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**APPLYING THE MEDICAL-LEGAL
PARTNERSHIP APPROACH TO
POPULATION HEALTH, PAIN
POINTS AND PAYMENT REFORM**

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THE NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

The mission of the National Center for Medical-Legal Partnership (NCMLP) is to improve the health and well-being of people and communities by leading health, public health, and legal sectors in an integrated, upstream approach to combating health-harming social conditions. Over the past several years, NCMLP has helped increase the number of medical-legal partnerships in the U.S. to nearly 300. These partnerships serve children, chronically ill adults, the elderly, Native Americans, and veterans. NCMLP spearheads this work in four areas: (1) transforming policy and practice across sectors; (2) convening the field; (3) building the evidence base; and (4) catalyzing investment.

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GLOSSARY

A glossary of terms is included on page 13.

INTRODUCTION

In an effort to control health care costs, many health care delivery organizations have agreed to contracts that incentivize the provision of high-quality care and penalize unnecessary or preventable health care utilization.¹

This is consistent with the Affordable Care Act's emphasis on improving health care quality and the introduction of quality standards.² Health care providers thus must adapt how they practice in response to this payment reform, often without the tools to understand how to meet quality standards and reduce their costs or utilization patterns.³ Population health management has emerged as a solution to the "pain points" — missed quality metrics or incentives that affect the amount a health care institution is paid — associated with payment reform.⁴ Population health management assesses the health outcomes that exist within a defined population and asks what medical, social, and civil legal needs are affecting those outcomes.⁵ By identifying risks within the population and seeking to intervene before those risks become costly medical crises, health care providers can maintain or even improve the health of their patients while also reaping financial rewards for the health care delivery organization.⁶

In medical-legal partnerships (MLPs), legal professionals work on-site in the health care setting to address civil legal needs that adversely affect health and increase health care utilization,⁷ and thus are ideally suited to help health care providers identify risk, improve patient care, and resolve patients' health-harming civil legal needs. There are opportunities for MLPs to be part of the population health management assessment process, and it is up to MLPs to demonstrate their value to health care organizations in the new world of population health management and payment reform.

This issue brief examines two examples of payment reform pain points felt by health care institutions adapting to new reimbursement models, and the treatment of those pain points through collaboration with MLPs. This is followed by recommendations on how an MLP can become part of those population health management teams that are revolutionizing health care one population at a time, and the advantages of doing so, both for the health care institution and for the sustainability of the medical-legal partnership approach.

UNDERSTANDING POPULATION HEALTH, PAYMENT REFORM, AND PAIN POINTS

How Health Care Organizations Practice Population Health

Health care delivery organizations that embrace population health consider the individual needs of their patients as part of a larger whole. Within that whole, they discern patterns of risk, social factors, and health outcomes, and undertake preventive measures on a broad scale.⁸ Under the population health approach, providers consider the prevalence of biologically-based medical conditions along with the social determinants of health within the group.⁹ Social determinants, defined as the conditions in which people are “born, live, learn, work, play, worship, and age,” may include housing instability, food insecurity, and lack of income supports that make maintaining or improving health difficult.¹⁰ The “population” can be defined by geographic location, status (e.g., prisoners or the elderly), or the panel of patients served by a particular doctor or health care facility.¹¹ Improving population health is one of the goals of the Institute for Healthcare Improvement’s Triple Aim that also includes improving patient experiences and reducing the per-capita costs of care.¹² The Triple Aim has been embraced by the Centers for Medicare and Medicaid Services¹³ and the Affordable Care Act’s National Quality Strategy.¹⁴

Institutions and providers engaging in population health management identify and stratify the risk within the population in order to determine which patients are most likely to develop health problems or become sick-er.¹⁵ By better understanding the risks of their patient populations and communities, providers can prioritize care for those at highest risk, and identify preventive measures that will keep risk from rising.¹⁶ For example, providers may strategize to prevent a diabetes patient’s condition from becoming out of control through the aligned efforts of a primary care physician, nutritionist, pharmacist, and a community-based exercise program.¹⁷ In this way, the team can prevent a potentially costly

medical crisis by controlling his/her condition through coordinated efforts. Population health management also engages patients in their care so that they are invested in their health outcomes and understand the value of early interventions, such as exercise and nutrition, on their health status.¹⁸

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How Payment Reform is Changing Health Care

Health care delivery payment reform seeks to reduce health care costs without undercutting value. Payers, such as insurance companies, have begun to tie financial incentives to the quality of care provided through value-based contracting.¹⁹ This is in contrast to the traditional fee-for-service model, in which providers are paid based on the amount and type of care provided.²⁰

APPROACHES TO VALUE-BASED CONTRACTING

	INCENTIVE-BASED CONTRACTS	RISK-BASED PAYMENT MODEL
DEFINITION	Quality standards are built into the contract, and health care providers that satisfy these standards will be eligible for incentive payments. ²¹	The expected costs to treat a particular patient population or condition are set based on an estimate. ²² Providers that stray above those estimated costs are held accountable for the difference, while providers that control expenses are rewarded. ²³
EXAMPLE	The Centers for Medicare and Medicaid Services use the Healthcare Effectiveness Data and Information Set (HEDIS) measures to assess quality performance. If the hospital or health system meets those quality measure targets, they are eligible for incentive payments.	Bundled payments, in which payment is designed around a budget that factors in the continuum of care for a single episode of care or over a specified period of time. ²⁴ The payer combines payments for care rather than dividing payment among all of the providers. ²⁵
BENEFITS	Rewards providers for satisfying quality standards based on discrete measures on such issues as clinical quality, patient satisfaction, and efficiency.	Providers are not penalized for providing care; rather, they are penalized for providing care beyond what the condition requires.
DRAWBACKS	Providers may not be aware of the quality standards and how they apply to their practice. ²⁶	It may not be possible to accurately predict expected costs.

Under the population health framework, networks of care are organized into Accountable Care Organizations (ACOs), though there are other names for this concept such as Accountable Health Communities, Coordinated Care Organizations, or Integrated Care Organizations. In this brief, for simplicity, we use the term ACO. The ACO model of care illustrates the application of quality-based contracting to population health.²⁷ Included in the Affordable Care Act's amendments to Medicare and Medicaid, but now embraced by private insurance as well, ACOs are an approach to care delivery that manage the health of a population by coordinating patient care through a primary care provider in an effort to reduce duplication of services, eliminate unnecessary services, and involve patients in their care.²⁸ Along with primary care providers, specialists, home health care, and hospital systems participate in ACOs.²⁹ ACOs are held to a certain quality standard or set of standards and share the financial risk for clinical performance.³⁰ The ACO providers are either rewarded when they meet these quality standards or penalized when they do not.³¹ ACOs, particularly those serving the uninsured or Medicaid enrollees, are also attuned to the social determinants that affect health and often integrate mental health and case management services into their patients' care.³²

Why Addressing Health Care Pain Points Requires New Partners

Notwithstanding the potential benefits of various payment reform options, the transition to value-based contracting has caused problems for many health care organizations as they struggle to adapt to the new reimbursement models. Such pain points may arise, for example, when high-risk patients who historically require a high volume of services now cause the organization to exceed the established costs for care. Other times, the health care organization's traditional approaches to providing services may not align with the focus on quality metrics in value-based contracts.³³ Furthermore, health care organizations may lack the knowledge to determine how non-medical factors influence their patients' health and the likelihood that these factors will lead to costly medical interventions. Fortunately, the core concepts of population health management and collaborations with other sectors, can assist health care delivery organizations and their patients in the transition to payment reform and in addressing pain points. One such strategy is using the medical-legal partnership approach.

HOW THE MEDICAL-LEGAL PARTNERSHIP APPROACH CAN HELP ADDRESS PAIN POINTS

The medical-legal partnership approach aligns with the movement toward improved population health because it seeks out opportunities to prevent costly medical episodes through treatment of the whole person. In an MLP, legal professionals work on-site together with health care providers to address and treat the most complex social determinants, which require legal solutions.³⁴ These unmet health-harming civil legal needs include unlawful evictions, unsafe living conditions, and a lack of income supports, such as the improper denial of public benefits.³⁵ By addressing underlying social determinants that contribute to poor health, the MLP approach seeks to improve the health condition of individuals in coordination with their health care providers.³⁶

In MLPs, staff in a health care setting screen patients to determine if they have health-harming civil legal needs. Through screening, an MLP may discover that a patient's housing is infested with rodents, which could exacerbate certain health conditions, such as asthma. The MLP attorney will proactively address the issue by, for example, sending a letter to the landlord or representing the patient in a lawsuit challenging the unlawful housing conditions.³⁷ By resolving the legal issue, the patient's health may be improved, translating into cost savings on the medical side. Some MLPs also engage in broad-scale policy work in which they consider patterns of social determinants in a population, and advocate for policy changes that have an impact on population health.³⁸ For example, MLPs may advocate for stricter housing code regulations or tougher protections for tenants in housing disputes.

MLPs are experts at effectively addressing need by viewing individuals not just as having “legal” or “medical” problems, but considering the impact of these issues on one another. The table to the right describes how MLPs shift the focus of traditional civil legal aid policy work to align with how health care defines populations.

With this shift in focus, MLPs are ideally suited to assist health care organizations in tackling pain points they face through changing reimbursement models. Pages eight and nine include two examples of pain points faced by health care organizations — one with a potential bundled payment or risk contract, and the other with an incentive based contract — as they adapt to payment reform, and the possibilities for MLPs to assist in easing these pains.

Note: The two case studies on pages eight and nine discuss real hospital contracts and real medical-legal partnerships' involvement in those contracts, while positing hypothetical individual patient cases.

HOW MEDICAL-LEGAL PARTNERSHIPS REDEFINE THE FOCUS OF POLICY WORK

POPULATION	HEALTH CARE-ONLY DEFINITION	LEGAL-ONLY DEFINITION	MEDICAL-LEGAL PARTNERSHIP DEFINITION
Asthmatic children	All children with asthma in a specific clinic	Children with housing problems in a specific geography	Children with uncontrolled asthma and housing problems in a specific geography
Seniors with diabetes	Patients with uncontrolled diabetes who are referred to an insurance hotline	Clients over 65 years old living under 200% federal poverty line	Elderly people with diabetes under 200% federal poverty line who cannot afford their medications
Children with sickle-cell anemia	All children with sickle cell disease in a certain pediatric office	Children in various school settings, some of whom have sickle cell	Children with sickle cell disease with problems in school requiring accommodations



MLP AND BUNDLED PAYMENT CONTRACTS: Helping High-Need, High-Cost Patients in Nebraska

Patients with complex health and social needs utilize emergency departments and health clinics, and are hospitalized at rates far higher than the general population. These high-need, high-cost patients make up only five percent of emergency department patients, but they account for 25 percent of all hospital visits in a given year.³⁹ Sometimes referred to as “super utilizers” — a moniker that perhaps unfairly stigmatizes these (generally poor) individuals as patients who are not truly in need of the services they seek — these high-need, high-cost patients are less likely to benefit from coordinated care models and have, on average, more unaddressed health-harming social or civil legal needs that result in poor health outcomes.⁴⁰ As Dr. Jeff Martin notes, high-use “is often driven by psychosocial, financial, and societal barriers to care and points to a lack of coordination between health care, social service, and civil legal aid infrastructure.”^{39,41}

The University of Nebraska Medical Center, which has the largest emergency department in the region, began to focus on the high-need, high-cost pain point in its practice as it prepared for the transition to bundled payments. Under its proposed agreement with its payer, if the cost of care for the Medical Center’s patient population is below the bundled payment amount, the Medical Center and its providers will be rewarded. If the cost of care is above the bundled payment amount, the Medical Center and providers will be penalized. Over-usage of the emergency department by high-need patients could cause the Medical Center to incur costs above the bundled payment amount.⁴²

The Medical Center has an established medical-legal partnership (MLP) with Legal Aid of Nebraska. With its unique perspective on those social and legal barriers that negatively affect population health, the MLP team was able to help the Medical Center strategize to meet its payment goals and ease this pain. The MLP worked with health care providers to assess risk within this patient population in light of health-harming social and civil legal issues that led patients to frequently use the hospital’s emergency department.

EXAMPLE

A 42-year-old woman with high blood pressure, degenerative disc disease, peripheral artery disease and anxiety, visited the emergency department three times during a one-year period for high blood pressure crises, each resulting in multiple-day hospitalizations. At her most recent visit to the emergency department, the staff discovered that she could not afford her high blood pressure medication, which usually kept her conditions manageable, and that she had been denied disability insurance. She was then referred to the Medical Center’s medical-legal partnership.

Through consultation with the patient, MLP attorneys determined she was in fact eligible for disability insurance, and appealed the decision with medical documentation from her health care providers. With the insurance, she can afford her medications. By maintaining her medication regime and controlling her conditions, she is less likely to need the services of the emergency department for high blood pressure crises. The Medical Center can thus ensure that costs stay below the bundled payment amount.⁴³



PHOTO CREDIT: MARK FREDERICKS

MLP AND RISK CONTRACTS: Patients with Serious Mental Illness in Indianapolis

When payment reform is introduced to new markets or new delivery systems, patients with serious mental illness may represent another pain point for health care institutions. Adults with serious mental illness are defined as having “a diagnosable mental, behavioral, or emotional disorder” that interferes with or limits one or more of their major life activities.⁴⁴ By one estimate, health care expenditures for individuals with serious mental illness reached \$147 billion.⁴⁵ When indirect costs are factored in, the tab for serious mental illness reached \$467 billion in 2012.⁴⁶ Patients with serious mental illness are often housed in state-operated facilities even when there is no medically-indicated need because there are social or legal obstacles to the patient living in a more integrated community setting.

At Indiana’s Eskenazi Midtown Mental Health Clinic (Midtown), health care providers are dialed-in to the difficulties associated with treating and maintaining the health of their seriously mentally ill patients, including those transitioning out of state-operated facilities back into community-based settings. Under its value-based contracts with the state, Midtown is penalized if the patients under its care occupy more than a certain number of beds in state-operated facilities. Midtown can earn a bonus if those patients that do not require institutionalization are instead treated in outpatient facilities and monitored by their providers in a community setting.⁴⁷ Midtown’s established medical-legal partnership with Indiana Legal Services, Inc. helps the health center identify those health-harming social and civil legal issues that may impede its patients’ transitions out of a facility and back into the community.

EXAMPLE

A thirty-three-year-old patient with serious mental illness housed in a state-operated facility had been stabilized and was ready to be discharged into an outpatient setting. However, she remained in the state-operated facility because she did not have the income to afford private housing, and her supplemental security income was cut off. The health center’s MLP attorney was called to consult with the patient to determine whether she was eligible for income supports. When the MLP secured supplemental social security income for the patient, she was able to find housing and leave the state-operated facility, thus helping Midtown meet its goal.⁴⁸

RECOMMENDATIONS: HOW MLPS CAN EMBRACE A POPULATION HEALTH MANAGEMENT PRACTICE

01



Get familiar with the value-based contracting used by your health care organization.

Population health management is specific to each health care delivery organization. In other words, knowing the type of contracts in place at the health care organization where you work or that you partner with is critical to understanding the specific culture that administrators and frontline health care providers operate within, and the environment that any new interventions must seek to complement.

The best way of doing this is to simply ask questions. The legal and health care staff involved in operating or planning a medical-legal partnership should talk to the health care organization's CEO and revenue cycle management team to determine what type of contracting is used by the health care organization, including determining whether there are penalties or incentives in the provider contracts. MLP teams should also ask whether there are quality measures within the contracts. The answers to these questions will help MLP legal professionals gain a better understanding of their partners' environment and priorities, and will help MLP health care providers understand what quality measures, if any, apply to their practice.⁴⁹

02



Work with your partner or potential partner to identify risk created by health-harming social and civil legal issues.

Medical-legal partnerships can help mitigate risk by targeting those patients at greatest risk for incurring the highest costs and determining, through screening and consultation, the unmet health-harming civil legal needs that may contribute to their risk. Screening, which should take place in the health care setting, is a valuable tool that health care providers should utilize to identify health-harming civil legal needs within their patient populations.

Screening procedures should be jointly developed. Legal professionals are well-versed in the specific health-harming civil legal needs that different vulnerable populations often face, and what questions to ask in order to uncover those needs. Health care providers are familiar with the factors that most frequently affect patients' health care utilization, and understand the points of screening that can have the largest impact and how best to standardize screening.

It is also important that the medical-legal partnership team is kept "in the loop" concerning the decisions of the staff charged with identifying and stratifying risk in the patient population. This is facilitated through the integration of the MLP legal team into health care operations.⁵⁰ Thus, when the population health management team identifies risk in the patient population, the MLP legal team is immediately notified and can quickly become involved in the process of delivering care.

03



Help the health care organization reveal and resolve its pain points.

Together, an MLP team's legal professionals and health care providers should probe the areas in which the health care organization struggles to reduce costs or meet quality standards. Helping to address these pain points is an MLP's greatest opportunity to demonstrate its value proposition to the health care organization. The MLP team can discover these pain points through conversations with administrative, financial, and clinical team members. In addition, the health care team in a not-for-profit hospital can direct the MLP to the hospital's Community Health Needs Assessment, which may indicate areas in which the hospital seeks to improve.⁵¹ Health care providers and MLP legal professionals can also find out what pain points afflict their health care organization or institution through discussions with Medicaid, Medicare, and other insurers.

Once identified, MLP teams should examine those pain points in context of the health-harming social and civil legal needs uncovered through patient screening, and target MLP services at the populations and needs that have the greatest potential to help patients and pain points alike.

Those examples are just two ways in which MLPs can help health care organizations meet their goals in the new era of payment reform and population health management. They also demonstrate how population health management—including the assessment of risk—can help health care organizations uncover the health-harming social and civil legal needs that drive up medical costs for millions of low-income individuals.

Medical-legal partnerships also benefit from becoming involved in the process of easing pain points by proving its value as a collaborative player in the move towards value-based care. It can

demonstrate to health care organizations that the MLP is valuable in strategizing to reduce costs, and, in doing so, help uncover new sources of revenue to support its work.

The six recommendations below can help health care providers and legal professionals position medical-legal partnership as a population health management strategy within their institutions. These recommendations are relevant both for existing medical-legal partnerships, as well as for organizations thinking about developing a medical-legal partnership. The latter can use the population health management framework in its planning discussions as a strategic way of determining its service delivery priorities and setting up the business case for the program.

04



Track the impact of your work on health care utilization.

Medical-legal partnerships should search their patient-clients' medical records for high-utilization patterns that were reduced after a medical-legal partnership intervention. This is information that health care team members and health care IT staff should take the lead on compiling. It will be easier to track and examine this kind of information if a clear target population and pain point were identified at the onset, rather than trying to assess utilization patterns among patients who do not share a common underlying condition. A few data points go a long way in the conversation of how an MLP can help address a population pain point, and they are critical in conversations about investment in MLP.

05



Re-conceptualize and message MLP's value and delivery in the context of backing up and enhancing the health care team, rather than as the legal intervention alone.

Medical-legal partnership teams should frame their work in terms of how they can help embed a culture of legal problem solving in the health care team through education and consultation, and strategize what infrastructure is needed to achieve that. This is a better argument of value to health care institutions than legal outcomes alone, and also a better capacity and sustainability model for medical-legal partnerships. A pilot study in Lancaster, Pennsylvania, showed that many of the health-harming civil legal problems identified among high-use, high-need patients could be treated with "indirect legal care" where a lawyer relayed legal information and resources to social workers and other members of the care team. The study showed that approximately 16 percent of disability-related health-harming civil legal problems required direct involvement and representation from an attorney, while almost 84 percent could be addressed by a lawyer supporting the case management team.⁵² This suggests that having legal expertise on the health care team expands the help patients' receive without a lawyer needing to provide direct assistance to every patient. This idea further makes the case for having legal professionals as part of the health care team, and MLP as a health care intervention.

06



Share your data and your stories with health care leadership and health care providers.

Once your medical-legal partnership has some initial data on its effects on utilization and pain points, make sure to share that data with the health care organization's CEO or Executive Director, population health management team, and front-line clinicians who work with the targeted patient population. Share the data alongside a single patient story and/or health care provider testimonial of the impact of the MLP. Ideally, you will be able to pair one compelling individual story with data that highlights broader impact across the health care organization.

LOOKING AHEAD

Hospitals and health systems are thinking about risk and patient problems at the population level.

For medical-legal partnerships to be considered a relevant health care intervention, they have to speak the language, understand the numbers, and be able to identify and assert their value in the context of a hospital or health system's pain points. This means moving beyond delivering civil legal assistance randomly to individual patients in clinics, to a more systematic identification of health-harming civil legal needs. MLPs must also build a culture of legal problem-solving and capacity building in the health care team. And to demonstrate their worth to hospitals and health systems MLPs must impact the metrics that the hospitals value — utilization patterns and patient satisfaction.

More information about medical-legal partnership and population health can be found on the National Center for Medical-legal Partnership's website at:
www.medical-legalpartnership.org/resources/

GLOSSARY OF TERMS

Accountable Care Organizations:

Organizations in which health care providers collaborate to provide coordinated, high-quality care to patients.

Health-harming civil legal need:

A social, financial, or environmental problem that has a deleterious impact on a person's health and that can be addressed through civil legal aid services.

Incentive-based payment contracts:

Quality standards are built into the contract, and health care providers that satisfy these standards will be eligible for incentive payments.

Medical-legal partnership:

An approach to health care delivery that embeds civil legal aid lawyers and paralegals alongside health care teams to detect, address, and prevent health-harming social conditions.

Pain points:

Missed quality metrics or incentives in the delivery of health care to patients that affects the amount a health care institution is paid under changing reimbursement models.

Population health:

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Risk-based payment model:

The expected costs to treat a particular patient population or condition are set based on an estimate. Providers that stray above those estimated costs are held accountable for the difference, while providers that control expenses are rewarded.

Social determinants of health:

The circumstances in which people are born, live, learn, work, play, worship, and age, as well as the systems put in place to deal.

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