers for enhanced payment can incentivize clinicians to create referral relationships to community social service agencies to improve outcomes measured for compensation purposes.⁶⁹ For example, if a bundled or episodic payment system requires the primary care provider’s reporting of patient outcomes and satisfaction, perhaps with a payment bonus depending on the results, the provider may be incentivized to connect patients to appropriate community social services providers.⁷⁰ In this instance, social services are not directly funded by health insurance.⁷¹ Instead, the payment model provides incentives for offering connections to social services in order to maximize caregivers’ income.⁷²

Compensation models that “nudge” providers to shift to value-based or coordinated care models are supported in the literature as mechanisms for improving quality and containing cost but have met with resistance from

65. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2703, 124 Stat. 119, 319 (2010); *Home Information Resource Center*, MEDICAID.GOV, <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/index.html> (last visited Apr. 1, 2019)..

66. 42 U.S.C. § 1396w-4(h)(4)(B)(v) (2018).

67. See generally Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in*

Promoting Health and Health Equity, HENRY J KAISER FAM. FOUND. (May 10 2018), <http://files.kff.org/attachment/issue-brief-beyond-health-care>; Gayle Shier et al., *Strong Social Support Services, Such As Transportation And Help For Caregivers, Can Lead To Lower Health Care Use And Costs*, 32 HEALTH AFF. 544, 548 (2013).

68. See Rajkumar, *supra* note 60, at 1967 (discussing alternative payment models that go beyond simple fee for service).

69. Rajkumar et al., *supra* note 60, at 1968.

70. *CMS’ Value-Based Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html> (last modified July 25, 2018).

71. See *Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov/initiatives/bundled-payments/> (last updated Mar. 7, 2019).

72. See generally Deborah Bachrach, *Addressing Patients’ Social Needs: An Emerging Business Case for Provider Investment*, COMMONWEALTH FUND (May 29, 2014), <https://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs-emerging-business-case-provider> (discussing different payment models that include economic incentives to providers in order to incorporate social interventions into care).

physicians.⁷³ Resistance springs from concerns about reductions in physician autonomy, concerns about administrative complexity and patient privacy, and beliefs that the motive – hidden or otherwise – in the models is to encourage the consolidation of physician practices.⁷⁴ These objections can complicate the adoption of value-based payment models, particularly when added to concerns for “mission creep” and “medicalization” of health care, as is more fully described in Part IV below.⁷⁵

Other models go beyond incentivizing providers to consider referrals to social services in order to provide value or contain costs, and more formally include mechanisms for joining the provision of medical and social services.⁷⁶ For example, states may wish to maximize their federal Medicaid revenue through initiatives such as Medicaid Health Homes,⁷⁷ but maintain independent funding for social services such as housing and vocational services. In that case, the state may use “braided funding,” which allows “coordinated multi-agency funding [within state government], but keeps different funding streams in separate and distinguishable strands, so each can be tracked at the administrative level.”⁷⁸ This strategy allows each contributing agency to track and account for resources.⁷⁹ Alternatively, the state could use “blended funding,” which allows states to combine money from different state accounts, thereby easing administrative burdens but reducing specific-agency accountability.⁸⁰

These models are specific forms of Health in All Policies (HiAP) programs, which comprise more or less coordinated, combined decision-

73. See Laura Panattoni, et al., *Nudging Physicians and Patients With Autopend Clinical Decision Support to Improve Diabetes Management*, 24 AM. J. MANAGED CARE 479 (2018) (describing physician incentives to coordinate care by reference to behavioral economics principle of “nudging”); see Sam Nussbaum et al., *Principles for a Framework for Alternative Payment Models*, 319 J. AM. MED. ASS’N 653, 653-54 (2018); Porter & Kaplan, *supra* note 17.

74. See Sheri Porter, *Proposed MACRA Implementation Rule Misses the Mark, AAFP Tells CMS*, 14 ANNALS FAM. MED. 483 (2016) (in the context of incentives under the Medicare Access and SHIP Reauthorization Act); Kristin S. Held, *New Medicare Payment Rule: a Trojan Horse for Government Takeover*, 21 J. AM. PHYSICIANS & SURGEONS 87 (2016); Margaret Amatayakul, *Carrots and Sticks for EHR Implementation*, HEALTH CARE FINANCING MGMT. 60 (2010) (in the context of Meaningful Use incentives under the American Recovery and Reinvestment Act).

75. See *infra* Part IV.

76. See Maria Crawford & Rob Houston, *State Payment and Financing Models to Promote Health and Social Service Integration*, CTR. FOR HEALTH CARE STRATEGIES (Feb. 2015), https://www.chcs.org/media/Medicaid_Soc-Service-Financing_022515_2_Final.pdf (discussing two types of funding: braided funding and blended funding).

77. See Bachrach et al., *supra* note 72 (discussing that Medicaid health home certifications trigger higher levels of reimbursement).

78. Crawford & Houston, *supra* note 76.

79. Crawford & Houston, *supra* note 76.

80. Crawford & Houston, *supra* note 76.

making by state or local governments to facilitate public health improvements.⁸¹ The agencies involved in HiAP programming may include those that have long overseen those services vital to addressing determinants of health, including housing, environmental services, and food/nutrition services.⁸² The benefit of HiAPs is the reinforcement among several government agencies (and those entities they regulate and/or fund) of the shared interest in enhancing the ability of separate programs to combine for the public's health benefit.⁸³

Conversely, the Accountable Communities for Health (ACH) model is premised on coordination but not unified control of population health-related spending.⁸⁴ ACHs gather public and private entities that share the goal of improving community health through coordination of services and the alignment of strategies.⁸⁵ The "two-pronged approach" of these collaborations is to "focus on improving health care for individuals with existing medical conditions. . . and . . . facilitate policy and environmental changes that benefit the entire community."⁸⁶ The entities forming an ACH, while sharing goals and strategies, do not share business management or funding.⁸⁷

Comparatively, Medicaid Accountable Care Organizations (ACOs) add a feature to the above collaborative methods of addressing the effects of social determinants of health.⁸⁸ These organizations, which share the goals of HiAPs and ACHs, add structural features that squarely raise the issue of Medicaid mission creep: they have unitary control over strategic decision-making, coupled with incentives to expand institutional services beyond medical care and into the realm of social services.⁸⁹

In contrast to Medicaid ACOs, Medicare ACOs are authorized by the

81. Jason Coburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URBAN HEALTH 623, 624-25 (2014).

82. See *Multiple Medicaid Missions*, *supra* note 28 at 101-03; Lawrence O. Gostin, *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PENN. L. REV. 1777, 1819-20 (2011).

83. Coburn, *supra* note 81.

84. Felicia Heider et al., *State Levers to Advance Accountable Communities for Health*, NAT'L ACAD. FOR ST. HEALTH POL'Y 1 (May 24, 2016), <https://nashp.org/wp-content/uploads/2016/05/ACH-Brief-with-Appendix.pdf>.

85. *Id.*

86. *Id.*

87. *Id.*; See Shana F. Sandberg et al., *Hennepin Health: A Safety-Net Accountable Care Organization for The Expanded Medicaid Population*, 33 HEALTH AFF. 1975, 1976-77 (2014) (providing an example of an Accountable Care Organization in partnership with a county human services and public health agency, a public hospital, and a federally qualified health center created an AHC).

88. Vera Gruessner, *Accountable Care Organizations Expand Use of Social Services*, HEALTH PAYER INTELLIGENCE (Oct. 28, 2016), http://www.skainfo.com/images/uploads/misc/ACO_Fact_Sheet.pdf [hereinafter SK&A].

89. *Multiple Medicaid Missions*, *supra* note 28, at 107; SK&A, *supra* note 88.

ACA.⁹⁰ These organizations were to incorporate the patient-centered care aspects of coordinated primary care, but also extend the care coordination principles to other providers, including hospitals and ancillary care providers.⁹¹ The guiding strategy of creating ACOs within Medicare was to provide an incentive for a collaborative organization in order to combat fragmented care by embracing clinical integration of care, while providing incentives to control costs yet increase value.⁹² The incentives flow primarily from the gainsharing features of the ACA's treatment of Medicare ACOs,⁹³ by which if an ACO's patients experience less Medicare utilization than projected, while the ACO maintains quality standards, the ACO receives a portion of the savings realized by the Medicare program.⁹⁴

There is no cognate provision in the ACA for Medicaid ACOs.⁹⁵ However, states are creating variations of ACOs for application to their Medicaid populations.⁹⁶ Some Medicaid ACO models use gainsharing mechanisms to create incentives for improved care and lower costs.⁹⁷ The combination of several factors – the realization of payments on reducing costs while maintaining quality, the vulnerability of Medicaid beneficiaries to the effects of social determinants of health, and the multifaceted organizational structure of some Medicaid ACOs – can result in these organizations going beyond medical care to provide, directly or through partners, social services, too.⁹⁸ This combination of these factors can, as Professor Mantel observed, “improve patient health [and thereby increase gainsharing income] by investing in social services and other nonclinical interventions. . . For example, a Medicaid ACO can improve health outcomes and lower the medical costs of treating its homeless patients by helping them obtain stable housing.”⁹⁹

Accordingly, the financing mechanism of some Medicaid ACOs incentivizes them to approach patients with the goal of determining what

90. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

91. *Id.*

92. See Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 985 (2010); see also John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L.J. 357, 374-75 (2014) [hereinafter *Medicaid Evolution*].

93. 42 U.S.C. § 1395JJ (2018) (describing Medicare Shared Savings program).

94. See Nicholas Hodges, *Accountable Care Organizations: Realigning the Incentive Problems in the U.S. Healthcare System*, 26 U. FLA. J.L. & PUB. POL'Y 99, 119-121 (2015).

95. See *Medicaid Evolution*, *supra* note 92, at 375.

96. See Jessica Mantel, *Tackling the Social Determinants of Health: The Central Role for Providers*, 33 GA. ST. U.L. REV. 217, 240-42 (2017); see also S. Lawrence Kocot et al., *Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities*, 16 POPULATION HEALTH MGMT. S-4, S-4 (2013).

97. Mantel, *supra* note 96, at 239-40.

98. See Kocot et al., *supra* note 96, at S-6.

99. Mantel, *supra* note 96, at 241.

interventions, medical or otherwise, will reduce the patient's need for health care.¹⁰⁰ If coordinated medical care is the answer, the ACO's response is in line with the incentives created by patient-centered medical homes. However, if access to social services is the best way to reduce the patient's need for expensive medical services, the ACO has incentives to go beyond medical care:

The financing structure that rewards Medicaid ACOs for reaching and treating people with chronic medical conditions can also reward [them] for reaching beyond medical care to the provision of social services to ameliorate the effects of the social determinants of health. By expanding the scope of their vision and their activities to include the social determinants of health, Medicaid ACOs can be transformative in their communities.¹⁰¹

Financial incentives in states' Medicaid programs have fueled an evolution of patient-centered care to improve quality and reduce the cost of care.¹⁰² When limited to coordination of medical care, particularly in the context of primary care, the results seem to keep health care and finance in their familiar roles. However, when these financial incentives encourage and empower Medicaid ACOs and their sister organizations to broaden their missions in order to include social as well as medical services,¹⁰³ the organizations and the Medicaid agencies that empower them will face objections on legal and philosophical grounds. Part IV now addresses those issues.

IV. MEDICAID'S LEGAL AND SOCIAL AUTHORITY TO EXPAND TO ADDRESS SOCIAL DETERMINANTS

Medicaid is a unique insurance program. From its inception, Medicaid combined aspects of traditional medical insurance with a social mission defined by the vulnerable population it was created to serve.¹⁰⁴ As Professor Watson has described this history,

100. Mantel, *supra* note 96, at 261.

101. *Multiple Medicaid Missions*, *supra* note 28, at 107.

102. Mantel, *supra* note 96, at 252 (discussing the patient-centered medical home model that allows individualized approaches to patients' social needs).

103. *See Multiple Medicaid Missions*, *supra* note 28, at 107-08 (stating that some organizations providing broad population-based services for Medicaid beneficiaries are called "TACOs," for "Total Accountable Care Organizations"); *see* Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid*, 9 ST. LOUIS U.J. HEALTH L. & POL'Y 235, 258-63 (2016) (stating that the relevant organization in Oregon is the "CCOs," for "Coordinated Care Organizations").

104. *See* Earl Dirk Hoffman Jr. et al., *Overview of the Medicare and Medicaid Programs*, 21 HEALTH CARE FINANCING REV. 1, 1-2 (2000).

Medicaid was rooted in the Social Security Act's commitment to provide public support for the needy so they could live in the community. Medicaid's purpose was to provide both “medical assistance” and “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” Medicaid would provide government funding for social support services and long-term care as well as hospital and physician care. It would fund both nursing home care and community based care.¹⁰⁵

The starting point for discerning the general purpose of Medicaid is usually found in the statutory language describing the conditions under which states may receive federal matching funds for their programs.¹⁰⁶ The relevant provision in the Social Security Act allows for appropriations:

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .¹⁰⁷

To the extent the services of community organizations extending care to vulnerable Medicaid recipients take the form of patient-centered medical homes, the ACA's amendments to the Medicaid statute specifically authorize the payment of enhanced payments to encourage the ACA's version of integrated care for beneficiaries with chronic conditions, provided through Medicaid Health Homes.¹⁰⁸ Karen Davis has described the purposes of this provision:

105. Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U.L. REV. 937, 953-54 (2010).

106. See *Stewart v. Azar*, 313 F.Supp. 3d 237, 260 (D.D.C. 2018) (citing Pharm. Research & Mfrs. of Am. v. Conannon, 249 F.3d 66, 75 (1st Cir. 2001)); see also Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal & Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J.L. & SOC. PROBS. 91, 132, n.235 (2003) (providing the proposition that 42 U.S.C. § 1396-1 is the touchstone for the core purpose of the Medicaid program).

107. 42 U.S.C. § 1396-1 (1984).

108. 42 U.S.C. § 1396w-4(c)(1) (2018) (providing that “[p]ayments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of” operating a Medicaid Health Home); 42 U.S.C. § 1396w-4(c)(2)(B) (2018) (providing that states may reimburse Medicaid Health Homes using alternative payment models); 42 U.S.C. § 1396w-4(a) (2018) (providing that states must file a state plan amendment to initiate Medicaid Health Home services); see *Section 2703, the Medicaid Health Home Provision of the Affordable Care Act*, CATALYST CTR. (June 2014), <https://cahpp.org/wp-content/uploads/2015/04/2703healthhome.pdf>.

The Affordable Care Act encourages the widespread adoption of PCMHs by offering states the option to increase reimbursement to primary care sites designated as “health homes” for Medicaid patients with chronic conditions. Health homes are similar to medical homes, but tend to emphasize the integration with public health. . . . Under the law, teams of primary care providers (including physicians, nurse practitioners, and physician assistants) will agree to provide comprehensive care management, care coordination and health promotion, transitional care between hospital and primary care, referral to community and social services, patient and family engagement and use of information technology to link services. The . . . provision gives states flexibility to design payment methodology that works for them, and allows for state variation in the payment approach that they choose.¹⁰⁹

The analysis is thus far uncontroversial; payment for primary care for people with chronic illnesses is specifically permitted by the Medicaid statute and states can use APMs to encourage the providers of primary care to coordinate care to increase quality and reduce cost.¹¹⁰ What of the more expansive care and payment models that sweep in social as well as medical services?

Notably, while states may fund services that support housing for beneficiaries, they may not use federally-matched funds to *directly* pay for room and board or otherwise pay directly for housing costs.¹¹¹ The United States Department of Health and Human Services (DHHS) has suggested that it may revisit this issue, and may even be open to permitting federal funding of state programs.¹¹²

DHHS Secretary Alex Azar recently suggested that, in line with the “whole person” direction in modern health care and finance, states may be given leave to use Medicaid funding for housing, healthy food, and other

109. Karen Davis et al., *How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation*, 26 J. GEN. INTERNAL MED. 1201, 1202 (2011).

110. See 42 U.S.C. § 1396w-4(c)(2)(B) (2018) (authorizing federal matching payments to state using alternative payment methods in Medicaid Health Homes).

111. See 42 C.F.R. § 441.310(a)(2) (2000) (providing that federally-matched Medicaid funding for room and board are prohibited in home and community-based waiver programs); see also Vikki Wachino, *CMCS Informational Bulletin*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 26, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf> (describing availability of federally-matched Medicaid funds to provide wrap-around services for housing, but not room and board or other direct housing costs); Julia Paradise & Donna Cohen Ross, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, HENRY J KAISER FAM. FOUND. (Jan. 27, 2017), <http://files.kff.org/attachment/Issue-Brief-Linking-Medicaid-and-Supportive-Housing-Opportunities-and-On-the-Ground-Examples>.

112. See Wachino, *supra* note 111, at 1.

goods and services related to social determinants of health.¹¹³ He elaborated:

What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food? . . . If that sounds like an exciting idea . . . I want you to stay tuned to what CMMI [Centers for Medicare and Medicaid Innovation] is up to.¹¹⁴

While sound arguments support Azar's suggestion,¹¹⁵ as discussed above, current regulations prohibit the use of federally-matched Medicaid funds to pay for rent or other direct housing costs.¹¹⁶ Social supports, such as housing costs, are acknowledged to be important health-related expenditures, but federally-matched Medicaid funding is unavailable for that purpose, and accordingly, organizations such as Medicaid ACOs are vitally important. Simply stated, Medicaid ACOs have the capacity to convert Medicaid funds to private ownership.¹¹⁷ That is, once the ACO receives gainsharing payments from a state's Medicaid agency, those funds belong to the ACO, and the ACO may direct those funds to any use within the ACO's corporate mission.¹¹⁸ Just as a private physician may contribute the proceeds of his or her Medicaid reimbursement check to a homeless person to help pay his or her rent, so too may a Medicaid ACO use its excess funds received from Medicaid to pay for housing supports.¹¹⁹ If the ACO's management

113. Paul Barr & Virgil Dickson, *CMS may allow hospitals to pay for housing through Medicaid*, MODERN HEALTHCARE (Nov. 14, 2018), <https://www.modernhealthcare.com/article/20181114/NEWS/181119981>.

114. *Id.*

115. See Mary Crossley, *Bundling Justice: Medicaid's Support for Housing*, 46 J.L., MED. & ETHICS 595, 597-98 (2018) (explaining that Medicaid is prohibited from directly funding housing costs and that those on Medicaid must rely on other state and local programs to help them find affordable housing); Kathy Moses, et al., *Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies*, CTR. FOR HEALTH CARE STRATEGIES (Jan. 2016), www.chcs.org/resource/supportive-housing-for-chronically-homeless-medicare-enrollees-state-strategies/ (arguing that given the linkage between housing instability and health care utilization and costs, policy makers should focus on expanding access to permanent supportive housing and addressing the health care needs of chronically homeless individuals).

116. 42 C.F.R. § 441.310(a)(2) (2000).

117. See Hodges, *supra* note 94, at 112 (stating that CMS makes direct payments to ACOs under the original Medicare Parts A and B fee-for-service program); *but see*, Rachael Matulis & Jim Lloyd, *The History, Evolution, and Future of Medicaid Accountable Care Organizations*, CTR. FOR HEALTH CARE STRATEGIES (Feb. 2018), https://www.chcs.org/media/ACO-Policy-Paper_022718.pdf (stating that many state ACOs have leveraged federal funds for delivery and payment reform initiatives).

118. See *Multiple Medicaid Missions*, *supra* note 28, at 106 (stating that ACOs have substantial discretion in how they use their gainsharing payments).

119. See generally Diana Crumley & Marlise Pierre-Wright, *Addressing Social Determinants of Health through Medicaid Accountable Care Organizations*, CTR. FOR HEALTH CARE STRATEGIES (Apr. 18, 2018), www.chcs.org/addressing-social-determinants-

concludes, as Azar suggests it should,¹²⁰ that paying for housing or other social service costs with funds comprising its operating margin will improve the health status of its patients and lower overall health costs, it would not only be permissible, but prudent, for the ACO management to do so.

The conversion of Medicaid funds to private funds is not mysterious. The ACO receives funds for services rendered, and can use them for its own purposes just as any Medicaid contractor may use its receipts from Medicaid for its own purposes.¹²¹ The noteworthy feature of ACOs' ability to so use its funds is that the steps outlined above permit state Medicaid agencies to lawfully circumvent the limitations on Medicaid spending through their contracts with Medicaid ACOs.¹²² States are authorized to contract for these services through the mechanism of Section 1115 waivers.¹²³

Section 1115 waivers allow the Secretary to waive some general federal requirements to permit states to use federally-matched funds if he finds that the state proposal is likely to assist in "promot[ing] the objectives" of Medicaid.¹²⁴ Under Section 1115 authority, the "Secretary can waive almost any Medicaid state plan requirement" and "can also permit federal financial participation for costs not otherwise matchable."¹²⁵ These waivers have become increasingly important as states strive to particularize their Medicaid programs to suit their own perceptions of programmatic need.¹²⁶

States have used the Section 1115 waiver process to obtain federal approval of the use of federally-matched Medicaid funds to support organizations such as Medicaid ACOs, which seek to widen the lens of health care delivery to integrate medical care and social services.¹²⁷ The models

health-medicare-accountable-care-organizations/ (providing an overview of state approaches to addressing social determinants of health such as homelessness).

120. Barr & Dickson, *supra* note 113.

121. *Multiple Medicaid Missions*, *supra* note 28, at 105-06.

122. *See generally Multiple Medicaid Missions*, *supra* note 28, at 107-08 (stating that Medicaid payments to ACOs gives them the flexibility to use their resources to address the particular cost-drivers of poor populations without creating a separate targeted form of Medicaid).

123. Matulis & Lloyd, *supra* note 117, at 4.

124. *About Section 1115 Demonstrations*, MEDICAID.GOV, www.medicare.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Apr. 1, 2019); Judith Solomon & Jessica Schubel, *Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care*, CTR. ON BUDGET & POL'Y PRIORITIES (Aug. 29, 2017), <https://www.cbpp.org/sites/default/files/atoms/files/8-28-17health.pdf>.

125. *Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION, www.macpac.gov/subtopic/waivers/ (last visited Apr. 1, 2019).

126. *See* Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1729-30 (2018) (noting that 1115 waivers have always been a tool to allow states to deviate from Medicaid requirements); *see* Hermer, *supra* note 103, at 237 (providing a description of 1115 waivers and their purpose).

127. *See* Hermer, *supra* note 103, at 258-63 (providing an example of how Oregon used federal funds for social supports); *see* Kocot et al., *supra* note 96, at S-6 – S-9 (describing

differ greatly one from the other;¹²⁸ the theory of the benefit of combining medical and social services is sound, but evaluation of these disparate programs will tell whether the programs successfully improve quality while containing care, and which models present the most promise.¹²⁹

Some integration of social and medical services in Medicaid comes from a different source. Increasingly, Medicaid managed care organizations (MCOs) are committed to evaluating the care needs of complex patients, and to providing the complex care these patients require.¹³⁰ As Medicaid MCOs address their most vulnerable members, they uncover social circumstances, such as housing insecurity, that exacerbate underlying medical needs.¹³¹ As Medicaid ACOs mature, they present opportunities for partnership, and competition, with MCOs.¹³² In this model, Medicaid ACOs contract with MCOs to provide services to identified members, with terms and conditions of the contract mutually agreeable to the parties.¹³³ Such contractual arrangements between two private parties does not require federal approval, and thereby further permits Medicaid ACOs' integrated model of care to find financial footing within the regulatory landscape.¹³⁴

Furthermore, amendments to regulations governing requirements for states' contracts with MCOs strengthened the potential for partnerships between Medicaid MCOs and Medicaid ACOs.¹³⁵ These amendments

state plans from Arkansas, Illinois, Oregon, Minnesota, New Jersey, Iowa, and Vermont, among others, and how they have implemented Medicaid ACOs); *see also* Jim Lloyd et al., *Medicaid Accountable Care Organization Programs: State Profiles*, CTR. FOR HEALTH CARE STRATEGIES (Oct. 2015), www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles-1115.pdf (gathering state examples of structuring Medicaid ACOs).

128. *See generally* Lloyd et al., *supra* note 127 (providing an overview of programs in Colorado, Illinois, Iowa, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont).

129. *See* Matulis & Lloyd, *supra* note 117, at 6 (reporting positive cost and quality results after evaluations conducted in five states); *see generally* K. John McConnell, *Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado*, 177 J. AM. MED. ASS'N INTERNAL MED. 538, 544-46 (2017) (providing a positive evaluation of two states' models).

130. *See* Sara Rosenbaum et al., *Medicaid Payment and Delivery Reform: Insights from Managed Care Plan Leaders in Medicaid Expansion States*, COMMONWEALTH FUND 1, 2 (Mar. 7, 2018),

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2018_mar_rosenbaum_insights_from_medicare_plan_leaders_ib.pdf (describing how MCOs cover and furnish care across a spectrum of health needs and may even specialize in certain services).

131. *Id.* at 2-3.

132. Matulis & Lloyd, *supra* note 117, at 5.

133. Matulis & Lloyd, *supra* note 117, at 3.

134. Matulis & Lloyd, *supra* note 117, at 3.

135. *See e.g.* 82 Fed. Reg. 180 (Jan. 3, 2017) (recognizing that partnerships could be a crucial driver of spending and quality); *see also* 82 Fed. Reg. 5428 (Jan. 18, 2017) (amending the rule to provide states and managed care plans with adequate time to design and implement payment systems as they see fit).

clarified states' abilities to require MCOs to adopt APMs and other incentive mechanisms to encourage integrated care.¹³⁶ States may "require [a participating MCO] to implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services."¹³⁷ Under these regulations,

States may encourage or require specific APMs, including models that drive investments in practices that connect health with nonmedical factors, such as routine screening for domestic abuse, environmental hazards in the home, food security, housing stability, and other potential red flags. Asking such nonclinical questions can identify substantial health risks that a standard clinical evaluation might miss.¹³⁸

States may also condition payment to the plan on its meeting certain requirements related to social determinants of health:¹³⁹

Under another provision, states can create payment incentives for the health plans, including potentially establishing performance metrics related to social and structural determinants of health. For example, a state could withhold part of a health plan's capitation rate unless it exceeds a state-set goal for reducing maternal mortality or improving lead screening for young children.¹⁴⁰

Therefore, states have several avenues to add integrated care to their Medicaid programs.¹⁴¹ They may add integrated primary care through Medicaid Health Homes.¹⁴² They may also add broader integration of social and medical care via ACOs, or similar organizations, either through Section 1115 waivers or through conditioning Medicaid managed care contracts on the plans' utilization of community-based, integrated care programs.¹⁴³ These mechanisms are available under current law, and can quickly alter state Medicaid programs for the better.

V. THE DANGERS OF EMPOWERING BROAD INTEGRATED CARE

136. *See generally* 42 C.F.R. § 438.6 (2017) (outlining requirements for state MCO payment models).

137. 42 C.F.R. § 438.6(c)(1)(i) (2017).

138. DAVID MACHLEDT, ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH THROUGH MEDICAID MANAGED CARE 1, 3 (Nov. 2017).

139. *Id.* at 2; 42 C.F.R. § 438.6(b) (2017).

140. MACHLEDT, *supra* note 138, at 3.

141. *See e.g.*, MACHLEDT, *supra* note 138 (discussing how revised regulations for Medicaid managed care plans encourages states to improve care coordination, adopt alternative payment models, and provide long-term services and supports in the home and community).

142. *See Medicaid Evolution*, *supra* note 92, at 373-74 (examining proposals for adapting Medicaid to the needs of twenty-first century health care by utilizing health homes).

143. *Medicaid Evolution*, *supra* note 92, at 374.

ORGANIZATIONS

This article candidly advocates for health care delivery and finance innovations that address root causes of ill health for poor and vulnerable people with complex medical needs.¹⁴⁴ The innovative methods described in this article are calculated to serve those goals, for the reasons stated herein. There are four sets of objections to the adoption of those methods discussed in this part: potential risk to community-based social service agencies, the risk that the “medicalization” of poverty will stigmatize the poor by virtue of the expansion of health care to include social determinants of health, the risk that the reforms described in this article will either undermine Medicaid’s broader mission through “mission creep” into non-health areas, and the risk that addressing broad social needs through a health care lens will undermine broader anti-poverty efforts. These are serious concerns, but this format allows only very brief responses to each.

A. The suggested reforms support social services

The development of Medicaid ACOs is unlikely to degrade support for community-based social services.¹⁴⁵ To the contrary, their development promises to increase support for these service providers.¹⁴⁶ Medicaid ACOs and other health entities engaged in addressing the effects of social determinants of health will need access to providers of social goods such as housing, employment/vocational, and healthy foods and nutritional services.¹⁴⁷ These entities will face build or buy choices when developing capacity for social services,¹⁴⁸ but it is likely that partnerships with, rather

144. See *Mission for the Poor*, *supra* note 27, at 187 (discussing that as the Centers for Medicare and Medicaid Services agency turns to the regulation of Medicaid managed care programs, it should leave states sufficient flexibility to encourage innovative programs for the poor); see also *Multiple Medicaid Missions*, *supra* note 28, at 105 (discussing social determinants of health and suggests the benefits of Medicaid adopting ACO methods to best serve the poor); see also *Medicaid Evolution*, *supra* note 92 (examining proposals for adapting Medicaid to the needs of twenty-first century health care in order to serve the poor and vulnerable Americans for whom Medicaid is intended).

145. See, e.g., *Multiple Medicaid Missions*, *supra* note 28, at 107 (describing the importance of “totally accountable care organizations” in the community).

146. See *Multiple Medicaid Missions*, *supra* note 28, at 106–08 (discussing that Medicaid ACOs can reach out to the chronically ill as well as ameliorate the effects of the social determinants of health).

147. See *Multiple Medicaid Missions*, *supra* note 28, at 106–08 (explaining that ACOs can target social determinants of health and can pursue a lot of which impacts health outcomes outside of the health care system such as good housing, healthy foods, and in-jail diversion programs).

148. See Taz Hussein & Mariah Collins, *The Community Cure for Health Care*, STAN. SOC. INNOVATION REV. (July 21, 2016), https://ssir.org/articles/entry/the_community_cure_for_health_care (discussing build or buy options in health system integration).

than displacement of, social service providers will be the norm.¹⁴⁹ Further, as is described below, associating social services with addressing the social determinants of health may enhance social support for community services for which support is currently somewhat abstract and uneven.¹⁵⁰

B. Organized funding for needed health services, broadly construed, does not pathologize beneficiaries with complex conditions

There is a risk of stigmatizing or “pathologizing” the Medicaid beneficiaries, or a broader cohort they may represent, through the “medicalization” of their conditions that are attributable to social disadvantages rather than biological pathologies.¹⁵¹ This issue is multifaceted. The concern for the “medicalization” of poverty is sometimes cast as an objection to the treatment of the *symptoms* — that is, the illnesses resulting from poverty, rather than the *underlying cause*, or poverty.¹⁵² But “medicalization” can also refer to the stigmatizing, or pathologizing, effect of turning everyday life events into something pathological by describing it in medical terminology.¹⁵³ Under either definition, medicalization of non-medical problems can be concerning – but the danger does not seem to be present in the settings described in this article.

Medicaid beneficiaries participating in integrated care programs are, or should be due to their medical complexity, deeply connected to the medical system with or without the overlay of these new payment models.¹⁵⁴ Their very medical complexity, then, assures that their lives are deeply intertwined with the health care delivery and finance systems. In a sense, then, the objection to these payment models as “medicalizing” social services have miss the mark: it is more accurate to say that social service providers, by their coordination with health care providers, broaden their understanding of the

149. See Sandberg et al., *supra* note 87, at 1975 (stating that health care payment and delivery models that challenge providers to be accountable for outcomes have fueled interest in community-level partnerships).

150. See Sandberg et al., *supra* note 87, at 1976 (discussing how bringing health care and social services together targets social determinants that drive poor health and addresses community needs).

151. See generally Helena Hansen et al., *Pathologizing Poverty: New forms of Diagnosis, Disability, and Structural Stigma Under Welfare Reform*, 103 SOC. SCI. & MED. 76, 76 (2014) (describing the subjective experience of structural stigma imposed by the increasing medicalization of public support for the poor).

152. See Lois Shepherd & Robin Fretwell Wilson, *Introduction: The Medicalization of Poverty*, 46 J.L., MED. & ETHICS 563, 563 (2018) (introducing papers from a conference on the medicalization of poverty).

153. See Joseph E. Davis, *How Medicalization Lost Its Way*, 43 SOC'Y 51, 51 (2006) (explaining the evolution of the term “medicalization” in the sociology literature).

154. See generally Long et al., *supra* note 8, at 29 (explaining that high-need patients are also more likely to be publicly insured).

etiology of their clients' needs for the supports such as housing, job training, and nutritional services. The relationship between social services and medical care mutually supports both systems' mission, then, as health care providers incorporate social services as a way to ameliorate the medical conditions that give rise to the high level of both medical and social need.¹⁵⁵

C. Alternative payment methods fit squarely within Medicaid's mission

The programs described in this article expand Medicaid's mission, and, to that extent, can be resisted as furthering "mission creep" for an expensive and vital program. The attachment of Medicaid funds to care integration either directly, as in the case of Medicaid Medical Homes,¹⁵⁶ or indirectly by incentivizing Medicaid MCOs to provide social services,¹⁵⁷ comprises an extension of the scope of Medicaid programs. There is a simple explanation: our understanding of the needs of people with complex medical conditions has evolved since Medicaid's origin, and appropriate health care has become more complex.¹⁵⁸ Attention to the housing needs of vulnerable, medically complex Medicaid beneficiaries is closer to the heart of the purposes of the Medicaid program than are, for example, work requirements,¹⁵⁹ restrictive pharmaceutical formularies,¹⁶⁰ or increased beneficiary copayments.¹⁶¹

D. Serving complex beneficiaries with organized care does not betray the struggle against inequality and poverty

The final concern is the most disturbing and the hardest to address. This

155. See Long et al., *supra* note 8, at 83 (improving care for high-need patients, often include the integration and delivery of social services in addition to better coordinated medical care); see generally Blumenthal & Abrams, *supra* note 12, at 1657 (noting that improving the care of high-need, high-cost patients should be a high priority for the next federal administration); see also Mantel, *supra* note 96, at 272 (noting that some states have initiated programs that help physician practices transition to the patient-centered medical home model).

156. See Davis et al., *supra* note 109 (describing the integrated care functions of primary care medical homes).

157. See MACHLEDT, *supra* note 138 (describing regulatory tools available to states to encourage Medicaid managed care organizations to connect complex patients to social services).

158. See Long et al., *supra* note 8, at xiii (explaining that care models and policies must extend beyond strictly medical approaches to address social and behavioral factors).

159. See generally Crossley, *supra* note 115, at 599 (discussing how supportive housing helps decrease unmet health needs and improve health outcomes for homeless persons, reinforcing housing's importance as a determinant of health).

160. See M. Christopher Roebuck et al., *Increased Use Of Prescription Drugs Reduces Medical Costs In Medicaid Populations*, 34 HEALTH AFF. 1586, 1586-1587 (2015) (cautioning that formulary restrictions in Medicaid can result in unintended consequences).

161. See Krutika Amin et al., *Effect of Medicaid Policy Changes on Medication Adherence: Differences by Baseline Adherence*, 23 J MANAGED CARE & SPECIALTY PHARMACY 337, 337 (2017) (copayments and increased periodicity of refills for pharmaceuticals can reduce adherence for some beneficiaries).

concern suggests that attending to the problems of inadequate housing, inadequate fresh food, and failing educational institutions through a health lens will impede broader social efforts to address poverty head-on. It is not hyperbole to state that poverty in one of the richest countries in the world is one of America's two original sins.¹⁶² Efforts to address the problem of poverty could be diverted if the core problems caused by poverty are thought of as susceptible of solution by improving the health system. That is, efforts to take on poverty directly through social and political action might be weakened by the perception that improvements in health finance and delivery offer a magic bullet capable of improving the lives of the most vulnerable without disturbing the underlying division of power and privilege.

That result seems unlikely. Instead, as Dayna Bowen Matthew has pointed out, the “association between housing affordability and health outcomes” can be beneficial.¹⁶³ It can encourage investment in a race-neutral way, and substitute a system with palpable goals for all for the somewhat more chimerical goals of justice and equity.¹⁶⁴ In addition, the coupling of health systems analysis with housing and other markers of poverty allows some ready metrics for describing the human toll of the social determinants of health in the context of a system that is capable of providing some organized response.¹⁶⁵ The ultimate verdict on the proper strategy to follow to end poverty in America is beyond the scope of this article. However, there seems reason for hope that adopting organized, integrated systems of health delivery and finance directed to the poor and vulnerable may pull us in the right direction.

VI. CONCLUSION

The health care delivery and finance systems have not been kind to the poor and vulnerable. The development of research supporting systems of care that integrate medical services for those with medically complex conditions, and even more significantly, integrate medical care and services directed at addressing social determinants of health provides some reason to hope. Promising health delivery methods are developing, and payment systems are similarly advancing.¹⁶⁶ The law of Medicaid is not in tension

162. *See generally* MATTHEW DESMOND, *EVICTED* (2016); JONATHAN KOZOL, *SAVAGE INEQUALITIES: CHILDREN IN AMERICA'S SCHOOLS* (1991); *see also* MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2012) (indicating that America's other original sin is racism).

163. Dayna Bowen Matthew, *Health And Housing: Altruistic Medicalization Of America's Affordability Crisis*, 81 L. & CONTEMP. PROBS. 161, 192 (2018) (arguing in favor of responding to the lack of affordable housing in America as a public health crisis).

164. *Id.* at 193–94.

165. *Id.*

166. *See* Sandberg et al., *supra* note 87, at 1975 (stating that health care payment and delivery models that challenge providers to be accountable for outcomes have fueled interest

with these reform efforts. In fact, these reform efforts demonstrate a harmony between good care and sound stewardship of a vital public program.¹⁶⁷ Models will evolve, and evidence will point the way to improvement, but the poor and vulnerable have some reason for optimism in the face of harsh life conditions.

in community-level partnerships); see *Mission for the Poor*, *supra* note 27 at 187 (discussing that as the Centers for Medicare and Medicaid Services agency turns to the regulation of Medicaid managed care programs, it should leave states sufficient flexibility to encourage innovative programs for the poor).

167. See generally *Medicaid Evolution*, *supra* note 92 (examining proposals for adapting Medicaid to the needs of twenty-first century health care in order to serve the poor and vulnerable Americans for whom Medicaid is intended).

