SENSITIVITY TO OUR GROWING, CHANGING, AND DIVERSE, SENIOR POPULATION

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Multiple Medicaid Missions: Targeting, Universalism, or Both?

John V. Jacobi*

INTRODUCTION

Medicaid began as a poverty program for the poorest of the "worthy poor." In the next five decades, it extended its reach to cover a broad population for some of its services, including, for example, about half of all childbirths in the United States,[1] and almost half of all long-term care services.[2] The Affordable Care Act (ACA)[3] pushed Medicaid's breadth further, although that extension was at least delayed in many states by the Supreme Court.[4] Some scholars embrace Medicaid's role as advancing toward universal coverage by filling the gap between Medicaid's traditional poverty population and the population able to access employment-based coverage. Others, however, are concerned that asking Medicaid to cover broader population groups runs the risk of diminishing its essential mission of providing coverage for the poorest, who face unique health needs.

This disagreement suggests a need to choose between a Medicaid targeted to particular needs of the poor and one increasingly universal in scope. Yet, under the ACA, Medicaid can achieve both a universal and targeted mission by following Theda Skocpol's "targeting within universalism" model.[5] "Targeted" social policies address poverty issues through "highly concentrated . . . services devised especially for the poor," while "universal" policies address poverty through broader programs that link the plight of the poor with those of the middle class.[6] Skocpol argues for targeted programs "*within* certain universal policy

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[1] *See* Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23 WOMEN'S HEALTH ISSUES e273, e275 (2013).

[2] *See Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings*, KAISER FAM. FOUND. 1 (2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7576-02.pdf.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the "Affordable Care Act," or the "ACA," and will be referred to as such herein.

[4] Nat'l. Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603-04 (2012) (Roberts, C.J., holding the ACA to be unconstitutionally coercive for requiring the states to expand Medicaid coverage).

[5] *See* Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, *in* THE URBAN UNDERCLASS 411, 411-36 (Christopher Jencks & Paul E. Peterson, eds., 1991).

[6] *Id.* at 412-13.

frameworks" to combine the benefits to the poor of targeted and universal policies.[7] Medicaid, I argue, can become a broad—and broadly popular—health insurance while consciously targeting the very poor, whose health challenges are different in kind from those of the rest of society.

This Article will, in Part I, briefly outline the path of Medicaid's development from 1964 to today, as its mission has broadened, with particular attention to the 2010-14 period of ACA implementation. Part II will describe the health status of America's poor. Medicaid is undoubtedly successful in connecting its beneficiaries to health care services, but the poor continue to experience health outcomes far worse those of the rest of society. This apparent paradox is easily explained: health coverage permits the treatment of illnesses, but the poor carry an increased burden of illness due to social factors, including substandard housing, the unavailability of healthy food, and few recreational resources. Health insurance has not historically addressed those "upstream" factors that drive a significant portion of the poor's excess burden of ill health. Part III outlines the dispute among advocates for the poor between advocacy for programs targeting the poor (providing resources where they are most needed, but risking the loss of political support) and advocacy for more universal programs (risking resource loss to higher-income, less needy persons, but likely gaining political viability). I argue that in the case of Medicaid, Skocpol's "targeting within universalism" best serves the poor.

Part IV illustrates how a broadening Medicaid that sweeps in a growing class of the near poor can nevertheless provide special benefits for the very poor. This strategy entails the use of new models of health care finance and delivery, such as Accountable Care Organizations (ACOs). ACOs are designed to combat health care's fragmentation, evidenced by poor communication and care coordination that can reduce the effectiveness of care and drive up costs. For non-poor recipients of care, financing innovations can improve the quality of care by fostering more integrated treatment. Similar medical treatment gains and cost savings are available when Medicaid adopts ACO methods. But an additional benefit is available for the poor. Community organizations forming Medicaid ACOs may receive supplemental reimbursement if they can improve the health status of populations of Medicaid recipients in a geographic area. This population orientation incents the organizations creating Medicaid ACOs to adopt a broader perspective toward health care, directly addressing some of the social factors beyond medical treatment that directly affect population health status. For the non-poor, ACOs can improve medical care. For the poor, ACOs can use the financial freedom created by population health rewards to incorporate social services not traditionally covered by Medicaid into their body of work. ACOs can be adapted to the needs of the poor by those in their community to help reduce the burden of disease and ill-health for those most in need. This functional targeting permits

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[7] *Id.* at 414 (emphasis in original).

expansion of Medicaid services not at the level of state regulatory design, but through the community-based choice of Medicaid ACOs' management.

I. SPECIFIC TO GENERAL: MEDICAID'S EVOLUTION

American Progressives sought a path to a general "sickness insurance" program for much of the twentieth century. As European democracies adopted various forms of social insurance and national health plans, America resisted for a range of social, political and economic reasons that are well-described elsewhere.[8] While other wealthy nations experimented and finally settled on systems for the provision of health care as a public or social expense, Americans maintained a marketplace notion of health care, supplemented by a variety of public and private charity ventures for the most obviously disadvantaged.[9]

The adoption of Medicare and Medicaid in 1964 represented an expansion of the federal footprint in health finance. Medicare is a very popular social insurance program for a discrete population of beneficiaries. Some hope has persisted that it could be a vehicle for expansion to reach a broader demographic. Thus far, Medicare has been expanded only to the permanently and totally disabled (after a two-year waiting period) and to persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis.[10] Medicaid's eligibility rules have evolved in a more complex fashion.

Medicaid was the successor to previous federal programs that provided grants in aid to states. These grants recognized the primacy of states in supporting the needy, and represented the furthest reach of the federal government into the patchwork of private and public charities directed to the plight of widows, orphans, and other particularly vulnerable—and "worthy"—poor.[11] Initially, eligibility was limited to very low-income single-parent families and the aged, blind, or disabled.[12] Even so, it was seen by some as a "sleeper" program, carrying with it the seeds of a more expansive public insurance program because of the breadth of its coverage structure. As Sara Rosenbaum has described, for some contemporary commentators "the program became the exemplar of a national health program of

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[8] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237-89 (1982).

[9] *See* Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 HEALTH CARE FIN. REV., no.2, 2005-2006, at 11, 11-15.

[10] *Id.* at 19-21.

[11] *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 438-45 (2011); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 418-19 (2008); John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L. J. 357, 359 (2013-2014); Sara Rosenbaum, *Medicaid At Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 8-9 (2006).

[12] *See* Jonathan Gruber, *Medicaid*, *in* MEANS-TESTED TRANSFER PROGRAMS IN THE UNITED STATES 15, 16 (Robert R. Moffitt ed., 2003).

the future, covering large population segments under a comprehensive scheme of government financing."[13]

Medicaid expanded in the ensuing decades, although the expansions fell short of reaching its potential as an anchor for a universal coverage system. Eligibility rules evolved, extending Medicaid coverage to higher-income children, pregnant women, and two-parent poor families with children. A further cluster of expansions followed through the adoption of optional aspects of the program and through statutorily permitted waivers from general federal eligibility and coverage rules. These expansions included long-term care benefits for the elderly and disabled well above the income-eligibility limits for the program generally and the expansion of new ranges of home and community-based services for people who otherwise would have been eligible for care in nursing homes.[14]

By the time the ACA was adopted in 2010, Medicaid had grown far beyond its 1964 roots. It was a large program, covering over 68 million people by fiscal year 2011. About half the enrollees were children, about a quarter were adults without disabilities, about fifteen percent were people with disabilities, and about ten percent were elderly.[15] Total federal and state program costs for fiscal year 2011 were approximately $414 billion.[16] A broad range of services—some beyond the norm for private insurance—were mandatory for all states, including:

- Hospital, physician, laboratory and imaging services;
- A broad range of services for children (enrollees under 21) under EPSDT;[17]
- Family planning services and supplies;
- Nurse midwife services;
- Transportation services;

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[13] Rosenbaum, *supra* note 11, at 10 (quotations and citations omitted).

[14] *See* Gruber, *supra* note 12, at 19-25 (describing expansion of eligibility and covered services); Rosenbaum, *supra* note 11, at 11-15 (summarizing the range of Medicaid expansion in its first four decades); Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at 35*, 22 HEALTH CARE FIN. REV. 23 (2000); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History,* 26 GA. ST. U. L. REV. 937, 959-67 (2010) (describing expansion of nursing home and home care services). .

[15] ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 13-14 (2011).

[16] *Medicaid: A Primer,* KAISER FAM. FOUND. 25 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

[17] Early and periodic screening, diagnostic, and treatment ("EPSDT") services comprise a broad range of scheduled diagnostic and treatment services for enrollees under 21 years of age. 42 U.S.C. § 1396d(r) (2012). Perhaps most significantly, after setting out a range of services that must be made available, the statute provides a final, catch-all category of required services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Id.

- Nursing facility services for those 21 years of age and above, and home health care services for those eligible for nursing home level of care; and
- Services provided by federally qualified health centers ("FQHCs") and rural health clinics ("RHCs").[18]

Most or all states also elected to cover a range of services beyond those required. These services include:

- Prescription drugs;
- Dental services;
- Eyeglasses and durable medical equipment;
- Case management;
- Personal care services and hospice services;
- Nursing facility and psychiatric facility services for those under age 21; and
- Home and community based services.[19]

By 2010, then, Medicaid was still a needs-based program, but one that had extended its eligibility rules to reach nearly one in seven Americans. It had also, in recognition of the broader needs of the poor, expanded its menu of covered services beyond core medical treatment to include health benefits other Americans are expected to purchase out of pocket. By the time the ACA was passed, it was a dominant payer of some services, covering about half of all births, and almost half of all nursing home services.[20] In addition, the eligibility criteria for Medicaid, which encompass poverty, disability, and old age, ensured that it disproportionately covers high-risk and high-cost persons.

The ACA significantly expanded Medicaid. In *National Federation of Independent Business v. Sebelius,* Justice Ginsburg and Chief Justice Roberts disagreed as to whether the expansions were part of a gradual evolution of the program, or representative of a dramatic shift in the nature of Medicaid. Justice Ginsberg described Medicaid as "a single program with a constant aim–to enable poor persons to receive basic health care when they need it."[21] In contrast, Chief Justice Roberts read the ACA as creating an entirely new program:

> Here, the Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that

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[18] 42 U.S.C. § 1396d (2012). *See* HERZ, *supra* note 15, at 5-6; *Medicaid: A Primer*, *supra* note 16, at 13-14.

[19] 42 U.S.C. § 1396d (2012). *See* HERZ, *supra* note 15, at 6; *Medicaid: A Primer*, *supra* note 16, at 14.

[20] *See* Markus et al., *supra* note 1, at e275; *Medicaid's Long-Term Care Users, supra* note 2, at 1.

[21] *See* Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part and dissenting in part).

> Congress could change the terms of Medicaid when they signed on in the first place. . . . The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.[22]

The Chief Justice's finding that the ACA's modification of Medicaid was one of "kind, not merely degree" allowed him to find that Congress's conditional spending powers do not extend to the enforcement of the ACA's Medicaid amendments on all states continuing to participate in Medicaid.[23] Whether the ACA's change was best characterized as evolutionary or revolutionary, it certainly added significantly to the scope of Medicaid's mission.

Under the ACA as written, then, states were required to sweep in all persons not previously eligible who have an income at or below 133 percent of the federal poverty level.[24] The extent to which each state's Medicaid enrollment would have been affected by this change hinged on the prior state-specific eligibility levels, but the estimates for total increases ranged as high as 21.3 million by 2022.[25] Those predictions had to be adjusted after the Supreme Court rendered the ACA's Medicaid expansion optional at the election of each state.[26] As of this writing, twenty-eight states have agreed to expand Medicaid to the income limits of the ACA, and two additional states are in discussions to do the same.[27] Whether and how the additional states will come into the fold is beyond the scope of this article.[28]

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[22] *Id.* at 2605-06 (opinion of Roberts, C.J.).

[23] *Id.* at 2606.

[24] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012), *invalidated by* Nat'l Fed. of Indep. Bus., 132 S. Ct. 2566 (2012).

[25] *See Medicaid's Long-Term Care Users, supra* note 2, at 11 (citing John Holohan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER FAM. FOUND. 4 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf).

[26] *Nat'l Fed. of Indep. Bus.*, 132 S. Ct. at 2635.

[27] *Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (2014), http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision.

[28] *See, e.g.*, Maia Crawford & Shannon M. McMahon, *Alternative Medicaid Expansion Models: Exploring State Options*, CTR. FOR STATE HEALTH CARE STRATEGIES (2014) http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf (describing alternative state models for expanding Medicaid); Stan Dorn et al., *What Is the Result of States Not Expanding Medicaid?*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. (2014),

A central success of the ACA has been the decrease in America's uninsurance rate. The uninsured percentage has dropped by about five percent as a result of increased private enrollment (through the federal and state exchanges or marketplaces and through off-exchange purchases of ACA compliant coverage) and through expanded Medicaid enrollment.[29] However, as Medicaid pushes into demographics beyond the very poor, care must be taken to preserve the aspects of "original" Medicaid that target the needs of the poorest and most vulnerable. The next Part addresses the particular vulnerability of that population.

II. BARRIERS TO HEALTH FOR THE POOR

As Medicaid's role in American health finance expands, we must be cognizant of the fact that the poor have health needs that are different from those of the non-poor. This Part will acknowledge the health access gains the poor have experienced from Medicaid coverage, but will demonstrate that the health status of the poor continues to lag behind that of the non-poor. It will argue that special services are therefore in order, and point out that some of those special services are embedded in the ACA's design.

Many studies have demonstrated that Medicaid coverage increases access to most types of health care. This research was recently summarized in the following terms:

> Consistently, research indicates that people with Medicaid coverage fare much better than their uninsured counterparts on diverse measures of access to care, utilization, and unmet need. A large body of evidence shows that, compared to low-income uninsured children, children enrolled in Medicaid are significantly more likely to have a usual source of care . . . and to receive well-child care, and significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. . . . Nonelderly adults covered by

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http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946 (describing financial cost to federal and state governments of states' Medicaid expansion decisions); Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf; Carter C. Price & Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And $8.4 Billion Less In Federal Payments*, 32 HEALTH AFF. 1030 (2013).

[29] *See* Sara R. Collins, et al., *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, THE COMMONWEALTH FUND (July 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf. *See also Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period*, ASSISTANT SECRETARY FOR PLAN. & EVALUATION (May 2014), http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

> Medicaid are more likely than uninsured adults to report health care visits overall and visits for specific types of services; they are also more likely to report timely care and less likely to delay or go without needed medical care because of costs.[30]

The link between access and health outcomes is somewhat harder to quantify. A recent, widely-publicized study of Oregon's pre-ACA Medicaid expansion compared otherwise similar populations that differed on the basis of whether or not they had gained access to Medicaid. The Medicaid-insured cohort predictably had better access to health care services than the uninsured cohort.[31] The measurable health outcomes were less clear-cut:

> Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups—persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups)—showed similar results.[32]

The study did find some health benefits, including a significant increase in the rate of diagnosis of depression and successful reduction over time in the manifestations of depression symptoms compared to the uninsured cohort.[33]

Other studies have reported additional correlations between positive health outcomes and Medicaid membership. A team of researchers at the Harvard School of Public Health recently assessed the effects of pre-ACA Medicaid expansions and found improvements in the expansion states.[34] In particular, they found decreased mortality rates associated with the Medicaid expansions, determining that the mortality improvements were "greatest among non-whites and older adults."[35] The effects of Medicaid will continue to be the subject of study, as the

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[30] *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?*, KAISER FAM. FOUND. 6 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf. *See* Marc L. Berk & Claudia L. Schur, *Access To Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169 (1998); Teresa A. Coughlin et al., *Assessing Access To Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073 (2005); Sharon Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39, 54 (2005).

[31] Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1718 (2013).

[32] *Id.* at 1716.

[33] *Id.* at 1716-17. Another significant difference over time between the groups with Medicaid and without was a reduction in "financial strain" related to health expenditures, and in particular a reduction in the rate of catastrophic medical expenses. *Id.* at 1718.

[34] *See, e.g.*, Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012).

[35] *Id.* at 1028.

expansion of Medicaid continues to be a sharply divisive political issue, and claims continue that Medicaid is "broken."[36]

Evaluating the effects of Medicaid is difficult in part because Medicaid historically has covered the most vulnerable of Americans. The non-elderly enrollment in Medicaid is over fifty-three percent Black or Hispanic, and the long history of race- and ethnicity-based health disparities in American health care strongly suggests that this overrepresentation of people of color will result in poorer health outcomes regardless of the faults or inefficacy of the Medicaid program itself.[37] In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.[38] People covered by Medicaid, then, are more medically fragile, have more complex health conditions, and are affected by determinants of poor health independent of their access to health coverage or care.

The inability of Medicaid to make healthy populations of the poor and vulnerable is not surprising. Health status is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of traditional health services.[39] One recent commentary observed 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."[40] These "determinants of health" that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.[41] The research on social determinants of health suggest that advocates of health care for the poor should broaden their perspective on what constitutes health services. In particular, the research demonstrates that medical

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[36] *See* Jacobi, *supra* note 11, at 364-69 (describing the contours of the argument that Medicaid is "broken").

[37] *See, e.g.*, BRIAN D. SMEDLEY ET AL., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED. (2003); *see also* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 857 (2012); David R. Williams & Pamela B. Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327-29 (2005).

[38] *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382-84 (2011); Williams & Jackson, *supra* note 37, at 327-28.

[39] *See* Kelly M. Doran et al., *Housing as Health Care–New York's Boundary-Crossing Experiment*, 369 NEW ENG. J. MED. 2374, 2374 (2013) ("experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest").

[40] 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).

[41] *See* Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & CMTY. HEALTH 284 (2010); Nicole Lurie, *What The Federal Government Can Do About The Nonmedical Determinants*, 21 HEALTH AFF. 94 (2002).

care should no longer be viewed in isolation but should be part of a system that coordinates a variety of medical and social services.[42] This systematizing of services can be achieved through the coordination of services provided by previously separate public agencies,[43] or through state Medicaid agencies' fostering of community organizations empowered and incented to integrate health and social services.[44] Both options would rethink the financing of health care for the poor to take into account the true barriers to good health.[45]

III. TARGETED OR UNIVERSAL MEDICAID?

Medicaid was, is, and undoubtedly will be a program of health care for the poor and near-poor. But whether it will be dedicated to the interests of society's most vulnerable or serve as one of the launching pads for truly universal healthcare is a question of great moment. The previous Section described the particular health needs of the poor, and identified strategies to make Medicaid more effective in addressing those needs. Such a turn in Medicaid policy to a deeper commitment to the poorest and most vulnerable is in potential conflict with the trend, exemplified by the eligibility expansion in the ACA, to extend Medicaid to the less poor--a population potentially less affected by substandard housing, food deserts, and other plagues of the poor. A Medicaid program reconfigured to address the particular needs of the poor would be a *targeted* program; one that is more configured to extend traditional health coverage to a broader population would be a *universal* program. On one hand, a more targeted Medicaid program might better serve the needs of the poorest and most vulnerable by sweeping in coordinated access to non-medical social programs in their particular interest. On the other, a universal Medicaid program would serve the health care needs of broader class of Americans, helping to knit together a more universal health insurance system, and perhaps thereby place the Medicaid program on a firmer political footing.

The tug between a targeted or universal Medicaid system is not a new one. Colleen Grogan, a leading Medicaid scholar, has observed that mission uncertainty has been present since Medicaid's inception. In an influential 2003 article, Colleen Grogan and Eric Patashnik observed that mission uncertainty has been present since Medicaid's inception, and that it has since the beginning been "not one

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[42] *See* Lurie, *supra* note 41, at 105.

[43] *See infra* text accompanying notes 63-68 (discussing Health in All Policies ("HiAP") initiatives).

[44] *See infra* text accompanying notes 79-85 (discussing Medicaid Accountable Care Organizations).

[45] Lurie, *supra* note 41, at 105 ("Donald Berwick's often-quoted adage, 'The system is perfectly designed to achieve exactly the results it gets. If you don't like the results, change the system,' applies not only to health systems, but also to the 'stovepiped' way in which policy and budget development often occurs." (citation omitted)).

program but many."[46] Grogan and Patashnik outlined one perspective on the choice between focused coverage of the poorest and most vulnerable, and expansion to other tiers of the uninsured:

> Two distinct paths for Medicaid's future evolution are in view, and they lead in opposite directions. If policy makers decide to continue taking incremental steps toward coverage expansion . . . Medicaid could serve as a path to a more universal health care system for millions of Americans. Alternatively, if policy makers opt for the second path, Medicaid could revert back to "welfare medicine."[47]

Grogan and Patashnik argued that Medicaid's role in American health finance is unsettled because of two ambiguities built into the program. First, the original statute failed to "provide precise definitions of the two concepts of medical indigence and comprehensive benefits."[48] Second, it failed to "resolve Medicaid's place in the overall U.S. welfare state and to determine whether or in what sense Medicaid benefits should be universal or targeted."[49] Grogan and Patashnik clearly favored the more universal vision of Medicaid. They posited that policy makers will be driven to expand Medicaid because of the failures of the private insurance markets and the inadequacy of Medicare coverage for vitally important long term care services: "it will be increasingly difficult for policy makers not to grasp the vital importance of Medicaid to working-class and middle-class families."[50] This prediction proved prescient; the ACA certainly responded to the logic of the argument for the expansion of both medical and long-term coverage to populations not previously within Medicaid's mandate.

Grogan and Patashnik approve, at least implicitly, of Medicaid's evolution as a "path to a more universal health care system for millions of Americans" and disapprove of a "reversion to 'welfare medicine.'"[51] There are, however, arguments for adhering to a narrower conception of Medicaid's mission. As is described above, the poorest and most vulnerable are in need of a different range of health and social services than are the working poor or middle class. They have housing, environmental, community resource, and other deficits that affect their health status significantly. Community health advocates increasingly argue for a broader range of responses to the complex health needs of the poor, informed by analyses of the social health determinants that drive their health status deficits.

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[46] Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821, 824 (2003).

[47] *Id.* at 822 (citing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974)).

[48] *Id.* at 852.

[49] *Id.*

[50] *Id.* at 854-55.

[51] *Id.* at 822.

A proposal to reconfigure Medicaid to reach broadly into social services would fit imperfectly with universalist Medicaid vision. Such a proposal would likely split Medicaid into a program for the very poor on one hand and the working poor and middle class on the other hand.[52] It would therefore drive Medicaid in a more targeted direction, as the additional social services would be significantly more appropriate for the traditional low-income Medicaid recipients, but less appropriate for working-class and middle-income recipients for whom Medicaid might otherwise be a path to ordinary health insurance coverage.[53]

The distinction between a Medicaid program focused on the "neediest among us"[54] or one that is "an element of a comprehensive national plan to provide universal health insurance coverage"[55] is a real one. Targeted social welfare programs have the virtue of concentrating limited resources and programmatic design toward those most in need of social welfare benefits; however, targeted programs face uncertain political viability, as the majority of voters do not benefit from such programs. Universal programs, on the other hand, tend to enjoy broader electoral support, while allowing the poor to avoid stigma by participating in mainstream programs. However, universal programs tend to devote the majority of their funding and programmatic attention to the non-poor, diminishing opportunities for high-level change in their circumstances.[56] But is the choice between those two visions a real or false one? That is, can Medicaid serve both the function of providing the range of services peculiarly appropriate for the poorest and most vulnerable, while also serving as a piece of the puzzle for expanding health insurance to the working poor and middle class? The answer is yes.

Policy makers face a dilemma in choosing between targeted social welfare programs and universal programs. Theda Skocpol describes the contours of this dilemma,[57] while also providing a possible third way—targeting within universalism:

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[52] Medicaid is not a unitary program as it stands. The Deficit Reduction Act of 2006 allowed states to substitute weaker "benchmark" benefits patterned on employment-based coverage for the richer traditional Medicaid coverage, although the most vulnerable Medicaid beneficiaries are exempted from this change. 42 U.S.C. § 1396u–7(a) (2012) (exempting, *e.g.*, blind, medically frail, and disabled recipients). The ACA similarly permits states to provide weaker "benchmark" benefits, and not the full traditional Medicaid benefits to the new eligible class, comprising mostly non-elderly adults not previously categorically eligible. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The proposal described in the text would clearly exacerbate this distinction.

[53] The distinction, too, could be overstated. Clearly, some working-class consumers in some markets suffer from poor housing stock and other social barriers to good health status. But the very poor are clearly more exposed to these barriers to good health.

[54] *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (opinion of Roberts, C.J.).

[55] *Id.*

[56] *See* Skocpol, *supra* note 5, at 412-14.

[57] *Id.* at 414.

> [R]oom has been made *within* certain universal policy frameworks for extra benefits and services that disproportionately help less privileged people without stigmatizing them. What I shall call "targeting within universalism" has delivered extra benefits and special services to certain poor people throughout the history of modern American social provision, and new versions of it could be devised today to revitalize and redirect U.S. public social provision.[58]

Skocpol recommends that policy makers structure necessary supports in a way that apply to universal needs, but that can be particularly beneficial to those most in need. While benefits can be general in nature, they could be provided more substantially to those in need. The earned income tax credit, for example, is operated through an income tax system in which all participate. The credit is available to all when and if their income drops to threshold levels, but the benefits accrue most powerfully to the neediest.[59]

Targeting within universalism for Medicaid, then, would allow for expanded services for the poor *within* the increasingly universal framework of Medicaid as a broadly available health insurance program. There are two models to accomplish this task. In the next section, I describe a form of Medicaid ACO that permits Medicaid funding to be spent to provide broad services for the poor without changing the general medical coverage mission for the broader population.[60] In the remainder of this section, I describe an alternative whereby Medicaid funds are not spent on new social services, but rather Medicaid partners with other social programs and agencies to address the social needs of the poor.

The City of Richmond, California is a poor city. It has adopted a novel plan to integrate social and medical services to address broader barriers to health. About nineteen percent of Richmond's residents are unemployed, and thirty-eight percent of its children live in poverty. Over half of its residents pay more than thirty percent of their income for housing.[61] Residents face "environmental pollution, neighborhood violence, unemployment, [and] unsafe physical infrastructure," and they lack access to affordable health care, nutritious food, and childcare.[62] Richmond has adopted a Health in All Policies ("HiAP") ordinance. HiAP calls for broad social policies across all public sectors that take into account determinants of health,[63] and further calls for cooperation among agencies

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[58] *Id.*

[59] *Id.* at 428-31.

[60] *See infra* Part IV.

[61] Jason Corburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URBAN HEALTH 623, 625 (2014).

[62] *Id.* at 627.

[63] *Id.* at 624-25 (citing Ilona Kickbusch, *Health in All Policies: Setting the Scene*, 5 PUB. HEALTH BULL. S. AUST. 3 (2008)) (published by the South Australian Department of Health).

responsible for health, food, income, environmental, and housing policies.[64] Its governing philosophy has been described in the following terms:

> The main principle behind the slogan 'Health in All Policies' is really very simple: Health is greatly influenced by lifestyles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly, decisions influencing people's health do not concern only health services or 'health policies', but decisions in many different policy areas have their influence on these health determinants.[65]

Richmond's HiAP program advanced these principles through the convening of a process that produced a coordinating strategy and a HiAPP ordinance. The ordinance developed programmatic and policy strategies to incorporate a health orientation in six focus areas:

- Governance and Leadership: all city agencies must incorporate and further HiAP methods and goals;
- Economic development and education: city will invest in workforce development, particularly for people of color and women, child care, and community schools;
- Safe communities: city will promote reduction in environmental stress and improve services such as health food through rezoning and community investment;
- Residential and built environment: city will address substandard housing and lead paint abatement, develop homelessness programs, and improve recreational opportunities;
- Environmental health and justice: city will reroute truck routes, improve air quality through improved toxic waste monitoring, and remediate hazardous waste sites; and
- Health home and social services: city will assist in ACA-related health insurance enrollment and enrollment in other safety net programs.[66]

The ordinance was only recently adopted,[67] and the city's ability and willingness to follow through on the requirements are therefore unknown. In addition, there are few mature models of HiAP-driven integrated programs in the United States with which to compare the Richmond initiative, although such

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[64] Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1819-20 (2011).

[65] Pekka Puska, *Health in All Policies*, 17 EUR. J. PUB. HEALTH 328, 328 (2007).

[66] Corburn, *supra* note 61, at 629-30.

[67] The ordinance was adopted in April 2014. Corburn, *supra* note 61, at 623-24.

programs are beginning to emerge, following on decades of development in other nations.[68]

The adoption of HiAP policies in the United States holds promise as a mechanism to foster cooperate among agencies that, collectively, could integrate health and social services central to improving the health status of the poor.[69] Those attempting to create HiAP-governed cooperative efforts, however, do face difficulties:

> HiAP implementation faces a number of challenges at the local, state, and national levels, including public health's limited connectivity to other sectors, organizational and technical barriers (eg, information systems, planning horizons, funding mechanisms), and intersectoral differences in values and cultures. Furthermore, intersectoral collaboration can be resource intensive, particularly in terms of staff time and expertise, which is a challenge in an era of decreasing public resources across government agencies.[70]

If governmental leadership is present, and if agency staff cooperation is forthcoming, HiAP collaboratives dovetail nicely with the targeting within universalism model: Medicaid continues to exist as a general insurance program, and additional services particularly needed by very poor Medicaid recipients can be provided by other agencies. In the absence of a broad willingness and capacity for inter-agency cooperation, other methods of addressing the needs of the poor are necessary. The next section describes addresses another model.

IV. TACOS

Medicaid is a vital program for the poor, even as expands to become a source of health coverage for the near-poor and middle class. Advocates for the poor may favor a targeted approach to Medicaid development to concentrate attention and funding on the neediest. They may also favor a universalist approach to reduce the program's stigma and to gain political support from the expanded program's broader constituency. Targeting within a universal Medicaid will permit special services for the poor without diminishing the program's universal reach.[71]

The previous section described how HiAP policies can target within a universal Medicaid program. HiAP programs permit Medicaid to expand medical services to the non-poor while coordinating with other public agencies to provide supplemental services to the poor. Logistical and operational difficulties may limit

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[68] Lauren N. Gase et al., *"Health in All Policies:" Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. PUB. HEALTH MGMT. PRAC. 529, 530 (2013).

[69] *Id.*

[70] *Id.* at 537.

[71] *See* Skocpol, *supra* note 5, at 413-14.

the proliferation of HiAP programs. This section describes Medicaid Accountable Care Organizations as alternative methods of targeting the poor within a general Medicaid program.

This section first describes the general problem of fragmentation in our health care delivery system, particularly for people with chronic illness. It then describes clinical innovations that integrate care for people with chronic illness, and explains how ACOs create organizational and financial support for such integration. Next, this section will demonstrate how the ACO model of integrating care for the chronically ill can be applied to Medicaid–a program that covers many people with chronic illness. Finally, it argues that the financing mechanism for Medicaid ACOs provides a promising means by which community-based organizations can be given the incentive and the Medicaid-provided financial capacity to provide poor and vulnerable Medicaid beneficiaries with the social services they need to thrive–without altering Medicaid's general medical insurance mission for the expansion population.

The fragmentation of the American health care system is one of its major faults. The Institute of Medicine's ground-breaking report To Err is Human described the nature and effects of that fragmentation:

> The decentralized and fragmented nature of the health care delivery system . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence . . . At the same time, 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.[72]

Fragmentation leads to bad decision-making due to a lack of coordination and communication among health care providers and institutions.[73] This fragmentation is further exacerbated by payment policies, which encourage fragmentation and increase costs.[74]

Fragmented care creates particular health dangers for patients with chronic illnesses, who by the nature of their condition require frequent care. The danger arises through lost opportunities for appropriate care and conflicting treatments that can do more harm than good:

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[72] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 3 (Linda T. Kohn et al. eds., 2000).

[73] *See* Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTHCARE: CAUSES AND SOLUTIONS 1-2 (Einer Elhauge ed., 2010).

[74] *See* Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 764-65 (2008).

> Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinical responsibility increases the chance that some services may not be provided at all. Among people with chronic conditions 71% report having no help coordinating their care. . . and 17% say they have received contradictory medical information from health care professionals.[75]

Robert Kane, one of the leading clinical researchers into care for patients with chronic illness, has described the problem as a myopic 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.[76]

The cure for the harm of fragmentation generally,[77] and for people with chronic illness in particular,[78] is the coordination of care across providers, disciplines, and institutions.

ACOs are one mechanism to remedy fragmentation. ACOs are organizations comprising a broad range of health care providers with the capacity to manage and be held accountable for improving health quality.[79] ACOs contain the raw material for reversing fragmentation, as they are provider-led organizations including primary care, specialty care, hospital care, and the range of other health services necessary to render coordinated care. Integrated delivery systems are not new; the innovation of ACOs is in the payment, by which the participating providers receive incentives for providing high-quality care in a cost-effective manner. The payment mechanisms can include gainsharing–the ability of the ACO to retain a portion of the cost-savings created by its efficient care management–or risk-based partial capitation, by which the ACO receives a set amount of compensation for each patient covered to spend as it judges best to provide some of the cost of care for

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[75] ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 50 (2005).

[76] *Id.* at 50-51.

[77] Berwick, *supra* note 74, at 765.

[78] Kane, *supra* note 75 at 71-74.

[79] *See* Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982-83 (2010); Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving The Cost and Quality Quandaries?*, URBAN INST. 1-2 (Oct. 2009), http://www.urban.org/uploadedpdf/411975_acountable_care_orgs.pdf.

the patients under its care.[80] At bottom, the payment is intended to provide incentives for ACOs to manage patient care well and efficiently, while devolving to the ACO substantial discretion on the means by which it can reduce costs while maintaining or improving quality.

The ACA created an ACO payment program in Medicare,[81] but did not create a similar program in Medicaid. Experimental programs are growing in several states, however, built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.[82] Much of the success of these ACOs is premised on their medical management, their ability to constrain health expenditures, and their ability to deliver coordinated care to improve the health status of Medicaid recipients.[83]

Medicaid disproportionately covers the poor, disabled, and elderly, and therefore the chronically ill.[84] As with Medicare ACOs, Medicaid ACOs are structured to integrate care, and therefore have the capacity to improve care for people with chronic illnesses. The financing mechanisms for Medicaid ACOs reverse the incentive to avoid high-cost patients, and instead encourage them to seek out and care for the sickest, including those with chronic illness. The incentive derives from the population-based reimbursement for most models of Medicaid ACO. The range of payment methodologies can include pay-for-performance agreements, global payments, and gain-sharing payments with state Medicaid agencies, Medicaid managed care organizations, and other payers, as well as grant funding from foundations.[85] This population-based model attributes all Medicaid recipients in a designated to community to the ACO, and any gains, or risk-based reimbursement, is dependent on the ACO's ability to maintain or improve quality while driving down the aggregate cost of care in that community.[86]

A community-based Medicaid ACO model, then, combines clinical integration with a financial incentive to reach out to the chronically ill in the ACO's geographic area to provide integrated chronic care. But the Medicaid ACO model

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[80] *See* Devers & Berenson, *supra* note 79, at 6-7.

[81] 42 U.S.C. § 1395jjj (2012) (Medicare shared savings program, authorizing Medicare ACOs).

[82] *See* Jacobi, *supra* note 11, at 374-76; Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care Organizations in New Jersey*, 16 POPULATION HEALTH MGMT. S-12, S-14-S-16 (2013); Tricia McGinnis & David M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES 5-8 (2012), http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf.

[83] McGinnis & Small, *supra* note 82, at 2-3.

[84] *See* John Billings & Tod Mijanovich, *Improving Care for High-Cost Medicaid Patients*, 26 HEALTH AFF. 1643, 1644-45 (2007).

[85] *See* Valerie A. Lewis et al., *The Promise And Peril of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles*, 31 HEALTH AFF. 1777, 1781 (2012).

[86] *See* N. J. REV, STAT. § 30:4D-8.5 (2013) (describing community-based gain-sharing program in New Jersey's Medicaid ACO program); Jacobi, *supra* note 11 at 375-76; McGinnis & Small, *supra* note 82, at 2.

can go beyond the provision of coordinated medical care. The financing structure that rewards Medicaid ACOs for reaching and treating people with chronic medical conditions can also reward it 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.

Poor and vulnerable populations can benefit much more from the broad integration of social and health services than they can from the integration of health services alone. Medicaid ACOs are designed to address the needs of both the clinically vulnerable and the socially vulnerable.[87] As is described above, the former group is a population that could be targeted by the medical care aspects of ACOs: those with chronic conditions or risk factors that can be addressed with sophisticated coordinated care.[88] The second group–the socially disadvantaged–require a stretching of the model.

Organizations that pursue this melding of social and medical coordination for the benefit of clinically and socially vulnerable patients have been christened "totally accountable care organizations," or "TACOs."[89] These organizations recognize that "much of what impacts health outcomes occurs outside of the health care system," including in-jail diversion programs, improved substance use disorder services, and housing support services.[90] The flexibility created by population-based reimbursement systems allow TACOs to be responsive to the broad range of clinical and social barriers that affect their vulnerable target populations and that cause the population to absorb such a large portion of the cost of care.

Rewarding TACOs for reducing the overall burden of Medicaid costs gives them the flexibility to use their resources to address the particular cost-drivers of poor populations. They will have the funding, the capacity, and the incentive to target a broad range of social services:

> [The reimbursement incentives available to Medicaid ACOs] may foster closer collaboration among health care providers and social service organizations, addressing a more holistic set of patient needs. For example, ACOs serving a sizeable homeless population may be able to use a portion of their shared savings

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[87] *See* Lewis et al., *supra* note 85, at 1778.

[88] *Id.*

[89] *See* Jennifer DeCubellis & Leon Evans, *Investing In The Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier; Stephen Somers & Tricia McGinnis, *Broadening the ACA Story: A* Totally *Accountable Care Organization*, HEALTH AFF. BLOG (Jan. 23, 2014), http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization.

[90] DeCubellis & Evans, *supra* note 89.

> to work with local housing agencies to help patients get into stable housing and thereby reduce related, unnecessary medical spending–such as a longer-than-necessary hospital stay that occurs simply because a patient doesn't have a home to go to.[91]

TACOs, then, can achieve these improvements in the lives of the members of their communities through the melding of medical and social services. Further, they can do so without necessitating the creation of a separate, targeted, form of Medicaid. TACOs can coexist with other Medicaid provider organizations and share methods with them. All Medicaid providers–indeed, all health care providers–can explore the value of integrated care as a means to improve care for patients with chronic conditions, even though organizations serving higher-income beneficiaries are less likely to engage in housing or jail diversion efforts. Higher-income Medicaid ACOs may serve their populations well without the need to graduate to the status of TACOs.

TACOs are distinct from other Medicaid clinical providers not by virtue of their legal or regulatory mandate, but by virtue of the means they adopt to satisfy exactly the same mandate. That is, TACOs would not be required by Medicaid statutes or regulations to add social services to their activities. Instead, they would be empowered by state law to gain financially for improving care and reducing cost for a population of Medicaid-eligible residents of a community. They could use the gains they realize for achieving improvements to fund non-Medicaid services with their own funds, garnered through the gains they realize from care improvement and cost reduction.

Their special targeting of very vulnerable Medicaid recipients, then, satisfies the requirements described above[92] to achieve targeting within Medicaid without impeding the goal of using Medicaid as a path to insurance expansion. TACOs serve Medicaid goals by correcting providers' perverse financial incentives and thereby reducing fragmentation of care. Once TACOs obtain a financial reward for reducing the cost of care to Medicaid, they can employ those rewards to use social services to counteract the effects of the social determinants of health. They could follow a virtuous cycle of employing gains from reducing costs of care for the poor to further reduce those costs by attacking the social impediments to health. By using a return on investment and not funds directed to social services by a state Medicaid agency, they can accomplish particular gains for the poor within the existing legal structure of the Medicaid program.

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[91] *Id.*

[92] *See supra* Part IV.

CONCLUSION

The very poor often live with clinical and social vulnerabilities that require care that is different in kind from that required by the less poor and less vulnerable "expansion" populations added by the ACA. The ACA uses the Medicaid program to expand opportunities for access to health insurance to populations of higher-income working poor persons, and it may be so used in the future. The poor can benefit from this broadening, as a broader Medicaid is likely to be less stigmatizing to the poor and will gain political support through its wider reach into the American voting population. The broadening may, however, risk the reduction in Medicaid's focus on the particular needs of the poor. Total Accountable Care Organizations–TACOs–in Medicaid can continue and enhance Medicaid's services to the poorest and most vulnerable while allowing Medicaid to morph into a broader health insurance system, thereby achieving targeting within universalism. TACOs can employ general tools to coordinate care and expand access–tools that are available to all Medicaid providers under the ACA, and would also be available to Medicaid ACOs. In the case of TACOs serving very vulnerable populations, however, providers can choose to use their funds to address social concerns, such as substandard housing and food deserts that are less likely to affect higher-income Medicaid beneficiaries.

By allowing TACOs to serve social needs, Medicaid can create incentives and capacity for community organizations to provide specialized clinical and social services to our most vulnerable, while also providing general public health insurance to those shut out of private coverage. Organizations devoted to the care of the poor and vulnerable are moving toward the creation of functioning TACOs. Their actions should be supported and applauded without fear for the broader, equally important insurance-expansion mission of Medicaid.

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CHRONIC CARE AND PREVENTION: EVOLUTION IN PRACTICE AND FINANCE

John V. Jacobi*

Modern health care is complicated. Many advances in medicine in recent decades have been exquisitely refined, technologically stunning solutions to conditions previously thought incurable. The proliferation of treatments for serious diseases has had the obvious effect of offering relief to critically ill patients. The success of 20th century medicine allows us to live longer, survive previously fatal conditions, and, unfortunately, engage in unhealthy behavior; we therefore experience a sharp increase in chronic illness – the prevention and treatment of which is the main task of 21st century medicine. The rise in serious chronic illness has created a demand less for high-tech intervention than for low-tech, ongoing assistance. In addition, it has created a need for the coordination of the care-needs of people with chronic illness, who too often experience bewilderingly uncoordinated services from a host of poorly connected professionals, leading to treatment that is far less than the sum of its parts. This paper will discuss two interrelated movements responsive to the growth of chronic illness: the growth of models of chronic care management, and the renewed attention to the provision of primary and preventive care. These movements offer relief to those at risk of and affected by chronic disease, and they are two of the few promising sources of health care cost containment.

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The newly enacted Affordable Care Act[1] contains several gestures toward heightened attention to chronic care management.[2] Attention to chronic care management offers an opportunity to rethink our health delivery and finance system. Chronic care management's focus on interdisciplinary care, patient self-direction, and support for family and community care-givers shows a way to improve the health and the lives of people with serious chronic illness, and mounting evidence suggests that doing the right thing may even save money. While research into chronic care management continues, the quest turns to those not (yet) chronically ill. Can multi-disciplinary, patient-focused primary and preventive care be applied more generally, and, if so, can we afford it? This paper will briefly describe the rise of chronic illness, the health care system's long history of failure in treating those with serious chronic conditions, and some promising methods to change practice and payment in response. It will then explore the extension of these methods to primary and preventive care more generally,[3] and the funding issues that must be resolved if coordinated care is to be the norm rather than the exceptional case. The ACA suggests a movement toward both chronic care management and improved provision of primary and preventive care. This paper will argue that success in the implementation of those ACA provisions is socially important and that lessons from chronic care management can apply to efforts to improve primary and preventive care.

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[1] The health reform legislation is contained in two separate acts, the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended and supplemented by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Neither title rolls off the tongue, and collectively they have come to be known as the Affordable Care Act. *See* http://www.healthreform.gov/. This paper will use "Affordable Care Act" or "ACA" to reference the reform laws collectively unless otherwise indicated.

[2] *See, e.g.*, PPACA § 1302(b)(1)(I) (including chronic disease management as an "essential" benefit); *see also* PPACA § 2703 (creating a state option for a program of health homes for Medicaid beneficiaries with chronic conditions).

[3] The ACA also lends some focus to the importance of primary care. *See, e.g.*, PPACA § 4001 (creating a National Prevention, Health Promotion, and Public Health Council); *see also* PPACA §§ 4103 – 4108 (improving access to preventive services in Medicare and Medicaid).

THE SHIFT TO CHRONIC CARE

Health care needs have shifted over the past several decades. Needs had been for acute care - usually one or a few closed-ended episodes of intense service, with little or no follow-up care.[4] The trend over the past twenty years, however, has been movement away from acute care and toward chronic care.[5] The number of Americans living with chronic conditions, depending on the definition employed,[6] is large and growing. A recent study estimated that 43.8% of civilian, non-institutionalized persons had one or more chronic illnesses.[7] The Institute of Medicine has estimated that about 100 million Americans had a chronic illness as of the late 1990s (about 44 million of whom had more than one), with the number expected to rise to 134 million by 2020.[8] The increased incidence of chronic illness is traceable in part to the success of scientific medicine and acute care in the 20th century. Conditions that would previously have killed or resulted in a greatly shortened life span are now treatable, but sometimes the treatment leaves the patient with chronic care needs. In addition, treatments which cure previously fatal conditions now allow patients to grow older, and the incidence of chronic illness rises inexorably with age.[9]

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[4] *See* ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 9 (2005).

[5] *See* Kenneth Thorpe et al., *Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006,* 29 HEALTH AFF. 718, 722 (Apr. 2010), ("Increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall growth in spending in the traditional Medicare program.").

[6] *Compare* Katherine Anne Paez et al., *Rising Out-Of-Pocket spending for Chronic Conditions: A Ten-Year Trend,* 28 HEALTH AFF. 15, 16 (Jan./Feb. 2009) (conditions lasting 12 months or longer and resulting in "physical limitations and/or the need for ongoing medical care") (citation omitted); *and* KANE ET AL., *supra* note 4, at 7 (condition of lengthy duration that is "not self-limiting, waxes and wanes in terms of severity, and typically cannot be cured"); *with* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 27 (2001) (illness lasting longer than three months that is not self-limiting).

[7] Paez et al., *supra* note 6, at 17.

[8] COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 27.

[9] *See* KANE ET AL., *supra* note 4, at 29; COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 26-27; Edward H. Wagner et al., *Improving Chronic Illness Care:*

With increased incidence of chronic illness comes an increase in reimbursed medical treatment for those illnesses. Americans increasingly need treatment for "chronic illnesses that require on-going long-term attention and management,"[10] including "diabetes, kidney disease, hyperlipidemia, hypertension, mental disorders, and arthritis."[11] Treatment is often provided in ambulatory care settings, including physicians' offices, rather than inpatient settings.[12] The increased diagnosis and treatment of chronic conditions, the identification of new forms of chronic illness, and adoption of new modalities of treatment for old and new chronic conditions together explain why chronic care is at the heart of increases in medical costs, particularly in Medicare.[13] Care for people with chronic illnesses consumes about seventy-five percent of health care costs,[14] and most of the inflationary pressure in Medicare results from increased identification and treatment of chronic illnesses.[15] The average cost of care for a person with one chronic condition is more than twice that of a person without chronic conditions.[16] For a person with two or more chronic conditions, costs average almost six times that of care for persons without chronic illnesses.[17] Many of the fifteen most expensive medical conditions are chronic diseases.[18]

Translating Evidence Into Action, 20 HEALTH AFF. 64, 64 (2001).

[10] KANE ET AL., *supra* note 4, at xvii.

[11] Thorpe et al., *supra* note 5, at 722.

[12] *Id.*; Sandra L. Decker et al., *Uses of Medical Care for Chronic Conditions*, 28 HEALTH AFF. 26, 30-32 (2009).

[13] *See* Thorpe et al., *supra* note 5, at 719-720; Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*, HEALTH AFF., WEB EXCLUSIVE, w378, w385 (Aug. 22, 2006), *available at* http://content.healthaffairs.org /cgi/reprint/25/5/w378.

[14] Catherine Hoffman et al., *Persons With Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1476 (1996); *see also* Alain C. Enthoven, *Employment-Based Health Insurance is Failing: Now What?*, HEALTH AFF., WEB EXCLUSIVE, w3-237, w3-238 (May 28, 2003) (citing Hoffman *et al.*), *available at* http://content.healthaffairs. org/cgi/reprint/hlthaff.w3.237v1.pdf

[15] Thorpe et al., *supra* note 5, at 718-19.

[16] Hoffman et al., *supra* note 14, at 1477.

[17] *Id.*

[18] Joel W. Cohen & Nancy A. Krauss, *Spending and Service Use Among People*

Notwithstanding increases in funding and treatment, the quality of chronic care and the satisfaction of patients with that care have been unacceptably low. This quality shortfall is attributable in part to a failure to make the transition from procedure-based service delivery to a coordinated, long-term view of patient care:

> 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 disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.[19]

This fragmentation of care is widespread, and creates risks of harm to patients through lost opportunities and conflicting treatment:

> Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinician responsibility increases the chance that some services may conflict with others . . . and that still other needed services may not be provided at all. Among people with chronic conditions 71% report having no help in coordinating their care . . . and 17% say they have received contradictory medical information from health care professionals.[20]

This lack of coordination presents obvious risks of medical

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with the Fifteen Most Costly Medical Conditions, 1997, 22 HEALTH AFF. 129, 135 (2003). The fifteen most expensive conditions were: heart disease, cancer, trauma, mental disorders, pulmonary conditions, diabetes, hypertension, cerebrovascular disease, osteoarthritis, pneumonia, back problems, endocrine disorders, skin disorders, kidney disease, and infectious disease. *Id.* at 134. *See also* Benjamin G. Druss et al., *Comparing the National Economic Burden of Five Chronic Conditions*, 20 HEALTH AFF. 233, 235-36 (2001) (data examining cost of treatment of patients with one or more of five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) accounted for forty-nine percent of the nation's health spending in 1996).

[19] KANE ET AL., *supra* note 4, at 50-51.

[20] *Id.* at 50 (citation omitted).

errors.[21] In addition, this confusion of services and information can be emotionally wrenching for those with chronic conditions and their family members – who often provide substantial "informal" care.[22]

Our health care delivery and finance systems have slowly pivoted toward the need for coordinated and consistent care of chronic conditions.[23] The organizational reforms attempting to enhance care coordination are diverse.[24] As employers' and insurers' concerns about the cost of chronic care rose in the 1990s, disease management programs were created. These programs were, and are, add-ons to traditional insurance design, are provided through referral, and operate "in parallel" with primary medical providers.[25] Disease management referrals are often made for plan members with single, serious chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), cancer, or kidney disease.[26] The disease management vendors often receive a monthly fee for each referred patient, and often guarantee cost-neutrality (or better) to the medical plan sponsor.[27] They often rely on

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[21] *See* COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 28.

[22] *Id.* at 27. *See* NATIONAL ALLIANCE FOR CAREGIVING & AARP, CAREGIVING IN THE U.S. 2009 12-13 (2009), *available at* http://assets.aarp.org/rgcenter/il/caregiving_09_fr.pdf.

[23] KANE ET AL., *supra* note 4, at xvii. *See* Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform,* 9 YALE J. HEALTH POL'Y L. & ETHICS, 453, 454-55 (2009); Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform,* 14 CONN. INS. L.J. 199, 222-23 (2008); John V. Jacobi, *Reform With a Patient Focus,* 37 CUMB. L. REV. 437, 454-55 (2007); COMM. ON QUALITY OF HEALTH CARE IN AMERICA, *supra* note 6, at 9-10 .

[24] *See* Soeren Mattke et al., *Evidence for the Effect of Disease Management: Is $1 Billion a Year a Good Investment?*, 13 AM. J. MANAGED CARE 670, 671 (2007) (describing different types of "disease management" programs); Jennifer L. Wolff & Chad Boult, *Moving Beyond Round Pegs and Square Holes: Restructuring Medicare to Improve Chronic Care,* 143 ANNALS INTERNAL MED. 439, 440 (2005) (comparing programs that operate separately from primary care professionals with those that are "integrated within provider practice").

[25] *See* Wolff & Boult, *supra* note 24, at 440.

[26] Glen P. Mays et al., *Convergence and Dissonance: Evolution In Private-Sector Approaches To Disease Management And Care Coordination,* 26 HEALTH AFF. 1683, 1686-87 (2007).

[27] *See* David M. Bott et al., *Disease Management For Chronically Ill Beneficiaries In Traditional Medicare,* 28 HEALTH AFF. 86, 89 (2009).

periodic home nursing visits, supplemented by on-line and telephone contacts to encourage compliance with medication and self-care aspects of a care plan, to assess the participant's health status and to assist in the coordination of care for the chronic condition.[28]

The benefits of these add-on disease management programs have been difficult to assess. The programs have evolved rapidly and divergently, and the cost and quality implications remain unproven.[29] The application of these programs in traditional fee-for-service Medicare has been a challenge. Cost savings have been slow to materialize.[30] Patient satisfaction has not been shown to increase significantly, and primary care physicians have not reported improvements in the coordination of care.[31] Growing dissatisfaction with these add-on disease management programs has spurred attempts to enhance treatment compliance and care coordination from another direction: the enhancement of the ability of primary care practices to themselves engage the fundamental mechanisms of chronic care coordination necessary to maintain the health and functioning of the patient and her family.[32]

These programs of primary care-based coordinated care management have not produced robust data on health and cost outcomes, in part because they have arisen more recently than add-on disease management programs. Some emerging evidence is, however, tentatively positive on clinical benefit, suggesting that practices adopting integrative care management "generally improve the quality of care and the outcomes for patients with various chronic illnesses."[33] The appeal of this

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[28] *See* Bott et al., *supra* note 27, at 95; Peikes et al., *Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries*, 301 JAMA 603, 607 (2009).

[29] *See* Mays et al., *supra* note 26, at 1690.

[30] *See* Peikes et al., *supra* note 28, at 612-14.

[31] *See* Bott et al., *supra* note 27, at 92-93. *See also infra*, Part III(A).

[32] *See* Katie Coleman et al., *Untangling Practice Design from Disease Management: How Do We Best Care for the Chronically Ill?*, 30 ANN. REV. PUB. HEALTH 385, 385 (2009).

[33] *See* Katie Coleman et al., *Evidence On The Chronic Care Model In The New*

shift from outside, vendor-provided care management to management by a primary care practice, or "medical home" has substantial appeal to primary care providers.[34] Issues of health central to their neediest patients are incorporated into their professional practice, enabling them to undertake the cognitive and care-giving work central to primary care practice. The appeal of these models to people with chronic illness and their community caregivers may also be substantial, as they provide a focus for care and care guidance in an integrated, coherent setting rather than through a confusing patchwork of providers.

There are many models of integrated, coordinated chronic care with substantial levels of adoption.[35] All share an orientation toward whole-person treatment, support of patient and family self-direction, and integrative care.[36] The most prominent and most studied chronic care program is the Chronic Care Model ("CCM"), created at the Group Health Cooperative in Seattle, and adopted by several hundred health care organizations.[37] It is avowedly multidisciplinary and collaborative:

> This model endorses reliance on multidisciplinary teams of health care professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic diseases. Individually tailored evidence-based treatment plans guide clinical decision making and the frequency of patients' planned visits for chronic care. Supported by customized treatment plans and multi-disciplinary teams of health care professionals, patients are charged with undertaking necessary lifestyle and behavioral modifications to manage their diseases responsibly.

Millennium, 28 HEALTH AFF. 75, 81 (2009); *see also* Coleman et al., *supra* note 32, at 385.

[34] *See* Coleman et al., *supra* note 33, at 76; Am. Acad. of Family Physicians et al., *Joint Principles of the Patient Centered Medical Home*, PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (February 2007), http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home; *see also* Michael S. Barr, *The Need to Test the Patient-Centered Medical Home*, 300 JAMA 834, 834 (2008).

[35] *See* KANE ET AL., *supra* note 4, at 216-26.

[36] *Id.*

[37] *Id.* at 216-218.

> Information technology facilitates provider practice redesign, including the creation of disease registries, proactive outreach to patients, and greater involvement of nonphysician health professionals.[38]

CCM is an "organizational approach to care" built on six features intended to emphasize the patient's and her community's participation. Its components are:

> - Self-management support: Empower and prepare patients to manage their health and health care. . . .
> - Delivery system design: Assure the delivery of effective, efficient clinical care and self-management support. . . .
> - Decision support: Promote clinical care that is consistent with scientific evidence and patient preferences. . . .
> - Clinical information system: Organize patient and population data to facilitate efficient and effective care. . . .
> - Health care organization: Create a culture, organization, and mechanisms that promote safe, high-quality care. . . .
> - Community: Mobilize community resources to meet needs of patients. . . .[39]

CCM has been the subject of a large number of reviews (including case-control studies) to test whether it is easily adaptable to primary care practices, results in improved processes of care, and results in improved health outcomes.[40] The results of these studies have recently been gathered, and the authors of that meta-study have concluded that:

> Considerable experience using the CCM to improve the quality of chronic illness care has accumulated over the past decade. Although not definitive, published evidence suggests that practices redesigned in accord with the CCM generally improve the quality of care and the outcomes for patients with various chronic illnesses. This finding appears to be consistent in both

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[38] Wolff & Boult, *supra* note 24, at 439.

[39] KANE ET AL., *supra* note 4, at 217-18.

[40] *See* Coleman et al., *supra* note 33, at 77-79.

U.S. and international settings.[41]

The strategies central to CCM emphasize the use of a variety of resources to support patient management of their care,[42] such as the use of non-physician professionals, including nurse educators, dieticians, and social workers,[43] and the use of community resources.[44]

While the evidence on cost-effectiveness is thinner than the evidence on quality, it appears that CCM is "worth it." Studies suggest that "interventions that result in improved disease control reduce total health care costs for patients" with chronic illnesses.[45] More work must be done to validate this initial conclusion and difficult questions of the timing of the costs and savings remain. If a substantial cost incurred this year will save even greater costs ten years hence, is the expenditure this year "worth it?" The answer may well depend, as is discussed below,[46] on who is being asked: the answer from Medicare (presuming the patient is and will be Medicare-eligible) is different than that from an insurer that believes the patient will be some other insurer's responsibility ten years hence.[47] This timing issue aside, it is increasingly clear that CCM saves more than it costs.[48]

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[41] *Id.* at 81.

[42] *See* KANE ET AL., *supra* note 4, at 217.

[43] *See* Susan L. Norris & Darin E. Olson, *Implementing Evidence-Based Diabetes Care in Geriatric Populations*, 59 GERIATRICS 35, 37 (2004).

[44] *See* Coleman et al., *supra* note 33, at 75.

[45] *Id.* at 81.

[46] *See infra* pp. 59-64.

[47] *See* Coleman et al., *supra* note 33, at 81 (discussing the problems that arise in paying for CCM when one party is responsible for implementation and another reaps the financial benefits).

[48] A separate question is also briefly addressed *infra* pp. 59-64. That is, is an intervention "worth it" if premature death is avoided, if the patient will in the future (because he lives an additional period of years) experience other, unrelated medical costs that could have been "avoided" had he died prematurely. This could be referred to as the "Philip Morris argument," after a report titled *Public Finance Balance of Smoking in the Czech Republic* by Arthur D. Little in support of a Philip Morris position that the Czech Republic saved money from the premature death of smokers, and that Philip Morris therefore did not owe the Republic compensation for tobacco-related injuries. Text of document available at http://www.mindfully.org/Industry/Philip-Morris-Czech-Study.htm. As is described below, the argument

Chronic care management techniques, and in particular CCM, have demonstrated some promise in turning health care from over-emphasis on acute care and technological advancement, and toward the incorporation of integrative methods of care suited to 21st century needs. Studies to date preliminarily affirm that a patient-first orientation, in which interconnected health needs are addressed in partnership with physicians and other health professionals, the patient, and the patient's family and community can not only reduce frustration with health system interactions, but can also produce improved health outcomes for those most in need – people with chronic illness – and that such reforms may be pursued cost-effectively.

The next Part turns to care for those without chronic conditions, and asks whether the value of coordinated, patient-centered care emerging in chronic care can be achieved in broader populations, and in particular whether goals of improving prevention of illness can be advanced by borrowing from chronic care models.

APPLICATION OF CARE MANAGEMENT TO PRIMARY/PREVENTIVE CARE

The discussion above suggests that American health care's structure ill-serves people with chronic conditions and that programs such as CCM can bridge the gap. Discussions leading to the recent health reform legislation, and the shape of the Affordable Care Act itself, suggest the need to shift American health finance and delivery's attention toward primary and preventive care.[49] These concerns are congruent with those driving chronic care reform: frustration at our current over-

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about cost-effectiveness over time can be difficult. *Public Finance Balance of Smoking in the Czech Republic*, MINDFULLY.ORG, http://www.mindfully.org/Industry/Philip-Morris-Czech-Study.htm (last visited Nov. 19, 2010).

[49] *See* Dianne Rittenhouse et al., *Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform*, 361 NEW ENG. J. MED. 2301, 2301 (2009); Diane R. Rittenhouse & Stephen M. Shortell, *The Patient-Centered Medical Home: Will It Stand the Test of Health Reform?*, 301 JAMA 2038, 2038 (2009).

emphasis on specialty care[50] and skepticism that we are receiving value from our costly current system.[51] Ken Thorpe's recent analysis of the role of chronic conditions in driving up Medicare costs suggests the need to consider application of delivery system reform, emphasizing primary care and care coordination to people with and without chronic illness:

> The U.S. health system remains predicated on providing acute, episodic care that is inadequate to address the altered patterns of disease now facing the American public. Our results highlight the need for prevention and care outside doctors' offices and hospitals designed to address the changing needs of patients at risk for or living with chronic disease and, often, multiple comorbidities. As Congress and the Obama administration, along with providers, insurers, and consumers, continue their efforts to reshape the U.S. health system, they must address these changed health needs through evidence-based preventive care in the community, care coordination, and support for patient self-management.[52]

How, then, do prevention and primary care fit into chronic care management and, by extension, into reformed primary care models?

PREVENTION

Steps that can prevent serious chronic illnesses are "often common sense, low-tech, and straightforward" but they can nevertheless be difficult to implement.[53] There is clear overlap in the needs for sound preventive care among those who have chronic illness and those who do not (yet). The literature

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[50] *See* Rittenhouse & Shortell, *supra* note 49, at 2038.

[51] *See* Mauricio Avendano et al., *Health Disadvantage in US Adults Aged 50 to 74 Years: A Comparison of the Health of Rich and Poor Americans With That of Europeans*, 99 AM. J. PUB. HEALTH 540, 546 (2009) (pointing to American focus on specialty, rather than primary care and prevention, as a possible cause for the lower health status of older Americans across all economic groups as compared with European comparison groups).

[52] Thorpe et al., *supra* note 5, at 723.

[53] Jennifer Fisher Wilson, *Can Disease Prevention Save Health Reform?*, 151 ANNALS INT. MED. 145, 146 (2009).

supports an argument that CCM programs, leaving aside the coordination of primary care delivery, are sound vehicles for the delivery of "preventive services such as health risk assessments, individual and group counseling, and referral to community-based programs to address patients' health risk behaviors."[54] The concept of prevention in this context can be defined according to three aspects:

- *Primary prevention:* public education, advocacy, and practice encouraging good health and disease avoidance through, *e.g.*, the adoption of a healthy diet, an active lifestyle, and the avoidance of risky behavior;
- *Secondary prevention:* in response to risk indicators including elevated biometric values, guidance and practice intended to, *e.g.*, lower cholesterol levels, lose weight, and give up smoking;
- *Tertiary prevention:* attentive care to persons with chronic conditions to ameliorate or slow the progression of the condition by, *e.g.*, counseling exercise, or prescribing medication.[55]

It is axiomatic that it is preferable to prevent rather than treat an illness.[56] The behavioral and environmental causes of such illness are also not controversial. This connection is well illustrated by the graphic representation offered by authors from the Centers for Disease Control and Prevention ("CDC") in 2004.[57] The first chart[58] displays the ten leading causes of death in the United States in 2000, as reported by the CDC, and accounting for almost 80 percent of deaths in that year.

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[54] *See* Dorothy Y. Hung et al., *Rethinking Prevention in Primary Care: Applying the Chronic Care Model to Address Health Risk Behaviors,* 85 MILBANK Q. 69, 72 (2007).

[55] *See* Ron Z. Goetzel, *Do Prevention Or Treatment Services Save Money? The Wrong Debate,* 28 HEALTH AFF. 37, 38-39 (2009).

[56] The "cost-benefit," of primary prevention is discussed *infra* pp. 59-64. Cost aside, no one would argue against the human benefit of preventing, rather than treating diabetes or heart disease.

[57] Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000,* 291 JAMA 1238, 1239-40 (2004).

[58] *Id.* at 1239.

Chart 1. Leading Causes of Death in the United States in 2000

Cause of Death	**No. of Deaths**	**Death Rate per 100,000 Population**
Heart disease	710,760	258.2
Malignant neoplasm	553,091	200.9
Cerebrovascular disease	167,661	60.9
Chronic lower respiratory tract disease	122,009	44.3
Unintentional injuries	97,900	35.6
Diabetes mellitus	69,301	25.2
Influenza and pneumonia	65,313	23.7
Alzheimer disease	49,558	18
Nephritis, nephrotic syndrome, and nephrosis	37,251	13.5
Septicemia	31,224	11.3
Other	499,283	181.4
Total	2,403,351	873.1

This chart uses the usual means of identifying causes of death – the infectious diseases, traumas, or medical conditions that are the direct cause of the cessation of life. The second chart[59] displays the nine leading "actual" causes of death in 1990 and 2000, as estimated by the authors. "Actual" causes of death are defined as "major external (nongenetic) modifiable factors that contributed to death."[60]

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[59] *Id.* at 1240.

[60] *Id.* at 1238 (citing J. Michael McGuinnis & William H. Foege, *Actual Causes of Death in the United States,* 270 JAMA 2207, 2207-12 (1993)).

Chart 2. Actual Causes of Death in the United States in 1990 and 2000

Actual Cause	**No. (%) in 1990***	**No. (%) in 2000**
Tobacco	400,000 (19)	435,000 (18.1)
Poor diet and physical inactivity	300,000 (14)	400,000 (16.6)
Alcohol consumption	100,000 (5)	85,000 (3.5)
Microbial agents	90,000 (4)	75,000 (3.1)
Toxic agents	60,000 (3)	55,000 (2.3)
Motor vehicle	25,000 (1)	43,000 (1.8)
Firearms	35,000 (2)	29,000 (1.2)
Sexual behavior	30,000 (1)	20,000 (0.8)
Illicit drug use	20,000 (<1)	17,000 (0.7)
Total	1,060,000 (50)	1,159,000 (48.2)

* The percentages are for all deaths.

The 2000 data show that almost forty percent of the deaths were attributable to modifiable use of substances (tobacco, alcohol, and "illicit" drugs), poor diet, and physical inactivity.[61] Cross-walking the data in Chart 2 to Chart 1, the health benefits of primary prevention can be quantified in terms of saved lives. The inference to be drawn from these charts is that primary prevention measures that reduce or eliminate unhealthy behavior related to substance use, poor diet, and sedentary lifestyle could have eliminated hundreds of thousands of premature deaths in 2000.

Several aspects of existing chronic care management programs are consistent with enhanced primary preventive care. They rely on multidisciplinary teams, and therefore offer the opportunity for counseling of patients to modify their diet, join a local YMCA's exercise programs, or participate in wellness programs at the local senior center.[62] Similarly, counseling and

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[61] Chart 1 shows approximately 2.4 million deaths in 2000. Chart 2 shows approximately 537,000 deaths due to tobacco, alcohol, or illicit drug use, and 400,000 due to poor diet and physical activity in that year; 937,000 is about 37.8 percent of 2.4 million.

[62] *See supra* text accompanying notes 33-44.

education would be provided as secondary prevention measures when patients are guided in the process of reducing the risk presented by existing conditions such as high cholesterol levels. As one recent study concluded,

> [T]he implementation of CCM elements in primary care practices was positively associated with the use of interventions targeting risk behaviors identified as leading causes of morbidity and mortality in the United States. . . . [P]rimary care practices . . . may benefit from more widespread implementation of the CCM adapted for prevention that not only better controls existing chronic illnesses, but also reduces patients' risk of developing chronic diseases in the future.[63]

PRIMARY CARE

Tertiary prevention is the attentive care given to a person with a permanent or ongoing condition that ameliorates the effects of the condition and supports the patient's identification and navigation of appropriate coping responses to the condition.[64] As one leading advocate of chronic care explained, "[t]he core functions of primary care – comprehensiveness, accessibility (or first-contact care), continuity, and coordination – are also central to chronic illness care."[65] The return of emphasis on primary care is entirely consistent with continued resort to specialized care when needed; an overarching goal of chronic care management, however, is the close coordination of the patient's care, in partnership with the patient and her family, so that only care consistent with the patient's life goals is provided, and that all care (primary and specialty) is coordinated to ensure that a Sorcerer's Apprentice cascade of specialty treatments is not visited on the patient. The coordination in chronic care models is usually the domain of physicians, advanced practice nurses and other nurses, along with (as necessary) the participation of professionals and paraprofessionals in many

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[63] Hung, *supra* note 54, at 86.

[64] *See* Goetzel, *supra* note 55, at 39.

[65] KANE ET AL., *supra* note 4, at 93.

disciplines, including pharmacy, social work, physical and occupational therapy, and food science.[66]

Can these preventive and primary care services be generalized from chronic care patients to apply generally in primary care settings? A movement to a patient-centered model of primary health care has long argued for improvements in basic health care delivery. One formulation of eight "dimensions of patient-centered care" in primary care sounds very like those driving chronic care models:

1) respect for the patient's values, preferences, and expressed needs;
2) information and education;
3) access to care;
4) emotional support to relieve fear and anxiety;
5) involvement of family and friends;
6) continuity and secure transition between health care settings;
7) physical comfort; and
8) coordination of care.[67]

The coordinated model of primary care organization is often referred to as a "patient-centered medical home (PCMH)." Four national primary care physician organizations created an influential set of principles for PCMH in 2007.[68] The framers describe the principles as follows:

- ***Personal physician*** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

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[66] *See id.* at 93-94.

[67] Robert A. Berenson et al., *A House is Not a Home: Keeping Patients at the Center of Practice Design*, 27 HEALTH AFF. 1219, 1221 (2008) (citing Anne-Marie Audet et al., *Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey*, 166 ARCHIVES INTERNAL MED. 754, 755 (2006); *see generally* THROUGH THE PATIENT'S EYES: UNDERSTANDING AND PROMOTING PATIENT-CENTERED CARE (Margaret Gerteis et al. eds., 1993).

[68] The four groups are the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. These four organizations published *The Joint Principles for the Patient Centered Medical Home* in February 2007. The principles are available at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home. Am. Acad. of Family Physicians et al., *supra* note 34.

> - ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
> - ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
> - ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
> - ***Quality and safety*** are hallmarks of the medical home. . . .
> - ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
> - ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.[69]

PCMH's "core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high-quality, accessible care; and payments that recognize a medical home's added value for patients."[70] The similarity between these principles, and in particular the focus on the whole patient in context, has obvious similarity to those

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[69] American Academy of Family Physicians et al., *supra* note 34.

[70] John K. Iglehart, *No Place Like Home – Testing a New Model of Care Delivery*, 359 NEW ENG. J. MED. 1200, 1200 (2008).

defining CCM.[71] PCMH pilot projects are proceeding in a number of states,[72] and a Medicare demonstration project has been on again off again for several years.[73] It has been argued that further developmental work is necessary to "achieve [a] broader consensus on what medical homes reasonably can be expected to accomplish, and how they can best be developed in different practice environments and supported with altered payment policies."[74] One aspect of the effort to regularize the shape of PCMH and its finance and delivery implications has been the recognition process administered by the National Committee for Quality Assurance (NCQA).[75]

The passage of the Affordable Care Act raises the stakes for PCMH as medical homes are a central feature of the ACA's push to improve the coordination of primary and preventive care. Medical homes are featured in several places in the ACA,

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[71] *See generally* Larry A. Green et al., *Task Force 1: Report of the Task Force on Patient Expectations, Core Values, Reintegration, and the New Model of Family Medicine,* 2 ANNALS FAM. MED. S33 (2004); Iglehart, *supra* note 70, at 1200.

[72] *See* Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home,* 7 ANNALS FAM. MED. 254, 254-55 (2009).

[73] The Medical Home Demonstration was initially authorized by Section 204 of the Tax Relief and Health Care Act of 2006, and further funding for the demonstration was authorized in Section 133 of the Medicare Improvements for Patients and Providers Act of 2008. *See generally* MATHEMATICA POLICY RESEARCH, INC., DESIGN OF THE CMS MEDICAL HOMES DEMONSTRATION (October 3, 2008), *available at* http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_DesignReport.pdf. In response to Congressional reform efforts that would change the nature of medical homes demonstrations, CMS suspended development of the Demonstration on October 16, 2009. *See* Centers for Medicare and Medicaid Services, *Details for Medicare Medical Home Demonstration,* U.S. DEP'T HEALTH & HUM. SERVICES, http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1199247 (last modified Sept. 14, 2010). DHSS Secretary Sebelius announced on September 16, 2009, however, that Medicare would "join Medicaid, and private insurers in state-based efforts to improve the way health care is delivered" through the testing of "'Advanced Primary Care (APC) models' also known as medical homes." *See* HHS Press Office, *Secretary Sebelius Announces Medicare to Join State-Based Healthcare System Delivery Reform Initiatives,* U.S. DEP'T HEALTH & HUM. SERVICES (Sept. 16, 2009), *http://www.hhs.gov/news/press/2009pres/09/20090916a.html*.

[74] Berenson et al., *supra* note 67, at 1220.

[75] *See* Paul A. Nutting et al., *supra* note 72, at 254; Berenson et al., *supra* note 67, at 1220; *see also Physician Practice Connections – Patient-Centered Medical Homes,* NAT'L COMM. FOR QUALITY ASSURANCE http://www.ncqa.org/tabid/631/default.aspx (last visited Dec. 2, 2010).

including:

- § 1001. One of the "immediate improvements in health care coverage" is to require health plans and insurers to report on quality efforts, including "through the use of the medical homes model."[76]
- § 1301(a)(3). Permits "Qualified Health Plans" to deliver service through medical homes.
- § 1311(g)(1)(A). Allows enhanced reimbursement for methods that improve health outcomes, including, *inter alia*, through "the use of the medical home model."
- § 3021(b)(2)(A). Creates the Centers for Medicare and Medicaid Innovation, and requires testing of delivery and finance innovations including those "[p]romoting broad payment and practice reform in primary care, including patient-centered medical home models."
- § 3502. Requires the Secretary to provide grants or enter into contracts to establish "community health teams to support the patient-centered medical home."

The PCMH model is a developing one, and questions remain about its most effective and efficient form. Resolution of these questions will be vital to the implementation of the ACA.

It has been suggested, for example, that some versions of the model – and the NCQA recognition process – are too focused on electronic records and health information technology, perhaps to the detriment of the core patient care focus.[77] The fault here may be that efforts to normalize a developing model often focus on readily quantifiable measures. It is much easier to audit a requirement for a trail of electronic charts, referrals, and follow-up notices than to assess the extent to which a practice incorporates family and community input, or emotionally

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[76] This language amends the Public Health Service Act by adding a new § 2717.

[77] Berenson et al., *supra* note 67, at 1225.

supports patients to reduce fear and anxiety. The continuing value of the model will depend on its adherence to its patient-centered roots.

A second concern is that the PCMH may require primary care offices of a sufficiently large scale to support the electronic medical records components and 24/7 availability that are currently central to the design.[78] Many physicians' offices in many parts of the country are small, and will experience difficulty scaling up to meet operating standards.[79] These and other concerns may be resolved as PCMH develops. Perhaps the most serious non-fiscal concern,[80] however, is the adequacy of the primary care workforce.

The supply of primary care services generally, and for Medicare beneficiaries in particular, is nearing crisis level.[81] The American College of Physicians has warned of the "collapse" of the physician primary care supply.[82] The cause of this imminent collapse is often described as a combination of the growing workload of primary care physicians and the low level (at least relative to other physicians) of their compensation.[83] In addition, a general shortage of physicians is now projected,[84] a shortage that cannot improve the primary care situation. How will improvements in primary and preventive care be achieved without an adequate supply of primary care physicians?

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[78] *Id.* at 1226.

[79] *Id.* Berenson et al. suggest that a solution for small practices maybe to contract with an outside nursing service employing the Guided Care model of nursing support for people with serious chronic conditions. *See* Cynthia M. Boyd et al., *Guided Care for Multimorbid Older Adults*, 47 GERONTOLOGIST 697, 697 (2007). This suggestion may serve to fill gaps, as Berenson suggests, for people with chronic illness, although such out-sourcing is far from ideal for a program intended to integrated care in a primary care setting. It is unclear how the model could work for non-disabled persons.

[80] Reimbursement issues are addressed below in pp. 59-64.

[81] *See* Jana E. Montgomery et al., *Primary Care Experiences of Medicare Beneficiaries, 1998 to 2000*, 19 J. GEN. INTERNAL MED. 991, 991 (2004).

[82] *See* Thomas Bodenheimer, *Primary Care – Will It Survive?*, 355 NEW ENG. J. MED 861, 861 (2006).

[83] *See id.* at 861-62.

[84] *See* Anemona Hartocollis, *Expecting a Surge in U.S. Medical Schools*, N.Y. TIMES, Feb. 14, 2010, at A1.

Several factors contribute to the shortage of primary care physicians. Their compensation is far below that of specialty practitioners, and would be lower but for their high volume of appointments, increasing their fee-for-service payments.[85] This high volume, and the obligations to be on-call after normal business hours, strains their professional and personal quality of life.[86] Reimbursement-related concerns have been the focus of groups attempting to increase the supply:

> Primary care practice is not viable without a substantial increase in the resources available to primary care physicians. The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and MedPAC have recommended changes to rescue primary care from what the ACP has called an "impending collapse." The MedPAC, whose 17 members are appointed for 3-year terms by the U.S. Comtroller [sic] General, has been concerned with primary care because, as a watchdog of Medicare costs, it views a high ratio of specialists to population as a cost driver while a greater number of primary care physicians may help contain costs.[87]

But increased fees would not address quality of life concerns; increased reimbursement, coupled with a move from a procedure-driven fee-for service system to one that values patient communication and thoughtful management, would more fully address the problem.[88] In the meantime, and while those practice modifications remain aspirational, the Association of American Medical Colleges has committed to training more physicians by expanding the overall capacity of American medical schools.[89] A projected thirty percent increase in capacity is expected to add approximately 3,500 new medical graduates over the next ten years – including, it is hoped, more opting for a primary care practice.

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[85] *See* Thomas Bodenheimer et al., *The Primary Care-Specialty Care Income Gap: Why it Matters,* 146 ANNALS INTERNAL MED. 301, 301 (2007).

[86] Bodenheimer, *supra* note 82, at 861-62.

[87] Bodenheimer et al., *supra* note 85, at 304-05.

[88] *Id.* at 305.

[89] *See* Hartocollis, *supra* note 84.

There is substantial concern, however, that the supply of primary care physicians will not increase in the near term. First, in difficult fiscal times, it is unlikely that substantial new funds will be devoted to primary physician fees.[90] Second, it is unlikely that a shift of the balance of existing funds toward primary care would be advocated by physicians as a group,[91] thereby maintaining the gulf between specialty and primary care income. Third, prior experience with increases to the supply of physicians suggests that simply lifting the cap on medical school graduations will not improve the primary care workforce supply:

> Past experience shows that further increases in the number of physicians per capita will do little to redress the inverse care law that governs the location of physicians. Between 1979 and 1999, the per capita supply of physicians increased by 51%, but regional differences in physician supply changed little. For every physician who settled in a low-supply region, 4 physicians settled in regions with already high supply. Increasing overall supply is a blunt instrument for increasing supply in underserved communities, a need better addressed by focused reforms of medical education and financial and other practice incentives to change physician settlement patterns.[92]

Furthermore, a vanishingly small percentage of new medical school graduates enter primary care,[93] and absent a dramatic reconfiguration of compensation, status, and workload, that pattern is likely to continue, wherever the new graduates settle.[94]

Reform of the management of the chronically ill and the

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[90] One exception is the ACA's temporary increase in physicians' Medicaid fees for some primary care procedures to the Medicare level of reimbursement.

[91] *See* Bodenheimer et al., *supra* note 85, at 305.

[92] David C. Goodman & Kevin Grumbach, *Does Having More Physicians Lead to Better Health System Performance?*, 299 JAMA 335, 336 (2008). *See* David C. Goodman & Elliot S. Fisher, *Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription*, 358 NEW ENG. J. MED. 1658, 1659-60 (2008).

[93] *See* Bodenheimer et al., *supra* note 85, at 301.

[94] *See* Robert Steinbrook, *Easing the Shortage in Adult Primary Care – Is it All about Money?*, 360 NEW ENG. J. MED. 2696, 2696-97 (2009).

more general reform of primary and preventive care practice will require an adequate supply of primary care professionals. In the event the dysfunction in physician training and compensation patterns continue, it may be that we will have to accept that physicians have largely abandoned the field of primary care. It may, therefore, be necessary to look elsewhere, for example, through the acceleration of the expansions in the scope of practice-permitted, non-physician primary care professionals, such as advanced practice registered nurses (APNs).

Many states have expanded APNs' scope of practice in recent years, although the progress has been uneven and slow. APNs are:

> registered nurses whose formal education and clinical training go well beyond the basic requirements for licensure. Most [APNs] are trained in master's degree programs. [APNs] are trained to diagnose and treat common acute illnesses and injuries, manage high blood pressure, diabetes, and other chronic problems; prescribe drugs, devices and treatments; order and interpret X-rays and other laboratory tests; and counsel patients on disease prevention.[95]

Although their scope of practice has been slowly expanding, APNs remain restricted in their practice by requirements for "formal relationships with MDs," and by restrictions to only limited practice forms or geographic regions.[96]

Researchers have for many years studied the quality of primary care provided by APNs in comparison to that provided by physicians, and have found equivalent results.[97] A study published in 2000, performed a randomized trial of primary care

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[95] Michael J. Dueker et al., *The Practice Boundaries of Advanced Practice Nurses: An Economic and Legal Analysis*, THE FED. RES. BANK OF ST. LOUIS: WORKING PAPER SERIES 2-4 (2005), *available at* https://research.stlouisfed.org/wp/2005/2005-071.pdf.

[96] *Id.* at 5.

[97] *See* Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians*, 283 JAMA 59, 59 (2000); M. Laurent et al., *Substitution of Doctors by Nurses in Primary Care (Review)*, 4 COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2004), *available at* http://www.hss.state.ak.us/hspc/files/Primary_Care_Substitution.pdf.

provided by physicians and APNs in which their primary care practices were "similar both in terms of responsibilities and patient panels."[98] Like prior studies, this trial found essential equivalence in relevant outcomes:

> This study was designed to compare the effectiveness of nurse practitioners with physicians where both were serving as primary care providers in the same environment with the same authority. The hypothesis predicting similar patient outcomes was strongly supported by the findings of no significant differences in self-reported heath status, 2 of the 3 disease-specific physiologic measures, and all but 1 of the patient satisfaction factors after 6 months of primary care, and in health service utilization at 6 months and 1 year.[99]

These results suggest that one answer to the problem of a shortage of primary care physicians is to more fully utilize APNs as primary care professionals. Several factors impede the ready introduction of APNs into full practice in primary care settings. First, more research must be done to confirm the body of evidence supporting the safety and effectiveness of APN practice.[100] Second, physicians must cooperate; there are some suggestions that a guild mentality or professional jealousy is inhibiting the integration of APNs into practice with physicians.[101] Third, compensation and reimbursement systems must facilitate this integration, as APNs, like physicians, have varying options in their choice of practice. Fourth, state licensure standards must be clarified and normalized so as to ensure that APNs can practice broadly, including in substitution for physicians, where such forms of practice are shown to be safe and effective.[102]

Were these conditions met, the path to APN status could be an appealing option in the "career ladder" for registered nurses,

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[98] Mundinger et al., *supra* note 97, at 59.

[99] *Id.* at 66.

[100] *See* Denise Bryant-Lukosius et al., *Advanced Practice Nursing Roles: Development, Implementation and Evaluation,* 48 J. ADV. NURSING 519, 526 (2004).

[101] *See* Dueker et al., *supra* note 95, at 19.

[102] *See* Bryant-Lukosius et al., *supra* note 100, at 524-25.

who now experience relatively flat salary progression and fairly limited professional advancement opportunities. These steps then could serve both to bolster the primary care workforce and to retain trained nurses in the profession by giving them an appealing "next step" in their nursing options. Expanding the primary care workforce to include APNs as independent practitioners seems consistent with the sense of CCM, which relies on multidisciplinary teams, and therefore might readily incorporate slightly different professional structures. As PCMHs have developed, however, they have tended to be oriented toward physician leadership, and incorporating more independent APNs into PCMHs will pose difficulties.

The next Part examines a particular barrier to the incorporation of CCM and PCMH into reimbursement policy. Decisions on cost effectiveness in health finance are not made in a vacuum. The ACA makes it clear that we will continue to rely on private insurance companies to manage the steps of health reimbursement closest to individual providers and patients. It is they, acting within the framework of general regulations, who will manage provider networks and influence the flow of funding for care. To the general question, is CCM (or PCMH) "worth it?" we must ask another question: worth it to whom?

FINANCING CHRONIC CARE AND PREVENTIVE/PRIMARY CARE: WHO DECIDES WHETHER IT'S WORTH IT?

The literature on chronic care management provides substantial evidence that models such as CCM, with patient-centered, multidisciplinary, community-coordinated care, are much more responsive to the needs of people with serious chronic conditions than is the currently dominant and fragmented system. The literature suggests that these models can also be cost-effective, in the sense that they show the promise of reducing the health costs patients would have experienced over time absent the interventions. There is less evidence that PCMH models are cost-effective in this sense, although future studies may demonstrate that they are. The cost effectiveness of these models is important, as cost concerns will play an enormous part in health reform decisions for the foreseeable future. And for good reason: as prices rise, extending coverage to high quality care becomes more difficult.

There are cost-effectiveness arguments for CCM and PCMH that are beyond the scope of this paper, [103] in which the primary focus is on cost-effectiveness in only a narrow sense: whether the provision of care through CCM or PCMH will reduce the cost of care provided to the patient in the future. This is an admittedly cramped use of the term "cost-effectiveness." Discussion of cost-effectiveness in this cramped sense has value, as coverage and access decisions in the foreseeable future are likely to be driven, in substantial part, on an analysis of the cost implications of those decisions for the health care system. While admitting to the artificiality of this constraint, its political and practical force is undeniable. How can we determine whether coordinated provisions of chronic care or primary and preventive care are cost-effective in the narrower sense that it promises a reduction in overall health care costs? There are issues that must be addressed to respond to this inquiry. One, obviously, is the question of the meaning of the term "cost-effective" in this narrow sense. The second is the identification of a time frame over which accrued costs will "count" for purposes of the analysis – a question of vital importance now that the ACA locks people into a system in which many consumers will shift from one commercial insurer to another during the course of their lives. The third is a process question and goes to the means by which the coverage question is answered if there are principled disputes as to cost-effectiveness.

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[103] The art of cost-effectiveness analysis (CEA) has been addressed in voluminous literature. *See generally* PETER J. NEUMANN, USING COST-EFFECTIVENESS ANALYSIS TO IMPROVE HEALTH CARE: OPPORTUNITIES AND BARRIERS (2005); *see generally* COST EFFECTIVENESS IN HEALTH AND MEDICINE (Marsha R. Gold et al. eds., 1996); *see generally* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFF. 11 (2001).

"COST-EFFECTIVE"

As is described above, there is "some evidence" that CCM can reduce total health care costs for at least some chronically ill patients.[104] If this conclusion is borne out on further study, then the cost-effectiveness question seems easy: the reduction in other health costs is greater than the cost of CCM; therefore, CCM is cost-effective in the narrow sense. The analysis for PCMH – and for prevention in general – is murkier. If CEA focuses on medical costs, there is substantial evidence that, "[d]espite savings in some categories," most preventive interventions "add more to medical costs than they save."[105] It will be important as primary and preventive care is institutionalized in the reimbursement system that sensible evaluation of value is undertaken. For example, much of the cost-increasing preventive care is of the high-tech variety, such as pharmaceutical products marketed as "maintenance" (that is subject to purchase and use for a patient's lifetime),[106] and not on lower-tech interventions such as health education and counseling about the benefits of proper diet and exercise.[107] As the philosophy of CCMs and PCMHs emphasize the lower-tech care, a more fine-grained analysis of the particular prevention methods they use will help guide this discussion.[108]

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[104] Coleman et al., *supra* note 33, at 81.

[105] Louise B. Russell, *Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings*, 28 HEALTH AFF. 42, 42, 45 (2009).

[106] *Id.* at 43.

[107] *See* Goetzel, *supra* note 55, at 38.

[108] In addition, those who argue that prevention creates net medical costs

> point out that in many instances, preventive measures do not save money, when compared to the cost of treating the disease that would otherwise have been prevented, because screening costs for healthy people far outweigh treatment costs for the few who [would have] develop[ed] the disease. They are absolutely right in that respect. Providing certain preventive services, mostly in clinical settings, does not save money. But, then again, neither do most medical treatments.

Goetzel, *supra* note 55, at 37.

TIME FRAMES

As is noted above, CCM has been determined to "reduce total health care costs" for some chronically ill patients.[109] The determination comes with an important caveat, however: in many cases, the cost-savings accrue over time and therefore may not benefit the payer responsible for the reimbursement of some substantial costs of providing the CCM.[110] For example, the cost of the primary-care-based CCM might be borne by one insurance company (either a private insurer or one providing coverage as a Medicare Advantage or Special Needs Plan ("SNP")[111]) covering a patient in 2010, but the cost savings (in the form of foregone surgery, for example) accrue to another insurer covering the same patient in 2015. Coleman dismisses this aspect of the CEA analysis with the perfectly reasonable, but not fully satisfying, observation that the treatment under those circumstances would be "cost-effective from a societal perspective."[112] But that observation demands recognition of the insurers' self-interest in calculating cost-effectiveness in a narrower time frame (during the three or four years insurers believe their members will stay with them), and some means of forcing consideration of a longer time frame.

RESOLVING THE "WORTH IT" QUESTION

Patient-centered chronic care and primary/preventive care have substantial appeal from the perspective of outcomes and patient satisfaction, and there is evidence of cost-effectiveness in at least some circumstances. If problems related to practice design and professional workforce adequacy can be

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[109] *See supra* text accompanying notes 44-47, *quoting* Coleman et al., *supra* note 33, at 81.

[110] *See* Coleman et al., *supra* note 33, at 81.

[111] *See* David C. Grabowski, *Special Needs Plans and the Coordination of Benefits And Services for Dual Eligibles*, 28 HEALTH AFF. 136, 137 (2009) (describing Medicare Special Needs Plans for, *inter alia*, Medicare beneficiaries with severe chronic illnesses).

[112] Coleman et al., *supra* note 33, at 81 (footnotes omitted).

addressed,[113] a major remaining impediment to incorporating models such as CCM and PCMH into coverage may well be financial, requiring an answer to the question of whether the cost of providing care through such models is "worth it." In some circumstances, the answer will be easy. Where, for example, the sponsor of coverage (in the case of Medicare, CMS, or in the case of a Medicare Advantage plan or SNP, the insurer) is able to determine that the addition of a coordinated care system costs less than that of avoided services within the sponsor-relevant time frame, the care system will be implemented. In these cases, the primary care team will have to be compensated in an amount and through a method that facilitates and encourages the provision of the services essential to the success of coordinated care models, most likely in the form of case payments or partial capitation.[114]

The more difficult cases arise when there is a more complex relationship between costs and benefits. In cases where the health care cost benefits of a coordinated care approach manifest several years in the future, the inclination to approve the implementation of a case management system may be more mixed. Public programs resolve this conflict by defining, with some particularity, the services participating insurers must cover including preventive and primary care services. What of privately insured persons? Insurers might be left free to make their own judgments. When the benefit of implementing a coordinated care system is substantial in the long term, but the benefits will not likely accrue to the insurer, the insurer is in a hopeless conflict of interest. Left to its own internal interests, the insurer will either reject implementation (if permitted to do so), or be inclined to engage in overt or covert exclusionary screening in order to avoid covering those in most need of the care coordination. Allowing insurers to act on their own

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[113] *See supra* text accompanying notes 78-94 (describing PCMH discussion of small practice settings and too few PCPs).

[114] *See* Bodenheimer et al., *supra* note 85, at 305; Wolff & Boult, *supra* note 24, at 442-43.

interests in such situations would be to simply frustrate the social judgment in favor of care coordination. No insurer would choose to cover such services when it could simply externalize the costs of chronic care, and at the same time discourage enrollment by chronically ill members.

The division of interest is between those paying for coverage and those selling coverage. It may be in insurers' interest to consider the benefit of a care coordination or wellness program within quite a narrow time frame, consistent with the short period it expects members to remain "theirs." It is in the interest of payers (government, employers, and individuals), however, that the time frame be expanded so that expenditures be made if they will pay off over a longer period. The ACA resolves what would otherwise be a clash of interest between payers and insurers by mandating several aspects of chronic care management and primary and preventive care.[115] Decisions on covering chronic care coordination, and primary and preventive care services then, cannot be left to private insurers even if cost-effectiveness is narrowly defined as producing a net savings in health care costs. The time frames during which insurers will calculate returns on investment are too short. Instead, the decisions must be made by public payers for their members and by regulators of insurance for those in the private market.

SOME BROADER CONSIDERATIONS

The discussion above argues for the addition of chronic care management and primary and preventive care services, and describes a narrow set of circumstances in which such services should certainly be provided by all plans and insurers, namely, those in which such coverage is narrowly cost-effective. While that narrow cost-effectiveness analysis is the focus of this section, there are other compelling arguments for adding robust

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[115] *See* Patient Protection and Affordable Care Act (PPACA), H.R. 3590, Pub. L. No. 111-148, 1§§ 1001, 1302 , 24 Stat. 119 (2010).

care coordination to all insurance. Most obviously, as has been described above, it appears that CCM improves the perceived quality of care for people with chronic conditions and allows patients and their families to suffer less anxiety and confusion in the course of their treatment. In that circumstance, the services should be provided even if they add marginal cost to the health care system. After all, other interventions – new cancer treatments or novel orthopedic surgeries – are covered if they are deemed medically necessary even if they add to marginal costs. Even in cost-constrained times, it is not clear that high-tech interventions (surgery on the knee to repair the sports injury of a "weekend warrior") should be covered, while low-tech interventions similarly assistive in advancing patient mobility (home health aide services to allow for the social integration of a person with severe mobility impairments) should be denied.

This is not to argue that trade-offs between cost and benefits will not be made. The health care cost containment imperative is powerfully felt, and all services should be subjected to reasonable tests for cost-effectiveness. The results of such analysis are certain to be contested and controversial. Health care does not exist in the first instance to save money, but rather to advance personal and social goals of wellness and well-being. New models of both chronic care management and primary and preventive care services are designed with those wider goals in mind. Producing higher levels of well-being for people with chronic illness and their families, and preventing serious illnesses is worth something beyond the saved cost of avoided future medical care. Achieving those goals can enhance social integration, economic productivity, personal satisfaction, and familial well-being.

CONCLUSION

Two forces are driving changes in health care delivery and finance. First, chronic care needs have supplemented and supplanted acute care needs. Through most of the 20th century, the care and finance focus was on acute care – the intensive intervention into a sudden and/or imminently serious disease or trauma, calculated to restore the patient to "normal" functioning. We increasingly, however, need care for ongoing chronic conditions instead of, and in addition to, acute care. The delivery system we inherited from the 20th century too often provides disjointed, frustrating, and ineffective care to people with significant chronic illness. Second, the finance system we inherited from the 20th century tends to value high-tech procedures, drugs, and devices. It little values the time spent by professionals to listen to or talk with their patients or each other. As needs have shifted to continuing care for multiple chronic conditions, this skewing of financial priorities has led to significant inefficiencies and cost increases. Models of patient-centered coordinated care offer some promise to address these two concerns. An important aspect of patient-centered coordinated care for people with chronic illness is the provision of wellness-directed preventive and primary care.

As the human, clinical, and fiscal benefits of chronic care models have become evident, researchers have asked whether their approach could be used to improve primary and preventive care for those who do not (yet) have chronic illnesses. The focus on maintaining wellness, addressing the whole person in the context of family and community, and furthering goals of patient empowerment, have generated support. Achieving optimal primary and preventive care – for those with and without chronic conditions – will depend on some structural shifts in a practice and finance environment that has grown too far removed from first principles of maintaining wellness rather than providing exotic care, and revision in the reimbursement methods to decrease emphasis on entrepreneurial interests and increase support for wellness and personal control. Adopting care coordination in some settings is clearly more cost-effective than maintaining our current system. In other settings, the costs and benefits are less clearly measured. In these cases social judgments must be made: how much is it worth to turn our health care system toward wellness and disease avoidance?