IMPROVING HEALTH OUTCOMES AND LOWERING COSTS: ATTORNEYS AS PROACTIVE, PAID PROVIDERS TREATING SOCIAL DETERMINANTS OF HEALTH

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ABSTRACT

Innovative and emerging value-based delivery models should include attorneys as health care team members to treat the social determinants of health. Social determinants of health ("SDH") are non-medical conditions that can produce or undermine health and include basic human needs like economic status, housing, nutrition, employment, and similar issues. Health care experts increasingly recognize the role that SDH play in driving the cost, utilization, and outcomes of medical treatment. The U.S. Department of Health and Human Services ("HHS") is looking for holistic ways to innovatively manage SDH, including paying for assistance—whether or not that assistance involves traditional healthcare services. Private payors and providers are financially incentivized to incorporate SDH management into their treatment plans because new payment models are already penalizing providers for quality measures largely affected by SDH. Attorneys can help "treat" SDH, such as financial distress, home environment (including housing, utility, and food security), employment issues, resolution of insurance/immigration/criminal/military status, and many other SDH. Instead of relying on the goodwill of attorney organizations to provide free legal services to patients, the health care delivery system should include reimbursement mechanisms to pay attorneys for this valuable service. The legal profession and the health care industry will both benefit from the development of payment mechanisms that incentivize attorneys to engage in new roles treating SDH. This Article explores ways that untreated SDH impact health care and how attorneys can

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add value by embracing advocacy roles for patients, providers, and payors to treat social determinants of health.

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"The aim of medicine is to prevent disease and prolong life, the ideal of medicine is to eliminate the need of a physician."[1]
William J. Mayo

I. INTRODUCTION

Attorneys can play an important role in health care delivery. As providers and payors recognize the importance of social determinants of health, innovative opportunities for attorney involvement in health care are arising that will benefit patients, payors for health care services, and health care providers. Social determinants of health ("SDH") are non-medical conditions that can "produce or undermine health" and include basic human needs like economic status, education, employment, housing, nutrition, and social integration.[2]

Research over many decades has shown "strong influences on health" caused by "socioeconomic, environmental, and behavioral factors" that include SDH.[3] Untreated SDH are widely recognized as drivers of medical cost and utilization, with epidemiological research demonstrating links between SDH and health-related morbidity and mortality.[4] Health care experts now generally acknowledge that "countries that spend more on social services, such as family/child supports, disability, unemployment, and housing, relative to their gross domestic product have significantly better population health outcomes."[5]

1. William J. Mayo, *The Aims and Ideals of the American Medical Association*, 66 NAT'L EDUC. ASS'N 158, 163 (1928).

2. ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH CARE PARADOX 12–13 (2013) (defining social determinants of health as "socioeconomic, environmental, and behavioral factors that research over many decades has shown to be strong influences on health"); *see also* James Teufel et al., *Rural Health Systems and Legal Care: Opportunities for Initiating and Maintaining Legal Care After the Patient Protection and Affordable Care Act*, 35 J. LEGAL MED. 81, 82 (2014) (defining SDH as "economic and social factors that impact health both directly and through health-related behaviors" including "social, human, and economic resources, and power structures and their distribution (e.g., income, wealth, education, social exclusion, employment, housing, and nutrition)").

3. BRADLEY & TAYLOR, *supra* note 2.

4. KPMG GOV'T INST., INVESTING IN SOCIAL SERVICES AS A CORE STRATEGY FOR HEALTHCARE ORGANIZATIONS: DEVELOPING THE BUSINESS CASE 2 (2018) ("The impact of social determinants of health (SDOH) as drivers of medical utilization, cost, and health outcomes is both widely researched and acknowledged."); *see also* Teufel et al., *supra* note 2, at 82–83 ("Social epidemiological research supports the link between SDHs and morbidity and mortality.").

5. William H. Shrank et al., *Redistributing Investment in Health and Social Services—The Evolving Role of Managed Care*, 320 J. AM. MED. ASS'N. 2197, 2197 (2018).

Social needs that are largely ignored or unmet by the current U.S. health care system are actually major determinants of health outcomes.[6] Some have estimated that the SDH may account for as much as 40% of health outcomes and a large number of deaths in the U.S.[7] In some cases, the percentages are even higher with social factors contributing to "more than 70 percent of colon cancer and stroke, more than 80 percent of coronary heart disease cases, and more than 90 percent of adult-onset (type 2) diabetes cases."[8]

Alex Azar, Secretary of Health and Human Services, recently summed up SDH this way:

> How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week? How can a mother with an asthmatic son really improve his health if it's their living environment that's driving his condition? This can feel like a frustrating, almost fruitless position for a healthcare provider, who understands what is driving the health conditions they're trying to treat, who wants

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6. *See, e.g.*, RUTH RECHIS ET AL., LIVESTRONG, "I LEARNED TO LIVE WITH IT" IS NOT GOOD ENOUGH: CHALLENGES REPORTED BY POST-TREATMENT CANCER SURVIVORS IN THE LIVESTRONG SURVEYS 1 (2011), https://www.livestrong.org/sites/default/files/what-we-do/reports/LSSurvivorSurveyReport_final.pdf (reporting only 20% of cancer survivors received help with practical concerns like financial concerns); *see also* BRADLEY & TAYLOR, *supra* note 2, at 13, 17 (noting that America is "one of only three industrialized countries (the other two were Korea and Mexico) to spend the majority of its total health and social services budget on health care," and stating (1) that socioeconomically disadvantaged people are twice as likely to face serious illness and premature death when compared to advantaged people, (2) that poverty, social isolation, psychological stresses, food insecurity, housing, and job insecurity "have all been shown to compromise health," and (3) that Stanford researchers found a common set of twenty-two socioeconomic and environmental variables (e.g., income, access to healthy food) that explain geographic and racial differences in early death).

7. DEBORAH BACHRACH ET AL., MANATT HEALTH SOLUTIONS, THE COMMONWEALTH FUND, ADDRESSING PATIENTS' SOCIAL NEEDS: AN EMERGING BUSINESS CASE FOR PROVIDER INVESTMENT 3, 9–10 (2014), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf ("Social and economic factors such as income, educational attainment, access to food and housing, and employment status have a profound impact on health . . . . account[ing] for as much as 40 percent of health outcomes . . . . Social factors are the direct cause of death for a large number of Americans" including deaths due to determinants like poverty, low educational attainment, and weak social support, and "[d]espite growing evidence documenting the impact of social factors on health, providers have rarely addressed patients' social needs in clinical settings").

8. BRADLEY & TAYLOR, *supra* note 2, at 13 (footnotes omitted).

> to help, but can't simply write a prescription for *healthy meals, a new home, or clean air*.[9]

That is where attorneys can step in! Attorneys *can* often "write the prescription" for healthy meals, a healthier home, or clean air by helping patients address legal needs affecting those issues. Supportive services and other non-clinical interventions that address SDH can "both improve . . . patients' health and curb health care spending."[10]

Attorneys have much to gain by getting more involved in health care delivery. First, many attorneys exhibit signs of diminished satisfaction and mental distress in traditional legal practice, and more direct involvement in patient care will likely provide opportunities for unsatisfied attorneys to pursue a different and possibly more satisfying pathway.[11] Attorneys' "work satisfaction is . . . related to the law grads'

9. Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs., The Root of the Problem: America's Social Determinants of Health at the Hatch Foundation for Civility and Solutions (Nov. 14, 2018) (emphasis added), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html.

10. ANNA SPENCER ET AL., CTR. FOR HEALTH CARE STRATEGIES, INC., USING MEDICAID RESOURCES TO PAY FOR HEALTH-RELATED SUPPORTIVE SERVICES: EARLY LESSONS 1 (2015), https://www.chcs.org/media/Supportive-Services-Brief-Final-120315-1.pdf.

11. *See* Joe Patrice, *Unhappiest Job in America? Take a Guess*, ABOVE LAW (Mar. 28, 2013, 1:40 PM), https://abovethelaw.com/2013/03/unhappiest-job-in-america-take-a-guess/ (noting that in a study of 65,000 employees, associate attorneys occupied the "unhappiest jobs" in America, ranking below the near minimum wage job of customer service associate); *see also* Patrick R. Krill et al., *The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*, 10 J. ADDICTION MED. 46, 46, 50–51 (2016) (noting that "[a]ttorneys experience problematic drinking that is hazardous, harmful, or otherwise consistent with alcohol use disorders at a higher rate than other professional populations"—including almost 1/3 (32%) of attorneys age 30 or younger—and that "[m]ental health distress is also significant," such as anxiety, depression, suicidal thoughts, and panic disorder prevalence); Jeena Cho, *Study Indicates Lawyers Struggling with Substance Use and Other Mental Health Issues*, FORBES (July 30, 2016, 11:13 AM), https://www.forbes.com/sites/jeenacho/2016/07/30/study-indicates-lawyers-struggling-with-substance-use-and-other-mental-health-issues/#3d77902db854 (noting that lawyers are more than twice as likely as doctors to report high levels of alcohol use); Jacquelyn Smith, *The Happiest and Unhappiest Jobs in America*, FORBES (Mar. 22, 2013, 2:55 PM), https://www.forbes.com/sites/jacquelynsmith/2013/03/22/the-happiest-and-unhappiest-jobs-in-america/#50aba0222edd (noting that associate attorneys "felt most unhappy with their company culture," which includes a focus on billable hours with several years required to reach partnership level, leading to associate attorneys "rat[ing] the way they work and the rewards they receive lower than any other industry"); Debra Cassens Weiss, *Want Career Satisfaction? Don't Chase Money and Prestige, Lawyer Survey Suggests*, ABA J. (July 1, 2013, 10:45 AM), http://www.abajournal.com/news/article/want_career_satisfaction_dont_chase_money_and_prestige_survey_suggests (noting that law school graduates making the most money tended to be the least happy).

perceptions of the social value of their work,"[12] and providing solutions for SDH in the health care delivery system may help fulfill those perceptions of social value.

Second, many new attorneys are struggling to find traditional legal jobs. According to the American Bar Association, over one fourth (27%) of 2016 law school graduates were NOT "employed in full-time long-term Bar Passage Required or J.D. Advantage jobs roughly 10 months after graduation."[13] In addition, the "actual number of full-time long-term Bar Passage Required or J.D. Advantage jobs declined by 4 percent from . . . 2015 . . . to . . . 2016."[14] So, the legal profession needs to look beyond traditional legal jobs for areas where legal services are needed. Finally, helping patients could improve the public perception of the legal profession by "enhanc[ing] the appreciation of an attorney's advocacy role" and by allowing attorneys to shun the "adversarial stereotype" that antagonizes many health care providers and the public.[15]

The health care industry also has much to gain by getting attorneys involved to treat SDH, as the national costs of health care are now approaching 18% of gross domestic product.[16] Attorneys have knowledge and skills that can provide tangible benefits to stakeholders like patients, hospitals, doctors, insurance companies, and the government by helping address important social issues that directly drive up the costs of health care and limit the quality of life for patients. Specifically, attorneys are uniquely qualified to "treat" many of the costly social determinants of health that have largely been untreated by the current American health care system.

Some researchers categorize SDH into six categories that all have possible legal ramifications as noted below:

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12. Weiss, *supra* note 11.

13. *ABA Legal Education Section Releases Employment Data for Graduating Law Class of 2016*, AM. BAR ASS'N (May 11, 2017), https://www.americanbar.org/news/abanews/aba-news-archives/2017/05/aba_legal_education/.

14. *Id.*

15. Stewart B. Fleishman et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLINICAL ONCOLOGY 2123, 2125 (2006).

16. *National Health Expenditures Per Capita, 1960–2023*, HENRY J. KAISER FAMILY FOUND. (Oct. 23, 2014), https://www.kff.org/health-costs/slide/national-health-expenditures-per-capita-1960-2023/; *see also Historical*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccounts Historical.html (last modified Dec. 11, 2018) ("U.S. health care spending grew 3.9 percent in 2017, reaching $3.5 trillion or $10,739 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 17.9 percent.").

(1) "Economic Stability": employment law, debtor/creditor law, disability law, domestic/family law, etc.

(2) "Neighborhood and Physical Environment": housing law, landlord tenant law, public works law, etc.

(3) "Education": education law, immigration law, discrimination law, etc.

(4) "Food": food law, social services law, etc.

(5) "Community and Social Context": discrimination law, public works law, etc.

(6) "Health Care System": health law and policy, insurance law, social services law, disability law, etc.[17]

Attorneys can play a role in addressing all six categories of SDH in some circumstances.

The government is beginning to realize the importance of SDH and is voicing a willingness to pay for services that are not traditionally thought of as involving health care. Secretary of Health and Human Services Alex Azar recently acknowledged that high costs and poor outcomes in health care "are often driven" by SDH and emphasized that HHS does more than healthcare services—evidenced by the fact that its name includes "health" and "human services."[18] Azar said, "In our very structure, we are set up to think about all the needs of vulnerable Americans, not just their healthcare needs, and how to help them before they become seriously ill or need especially expensive interventions."[19]

Azar noted that the Center for Medicare and Medicaid Innovation ("CMMI") and the federal government are looking for ways to innovate in the arena of the SDH.[20] Azar mentioned the importance of providing

17. SAMANTHA ARTIGA & ELIZABETH HINTON, HENRY J. KAISER FAMILY FOUND., BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 2 (2018), http://files.kff.org/attachment/issue-brief-beyond-health-care.

18. Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs., Remarks on Value-Based Transformation and the IPI Model at the Commonwealth Fund International Symposium on Health Care Policy (Nov. 14, 2018) [hereinafter Azar, Remarks], https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-and-the-ipi-model.html.

19. *Id.*; *see also* Steven Porter, *Azar Outlines HHS Ambition on Social Determinants of Health: 5 Takeaways*, HEALTHLEADERS (Nov. 14, 2018), https://www.healthleadersmedia.com/innovation/azar-outlines-hhs-ambition-social-determinants-health-5-takeaways.

20. Porter, *supra* note 19.

"solutions for the whole person" in driving down health care costs, "including addressing housing, nutrition and other social needs."[21] Further, he advocated a "holistic approach" to health care, including the need to pay for services not traditionally considered to be "medical" saying: "Paying for outcomes means paying for the right inputs—*whether they are healthcare services or not*."[22] Azar continued: "And we need to prevent disease not just by providing the right health services, but also the right holistic approach to prevention and well-being."[23] When adding health care and social service spending together, "the United States spends an average amount compared with its peers but has health outcomes that are no better and, in many areas, are worse."[24]

In addition, private payors are highlighting the importance of SDH, "[r]ecognizing opportunities that may improve member retention, clinician satisfaction, and health outcomes while also reducing costs."[25] Specifically, "many commercial [managed care organizations] are broadening . . . management programs to address upstream [SDH]; partnering with community organizations to ensure provision of basic social needs; tracking member engagement in these services and assessing their influence."[26]

Untreated SDH negatively impact payors by leading to higher healthcare costs. In addition, emerging "value-based" payment models are beginning to directly punish providers with lower reimbursements based upon readmission rates and outcome data that are largely affected by SDH out of reach of traditional medical care. Thus, payors and providers alike should be financially incentivized (in addition to morally incentivized) to find ways to "treat" SDH to improve patient outcomes and reduce readmission rates and therefore, willing to consider bringing attorneys into the arena to help "treat" important SDH factors that affect health.

This Article will examine ways that untreated SDH impact providers (i.e., mostly hospitals and hospital-based organizations like Accountable Care Organizations ("ACOs"), payors, and patients, and then, will explore ways attorneys can add value to the health care system by treating SDH.

21. *Id.*
22. Azar, *supra* note 9 (emphasis added).
23. *Id.*
24. Shrank et al., *supra* note 5.
25. *Id.* at 2198.
26. *Id.*

II. HOSPITALS AND PAYORS HAVE MUCH TO GAIN BY TREATING SDH

Poor health outcomes and hospital readmissions related to SDH directly impact hospital reimbursement while also driving up the costs paid by payors. Hospitals (and provider organizations) and payors adapting to a changing health care reimbursement environment that includes "value-based" payment models and adjustments to reimbursement based upon quality measures need to add SDH to their calculations to survive.

A. Hospitals and Provider Organizations

Health care delivery and reimbursement are moving to value-based care that is "evolving from diagnosis and treatment to community-based patient engagement."[27] Hospitals and provider organizations are being evaluated with regard to readmission rates, hospital-acquired conditions, and other quality measures that are significantly dependent upon SDH, and reimbursements are being adjusted based upon SDH-dependent measures, indirectly penalizing hospitals and provider organizations (e.g., ACOs) that fail to address SDH.[28] In addition, patients are increasingly able to make competitive marketplace decisions based upon hospital quality measures that depend upon SDH.[29]

1. Readmission Penalties

Hospital readmissions are a priority for cost reduction in the American health care system with programs now penalizing hospitals with high readmission rates. Policymakers view high rates of

27. Ara Ohanian, *The ROI of Addressing Social Determinants of Health*, AM. J. MANAGED CARE (Jan. 11, 2018), http://www.ajmc.com/contributor/ara-ohanian/2018/01/the-roi-of-addressing-social-determinants-of-health.

28. *See, e.g.*, Hillary J. Mull et al., *Association of Postoperative Readmissions with Surgical Quality Using a Delphi Consensus Process to Identify Relevant Diagnosis Codes*, 153 J. AM. MED. ASS'N SURGERY 728, 728–29 (2018) (noting that almost half of gall bladder surgery (i.e., cholecystectomy (47%)) readmissions were unrelated to surgical quality, and that overall "one-third of postoperative readmissions are unlikely to reflect problems with surgical quality"—which means that providers that fail to address SDH will be penalized when readmissions are used to measure and reward "quality"); *see also* BACHRACH ET AL., *supra* note 7, at 3 ("[C]hanges in the health care landscape are catapulting social determinants of health from an academic topic to an on-the-ground reality for providers, with public and private payers holding providers accountable for patients' health and health care costs and linking payments to outcomes.").

29. *See, e.g.*, *Find a Hospital*, MEDICARE.GOV, https://www.medicare.gov/hospitalcompare/search.html (last visited Dec. 15, 2018) (noting that hospitals are given star ratings based on a "variety of quality measures"—many of which are affected by SDH).

readmission as indicators of low-quality care during a hospital stay and poor care coordination.[30] "[R]educing avoidable readmissions by 10% could achieve a savings of $1 billion or more" for Medicare.[31] Readmissions are more costly than initial admissions for all payors—specifically, 30% higher for Medicaid and privately insured patients, 11% higher for uninsured patients, and 5% higher for Medicare.[32] Readmissions are often related to inadequate care coordination and management of care transitions.[33] Researchers estimate that unnecessary readmissions and complications resulted in $25–45 billion of wasteful spending in 2011.[34]

The Medicare Hospital Readmission Reduction Program ("HRRP") applies to most acute care hospitals and was created as part of the Affordable Care Act ("ACA").[35] The HRRP penalizes hospitals by reducing their Medicare reimbursement rates for *all* Medicare admissions by up to 3% if they have "higher-than-expected readmission rates for a key set of conditions common in the Medicare population."[36] The HRRP is especially punitive because "hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across *all* of their Medicare admissions—not just those which

30. NAT'L QUALITY FORUM, NQF REPORT ON 2017 ACTIVITIES TO CONGRESS AND THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 26 (2018), https://www.qualityforum.org/Publications/2018/03/2017_Annual_Report_to_Congress.aspx ("High rates of readmissions are costly to the healthcare system and can indicate low-quality care during a hospital stay and poor quality-care coordination.").

31. *Id.* at 26–27.

32. NAT'L QUALITY FORUM, ALL-CAUSE ADMISSIONS AND READMISSIONS 2017: TECHNICAL REPORT 7 (2017).

33. *Id.*

34. *Id.*

35. U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS: SOCIAL RISK FACTORS AND PERFORMANCE UNDER MEDICARE'S VALUE-BASED PURCHASING PROGRAMS 70 (2016) [hereinafter HHS REPORT TO CONGRESS], https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf; *see also* Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(q) (2012); 42 C.F.R. § 412.152 (2018).

36. HHS REPORT TO CONGRESS, *supra* note 35 (noting the maximum penalty was set at 3% in 2015 "where it will remain"); *see also* CRISTINA BOCCUTI & GISELLE CASILLAS, HENRY J. KAISER FAMILY FOUND., AIMING FOR FEWER HOSPITAL U-TURNS: THE MEDICARE HOSPITAL READMISSION REDUCTION PROGRAM 1–2 (2017) ("The HRRP was established by a provision in the Affordable Care Act (ACA) requiring Medicare to reduce payments to hospitals with relatively high readmission rates for patients in traditional Medicare."); *Hospital Readmissions Reduction Program (HRRP)*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html (last visited Dec. 15, 2018) (more specifically, CMS uses "excess readmission ratios" to measure performance in treating conditions like chronic lung disease, heart attacks, pneumonia, and coronary artery bypass surgery).

resulted in readmissions."[37] After some adjustments, each hospital is annually assigned a penalty for the upcoming year based on the Centers for Medicare and Medicaid Services' ("CMS") calculation of that hospital's rate of excess readmissions; "the greater each hospital's rate of excess readmissions, the higher its penalty."[38] The hospital's penalty is posted in the Federal Register and listed on the Medicare website.[39]

In 2018, 2573 hospitals faced readmission penalties—80% of hospitals analyzed.[40] Under the HRRP, CMS will withhold a total of $564 million in payments to those hospitals in 2018[41]—averaging *$219,199 per hospital* penalized.[42] The average penalty is 0.73% of Medicare payments to that hospital, but forty-eight hospitals will receive the maximum 3% penalty in 2018.[43] Regardless of the percentage penalty faced by a particular hospital, reduction in that penalty alone—considering the average was over $219,000—may be enough to pay for at least a part-time and possibly a full-time attorney's salary. And for "safety net" hospitals with disproportionate populations of patients living with socioeconomic challenges, the savings may be enough to pay for more than one attorney's salary. During HRRP's first year, 70% of hospitals with the highest proportion of poor beneficiaries were penalized versus only 40% of hospitals with the fewest poor beneficiaries—with similar findings reported in subsequent HRRP program years.[44]

Hospitals are now stratified into five peer groups (quintiles) and are basically competing with other hospitals in their quintile based partially on the socioeconomic makeup of their patients (e.g., the number of "dual-eligible" patients) and are penalized if they are below average.[45] So, an attorney treating SDH might make a significant difference in a particular hospital's reimbursement, even with relatively small improvements (e.g., by bumping them from below to above average) in

37. BOCCUTI & CASILLAS, *supra* note 36, at 2.

38. *Id.*

39. *Id.*

40. *2,573 Hospitals Will Face Readmission Penalties This Year. Is Yours One of Them?*, ADVISORY BOARD (Aug. 7, 2017, 11:00 AM), https://www.advisory.com/daily-briefing/2017/08/07/hospital-penalties.

41. *Id.*

42. $564,000,000 divided by 2573 hospitals equals $219,199.

43. *2,573 Hospitals Will Face Readmission Penalties This Year. Is Yours One of Them?*, *supra* note 40.

44. HHS REPORT TO CONGRESS, *supra* note 35, at 71.

45. CTRS. FOR MEDICARE & MEDICAID SERVS., NEW STRATIFIED METHODOLOGY HOSPITAL-LEVEL IMPACT FILE USER GUIDE 6 (2017), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/HRRP_StratMethod_ImpctFile_UG.PDF ("Hospitals are stratified into five peer groups, or quintiles, based on proportion of dual eligible.").

readmission rates compared to other hospitals in its quintile—especially if that hospital is already dealing with significant penalties under the HRRP.

SDH affect readmission risks. Multiple studies confirm that SDH such as "income, race and ethnicity, education, and social support" are associated with hospital readmission risk.[46] One study found that almost half of gall bladder surgery readmissions were unrelated to surgical quality, and that overall "[o]ne-third of postoperative readmissions are unlikely to reflect problems with surgical quality."[47] In a study reviewing 94,000 hospital admissions, increased readmission risk was noted in patients with (1) housing instability (readmission risk 25%), (2) depression (readmission risk 21%), (3) poor social support (readmission risk 20%), and (4) drug abuse (readmission risk 20%).[48]

For example, homeless patients have "strikingly high 30-day hospital readmission rates" with half of hospitalizations of homeless individuals resulting in hospital inpatient readmission and over 70% resulting in "either an inpatient readmission, observation status stay, or emergency department visit within 30 days of hospital discharge."[49] Likewise, homelessness is an independent risk factor for heart disease readmission.[50] In addition, homeless adults die at rates more than triple that of the general population, which likely translates into more hospital readmissions near death.[51]

Likewise, substandard and/or unstable housing contributes to many different ailments that can lead to costly hospital readmissions, including respiratory disease, neurological disorders, psychological dysfunction, and behavioral dysfunction.[52] Loss of utilities—like heat, air

46. HHS REPORT TO CONGRESS, *supra* note 35, at 71.

47. Mull et al., *supra* note 28, at 728.

48. AMOL S. NAVATHE ET AL., PENN LEONARD DAVIS INST. OF HEALTH ECON., HOSPITAL READMISSION AND SOCIAL RISK FACTORS IDENTIFIED FROM PHYSICIAN NOTES (2017), https://ldi.upenn.edu/brief/hospital-readmission-and-social-risk-factors-identified-physician-notes.

49. Kelly M. Doran et al., *The Revolving Hospital Door: Hospital Readmissions Among Patients Who Are Homeless*, 51 MED. CARE 767, 767 (2013).

50. Evan F. Shalen et al., *Abstract P333: Homelessness is an Independent Risk Factor for Cardiovascular Disease Hospital Readmission in the California Health Care Utilization Project*, 135 CIRCULATION (SUPPLEMENT) (Mar. 27, 2018), http://circ.ahajournals.org/content/135/Suppl_1/AP333.

51. MICHAEL NARDONE ET AL., CTR. FOR HEALTH CARE STRATEGIES, MEDICAID-FINANCED SERVICES IN SUPPORTIVE HOUSING FOR HIGH-NEED HOMELESS BENEFICIARIES: THE BUSINESS CASE 3 (2012), http://www.csh.org/wp-content/uploads/2012/06/SH-Medicaid-Bz-Case_Final.pdf ("Mortality rates among homeless adults are three or more times greater than that of the general population.").

52. Samiya A. Bashir, *Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis*, 92 AM. J. PUB. HEALTH 733, 733 (2002) ("Substandard and deteriorating

conditioning, and water—leads to poor health outcomes including readmissions related to excessively cold homes, excessively hot homes, and/or dehydration or poor hygiene related to lack of water. For example, one study estimated that home air conditioning has decreased the rate of premature deaths by 80% since 1960.[53] Without home air conditioning when temperatures reach over ninety degrees, people die or get sick[54] and end up back in the hospital (especially the elderly or those with pre-existing medical conditions, including those recently discharged from the hospital).

Similarly, nutritional status affects readmission rates. Food insecurity in adults has been associated with arthritis, asthma, cancer, chronic kidney disease, chronic lung disease (e.g., chronic obstructive pulmonary disease), heart disease, depression, diabetes, functional limitations, hepatitis, high blood pressure, insomnia, less physical activity, obesity, stroke, pregnancy complications, suicidal ideation, osteoporosis, peripheral artery disease, and other health problems.[55] Obviously, these diseases impact health care outcomes and readmission rates.

Also, job status affects readmission risk. Unemployed people "are less likely to get medical care or prescription drugs than people with jobs," regardless of whether they have health insurance.[56] According to the

housing contributes to a variety of ailments, from respiratory disease and neurological disorders to psychological and behavioral dysfunction. . . . Significant research demonstrates the harmful association of asthma, neurological damage, malnutrition, stunted growth, accidents, and injury with household triggers like poor insulation, combustion appliances, cockroach and rodent infestation, dust mites, hyper- and hypothermia, unaffordable rent, and dangerous levels of lead in soil and household paint.").

53. Juliet Eilperin, *Study: Home Air Conditioning Cut Premature Deaths on Hot Days 80 Percent Since 1960*, WASH. POST (Dec. 22, 2012), https://www.washingtonpost.com/national/health-science/study-home-air-conditioning-cut-premature-deaths-on-hot-days-80-percent-since-1960/2012/12/22/5b57f3ac-4abf-11e2-b709-667035ff9029_story.html?noredirect=on&utm_term=.44f2e6769e09 (citing Alan Barreca et al., *Adapting to Climate Change: The Remarkable Decline in the U.S. Temperature-Mortality Relationship Over the Twentieth Century*, 124 J. POL. ECON. 105 (2016)).

54. *See id.* ("The group found that days on which temperatures rose above 90 degrees Fahrenheit accounted for about 600 premature deaths annually between 1960 and 2004, one-sixth as many as would have occurred under pre-1960 conditions.").

55. HEATHER HARTLINE-GRAFTON, FOOD RESEARCH & ACTION CTR., HUNGER & HEALTH: THE IMPACT OF POVERTY, FOOD INSECURITY, AND POOR NUTRITION ON HEALTH AND WELL-BEING 4 fig.1 (2017), http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf.

56. Steven Reinberg, *Even With Insurance, Unemployed Have Worse Health Outcomes*, MEDICINENET (Jan. 24, 2012), https://www.medicinenet.com/script/main/art.asp?articlekey=153942; *see also* ANNE K. DRISCOLL & AMY B. BERNSTEIN, CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH AND ACCESS TO CARE AMONG EMPLOYED AND

Centers for Disease Control and Prevention study, unemployed adults (including insured and uninsured) had "poorer mental and physical health" and were "less likely to receive needed medical care" and needed prescriptions than employed adults.[57] There is much "[q]uantitative evidence" demonstrating the health benefits of employment and the "detrimental impacts of unemployment."[58] Working provides more than a paycheck: "employment can also provide the benefits and stability critical to maintaining proper health," and "[o]n the flip side, job loss and unemployment are associated with a variety of negative health effects."[59] In addition to the obvious financial benefits, work often provides substantial psychological benefits that impact health outcomes like readmissions.[60]

Finally, policymakers have acknowledged that other social factors "such as the availability of primary care, housing stability, medication adherence, and mental health and substance use disorders impact readmission rates, [and] are not evenly distributed between hospitals."[61] In another study, patients living in poverty were 24% more likely to be readmitted than other patients, and unmarried patients were more likely to be readmitted than married patients—which suggests social support affects readmission.[62] In particular, "hospitals with higher proportions of poor and minority beneficiaries have higher readmission rates," and "beneficiaries and hospitals in high-poverty communities have higher readmission rates."[63] Other studies have shown increased rates of

UNEMPLOYED ADULTS: UNITED STATES, 2009–2010, at 1, 3 (2012), https://www.cdc.gov/nchs/data/databriefs/db83.htm.

57. DRISCOLL & BERNSTEIN, *supra* note 56, at 1.

58. NANETTE GOODMAN, LEAD CTR., THE IMPACT OF EMPLOYMENT ON THE HEALTH STATUS AND HEALTH CARE COSTS OF WORKING-AGE PEOPLE WITH DISABILITIES 4 (2015), http://www.leadcenter.org/system/files/resource/downloadable_version/impact_of_employment_health_status_health_care_costs_0.pdf.

59. *How Does Employment, or Unemployment, Affect Health?*, ROBERT WOOD JOHNSON FOUND. (Mar. 12, 2013), https://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html.

60. GOODMAN, *supra* note 58, at 2 ("Employment can improve health by increasing social capital, enhancing psychological well-being, providing income, and reducing the negative health impacts of economic hardship.").

61. HHS REPORT TO CONGRESS, *supra* note 35.

62. Jianhui Hu et al., *Socioeconomic Status and Readmissions: Evidence From an Urban Teaching Hospital*, 33 HEALTH AFF. 778, 778 (2014), https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0816 ("Patients living in high-poverty neighborhoods were 24 percent more likely than others to be readmitted, after demographic characteristics and clinical conditions were adjusted for. Married patients were at significantly reduced risk of readmission, which suggests that they had more social support than unmarried patients.").

63. HHS REPORT TO CONGRESS, *supra* note 35, at 71.

readmission affected by additional social factors like age and race.[64] By having lawyers involved in treating these SDH, hospitals may improve their readmission rates in comparison with competing hospitals and decrease Medicare penalties while increasing Medicare reimbursement.

2. Hospital-Acquired Conditions

Hospital-acquired conditions also can result in readmission and are independently penalized by Medicare under its Hospital-Acquired Conditions Reduction Program ("HACRP"). Medicare's HACRP "is a Medicare pay-for-performance program focused on reducing the incidence of infections and other adverse safety events in U.S. hospitals."[65] Using various patient safety measures, Medicare assigns hospitals a Total Hospital-Acquired Conditions score and penalizes 25% of hospitals with the worst scores "a flat 1% on their total inpatient Medicare revenues"—including 1% of disproportionate share payments and medical education payments.[66]

SDH play a significant role in the development of hospital-acquired conditions. For example, social risk factors—including poverty and Medicaid insurance status—have been linked to patient safety events; one study found that hospital-acquired infections were more common among Medicaid patients than privately insured stroke patients, even within the same hospitals.[67] Poverty is associated with increased likelihood of MRSA (a dangerous drug-resistant infection often considered to be hospital-acquired) colonization, diabetes, renal failure, immunodeficiency, and nursing home residence.[68] In addition, diabetes (which is more common in patients living in poverty) increases the risk of surgical site infections by 70%.[69] The risk of MRSA infection is increased in patients with diabetes and in patients living in nursing homes.[70] Decreased or impaired functional status (such as in patients who are disabled or unable to maintain employment) "is associated with a higher risk of infection."[71] Additional social factors like language barriers, bias, and discrimination have been mentioned as possibly

64. *See, e.g.*, Michele D'Apuzzo et al., *All-Cause Versus Complication-Specific Readmission Following Total Knee Arthroplasty*, 99 J. BONE JOINT SURG. 1093, 1095 (2017) (noting higher readmission rates after total knee replacement based upon age > 85 years and black race).

65. HHS REPORT TO CONGRESS, *supra* note 35, at 100.

66. *Id.* at 100.

67. *Id.* at 102.

68. *Id.* at 103.

69. *Id.* at 102.

70. *Id.* at 103.

71. *Id.*

contributing to hospital-acquired conditions.[72] "Poor patient-provider communication" contributes to adverse events, with one study showing patients with limited English proficiency having "higher rates of adverse safety events in the inpatient setting."[73]

3. "Quality Measures" and "Value-based Purchasing" Penalties

Medicare's Hospital Value-Based Purchasing Program ("HVBP"), authorized by the ACA, withholds and redistributes a percentage of hospitals' Medicare payments annually based upon the hospital's performance on quality measures like "clinical outcomes (e.g., mortality for patients admitted with pneumonia), efficiency (costs of care per episode), and safety measures (e.g., in-hospital infection rates)" that can be significantly influenced by SDH.[74] Hospitals may lose up to 2% of their base-operating diagnosis-related group payments for poor performance on these quality measures.[75] Rural hospitals and safety-net hospitals performed notably worse than other hospitals under HVBP, again suggesting the importance of untreated SDH in these outcomes.[76]

"Economic security (the ability to pay for healthcare and other necessities), physical environment (safe neighborhood, access to doctors, grocers and transportation) and a person's social network (support from friends and family) greatly influence an individual's overall health," ultimately affecting health care outcomes regardless of the care delivered during a hospital stay.[77] Some researchers have even noted that "a person's ZIP code might be 'a stronger predictor of a person's health than their genetic code,'" highlighting the importance of environment in overall health.[78] Medicare is increasingly basing payment upon "quality" measures that may be highly influenced by untreated SDH related to patients' living environment.

Another "value-based" program where hospitals may lose money due to untreated SDH affecting quality measures is the Medicare Shared

72. *Id.* at 103 fig.6.1.
73. *Id.* at 104.
74. *Id.* at 143.
75. *Id.* (noting cap was set at 2% for 2017 and beyond).
76. *Id.* at 156.
77. Lisa Ward, *A New Emphasis on Social Factors to Reduce Readmissions*, MOD. HEALTHCARE (Sept. 2, 2016, 1:00 AM), https://www.modernhealthcare.com/article/20160902/TRANSFORMATION03/160839983/a-new-emphasis-on-social-factors-to-reduce-readmissions.
78. *Id.* (quoting HARRY J. HEIMAN & SAMANTHA ARTIGA, HENRY J. KAISER FAMILY FOUND., BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 3 (2015)).

Savings Program ("MSSP") established by the ACA.[79] The MSSP creates opportunities for Accountable Care Organizations—often anchored by a hospital—to receive "financial incentives tied to quality metrics and savings with the goal of increasing coordination of care and reducing unnecessary costs for Medicare beneficiaries."[80] ACOs are "groups of providers and suppliers that have agreed to be accountable for the care of a defined population of Medicare fee-for-service beneficiaries and have at least 5,000 assigned Medicare beneficiaries."[81] In April of 2016, "there were [already] over 430 ACOs participating in the [MSSP], with over 7.7 million assigned beneficiaries."[82] The MSSP rewards individual ACOs improvement in spending based on quality measures compared to prior years' performance.[83] ACOs take responsibility for population health and coordinate patients' care with a goal of providing cost-effective and evidence-based approaches to health care.[84] In other words, ACOs are clinically integrated organizations of physicians and hospitals that are also responsible for outcomes.[85] In order to improve outcomes, ACOs will need to direct attention to SDH.

Studies suggest that SDH play a significant role in an ACOs ability to achieve "shared savings" and hence, reap any financial benefits. ACOs "disproportionately serving beneficiaries with social risk factors, on average, had higher cost benchmarks than ACOs overall"—again signifying the importance of SDH in overall healthcare cost.[86] Instead of addressing SDH, some ACOs appear to be "cherry-picking" patients that tend to be higher-income patients, while "non-ACO beneficiaries were more likely to be Black, dually-enrolled, and disabled."[87] ACOs with a large proportion of patients with high social risk factors performed more poorly than ACOs overall.[88] If ACOs are to successfully diversify over time and help larger segments of the population, treatment of SDH by ACOs will be important.

Managed care organizations are already beginning to understand this issue and are trying to address it. "[A] number of managed care organizations and state-based accountable care organizations (ACOs) are

79. NAT'L QUALITY FORUM, *supra* note 30, at 42.
80. HHS REPORT TO CONGRESS, *supra* note 35, at 224.
81. *Id.*
82. *Id.*
83. *Id.* at 225.
84. Teufel et al., *supra* note 2, at 94 ("ACOs constitute a method of clinical care integration . . . that aims to improve care coordination and quality while reducing costs.").
85. *Id.* at 94–95 (observing that an integrator "would connect healthcare expenditures, as well as health outcomes and processes").
86. HHS REPORT TO CONGRESS, *supra* note 35, at 252.
87. *Id.* at 227.
88. *Id.* at 222–23.

incorporating non-medical services into care plans with the aim of addressing the [SDH]"—including Medicaid programs in Massachusetts, New York, Oregon, Utah, and Vermont.[89]

4. Competition and Market-Driven Penalties

Market forces should also encourage hospitals to address SDH. Hospital outcomes are now being compared on government websites like CMS's HospitalCompare.gov, so that patients can compare hospital outcome statistics and readmission rates directly when choosing a hospital. Therefore, market forces may also impact hospitals' financial results where SDH negatively impact publicly reported quality measures.[90] Improved outcomes related to treating SDH also may lead to lower incidence of malpractice lawsuits, which may also decrease costs and improve community reputation.

In summary, hospitals have a lot to gain financially through improving outcomes by addressing SDH before patients have SDH-related readmissions, hospital-acquired conditions, other complications, or generate bad outcomes affecting market factors. Surprisingly, hospitals continue to largely ignore SDH issues outside the hospital environment: "[m]ore than 72% of hospitals still do not have a dedicated budget to support population health initiatives," and "[t]wo-thirds of hospital electronic medical records do not screen for patient's social and behavioral needs."[91] This is true even though ICD-10 has now included numerous Z-codes to screen for the SDH.[92]

B. Payors (e.g., Insurance Companies, Medicare, Medicaid)

Untreated SDH drive up the costs of medical care to the detriment of payors. Obviously payors are affected by anything that drives up the cost or utilization of health care, with most ultimately passing excess costs on

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89. SPENCER ET AL., *supra* note 10, at 2.

90. *Find a Hospital*, *supra* note 29; *see also* BACHRACH ET AL., *supra* note 7, at 3 ("[N]ew models are creating economic incentives for providers to incorporate social interventions into their approach to care. . . . Investing in these interventions can enhance patient satisfaction and loyalty, as well as satisfaction and productivity among providers.").

91. Ohanian, *supra* note 27.

92. HITEQ CTR., ICD-10 Z-CODES FOR SOCIAL DETERMINANTS OF HEALTH (2017); International Classification of Diseases (ICD) Information Sheet, WORLD HEALTH ORG., https://www.who.int/classifications/icd/factsheet/en/ (explaining that the International Statistical Classification of Diseases and Related Health Problems, 10th Revision ("ICD-10") is a comprehensive list of diseases with assigned numerical codes that "defines the universe of diseases, disorders, injuries and other related health conditions" that is used by physicians and other health workers worldwide and is also used for research, reimbursement, and statistical analysis of morbidity and mortality data).

to the consumer (for private insurance) or taxpayer (for Medicare, Medicaid, and other government programs). Epidemiological research demonstrates clear links between SDH and health-related morbidity and mortality.[93] Untreated SDH drive medical cost and utilization[94] with much research showing that "socioeconomic, environmental, and behavioral factors" have "strong influences on health."[95] Thus, any opportunities to successfully treat SDH may have positive influences on payors, if the cost of such SDH intervention delivers an appropriate return on investment (i.e., if it does not cost more to treat the SDH than it costs to treat the resultant morbidity/mortality).

1. Health Care Costs Are Driven By SDH Like Housing, Utilities, Nutrition, and "Financial Toxicity"

Costs and results of health care are affected by home environment—including housing stability, availability of utilities like electricity and water, food availability and quality, and living in poverty. Homelessness is a significant problem driving health care costs.[96] Homeless people are much more likely to suffer from chronic medical conditions—like high blood pressure, HIV/AIDS, and diabetes—than the general population; they are also much more likely to suffer from complications from those chronic illnesses.[97] Almost half (46%) of homeless adults in shelters have chronic drug abuse issues and/or suffer from severe mental illness.[98] Crisis-related health care costs (e.g., emergency department visits) associated with homelessness are excessive due to the presence of under-treated chronic illness.[99]

93. Teufel et al., *supra* note 2, at 82–83.
94. KPMG GOV'T INST., *supra* note 4.
95. BRADLEY & TAYLOR, *supra* note 2, at 12–13.
96. AHIP, SAFE & AFFORDABLE HOUSING: SOCIAL DETERMINANTS OF HEALTH 1 (2018), https://www.ahip.org/wp-content/uploads/2018/09/SDOH-Housing-IB-FINAL.pdf ("On a single night in 2017, more than half a million Americans were homeless."); NARDONE ET AL., *supra* note 51, at 3 ("Mortality rates among homeless adults are three or more times greater than that of the general population.").
97. NARDONE ET AL., *supra* note 51 ("Homeless adults, particularly those who are chronically or long-term homeless, are far more likely to suffer from chronic medical conditions, such as HIV/AIDS, hypertension and diabetes and to suffer complications from their illness due to lack of housing stability and regular, uninterrupted treatment.").
98. *Id.* ("In 2010, an estimated 46 percent of adults in housing shelters had a chronic substance abuse problem and/or a severe mental illness.").
99. *Id.* ("Due to the high incidence of chronic illness and lack of regular care, health care costs, particularly crisis-related, for individuals who are homeless are excessive.").

For the homeless, the expensive emergency department tends to be their usual and sometimes only source of care.[100] Multiple studies—including studies in Boston, California, and New York—show that homelessness leads to disproportionately high utilization of expensive hospital emergency department services.[101] One study revealed homeless people were three to four times more likely be hospitalized or treated in the emergency department.[102] As noted above, homeless patients also have high hospital readmission rates and poor health outcomes related to their home situation.

Likewise, unstable and substandard housing increases costs of health care. For example, substandard housing contributes to asthma, elevated lead levels, developmental delay, behavioral pathology, injury, and transmission of infectious diseases.[103] Poorly maintained buildings can lead to health hazards like pest infestation and mold.[104] "[P]oor mental health, developmental delay, heart disease, and even short stature" have been found to directly correlate with "[o]vercrowding and poor-quality housing."[105] "Sick-building syndrome" can lead to building-related illness, cause new symptoms, or exacerbate pre-existing symptoms.[106] "[I]nadequate heat, dampness, noise, and disrepair, are associated with increased anxiety and depression."[107] Overcrowding caused by families "doubl[ing] up" to avoid entering shelters leads to

100. *Id.* (citing several studies revealing excessive emergency department use by homeless people).

101. *Id.*

102. AHIP, *supra* note 96, at 1 ("Hospitalization rates and emergency room use can be up to three to four times higher for those without a home.").

103. Andrew F. Beck et al., *Identifying and Treating a Substandard Housing Cluster Using a Medical-Legal Partnership*, 130 PEDIATRICS 831, 832, 834 (2012); Bashir, *supra* note 52, at 733 ("[R]esearch demonstrates the harmful association of asthma, neurological damage, malnutrition, stunted growth, accidents, and injury with the household triggers like poor insulation, combustion appliances, cockroach and rodent infestation, dust mites, hyper- and hypothermia, unaffordable rent, and dangerous levels of lead in soil and household paint."); Joshua Sharfstein et al., *Is Child Health at Risk While Families Wait for Housing Vouchers?*, 91 AM. J. PUB. HEALTH 1191, 1191 (2001).

104. Beck et al., *supra* note 103, at 832; Allyson E. Gold, *No Home for Justice: How Eviction Perpetuates Health Inequity Among Low-Income and Minority Tenants*, 24 GEO. J. ON POVERTY L. & POL'Y 59, 71 (2016) (noting that "water leaks, poor ventilation, dirty carpets and pest infestation" lead to mold and dust mite proliferation, which can "cause and exacerbate asthma," and that 44.4% of asthma among children and adolescents is attributable to such "residential risk factors" (quoting ROBERT WOOD JOHNSON FOUND., WHERE WE LIVE MATTERS FOR OUR HEALTH: THE LINKS BETWEEN HOUSING AND HEALTH 2 (2008))).

105. Bashir, *supra* note 52, at 733.

106. Beck et al., *supra* note 103, at 832.

107. Gold, *supra* note 104, at 73.

health problems and "negatively affects children's ability to cope with stress, maintain healthy social relationships, and sleep."[108]

Unstable housing and the threat of losing a home can impact health outcomes and readmissions. A recent study found that children under age four with low-income, unstable housing "had nearly a 20 percent increased risk of hospitalization."[109] Unstable housing "leads to depression, anxiety, and, in children, diminished functioning."[110] When properties go into foreclosure, families renting those properties "are at significant risk for housing instability, poor upkeep, and eviction"—all of which have health consequences.[111] Foreclosed properties often become "sick, substandard, poor-quality" dwellings with "significant health ramifications."[112] In addition, the process of foreclosure causes health issues, with one study demonstrating links "between foreclosure and higher rates of hypertension and renal disease among adult homeowners."[113]

Utility insecurity also leads to increased health care costs. Cold homes and fuel poverty have been associated with heart attacks, pneumonia, social isolation, sleep loss, stress, and mental illness—all of which can lead to poor health outcomes, and even death.[114] In fact, Excess Winter Deaths ("EWD") are associated with "low indoor temperature" and "low thermal efficiency of housing."[115] Forty percent of EWDs due to cardiovascular diseases and 33% of EWDs due to respiratory disease are associated with cold temperatures.[116] Patients with pre-existing health conditions—like diabetes, circulatory problems, asthma, respiratory problems, arthritis, depression, and anxiety—are especially vulnerable to the cold, along with the disabled, children, and the elderly.[117] The readmission risk of discharging this vulnerable patient population to a cold home seems obvious. Cold housing also exacerbates arthritis and increases the incidence of colds and flu, which likely increases doctor

108. *Id.*
109. AHIP, *supra* note 96, at 2.
110. Gold, *supra* note 104, at 73.
111. Beck et al., *supra* note 103, at 836.
112. *Id.*
113. *Id.*
114. *Cold Homes and Health*, CTR. FOR SUSTAINABLE ENERGY, https://www.cse.org.uk/advice/advice-and-support/heat-and-health (last visited Dec. 15, 2018); MARMOT REVIEW TEAM, THE HEALTH IMPACTS OF COLD HOMES AND FUEL POVERTY 9 (May 2011), https://friendsoftheearth.uk/sites/default/files/downloads/cold_homes_health.pdf (discussing Excess Winter Deaths and noting that cold housing and fuel poverty also negatively impacts mental health, especially among children).
115. MARMOT REVIEW TEAM, *supra* note 114.
116. *Id.* at 9, 26.
117. *Cold Homes and Health*, *supra* note 114.

visits and hospital admissions.[118] Similarly, lack of air conditioning during hot summer days can lead to poor health outcomes and readmissions to the hospital as noted above.

Loss of running water also leads to higher health care costs. The Centers for Disease Control and Prevention recognizes that "[b]asic water and sanitation services are important to overall health. Having in-home running water and flush toilets help to keep people healthy" and reduce "the spread of infectious diseases."[119] Lack of running water is associated with respiratory illnesses, skin infections, severe bacterial infections (including sepsis and meningitis), and dental cavities.[120] If a patient's water is shut off for non-payment or if the patient has been living without running water, health outcomes will be worse and readmissions likely.

Poor nutrition also increases health care costs. Food insecurity is one of the U.S.'s leading health and nutrition issues with nearly fifty million Americans affected.[121] For example, Secretary Azar recently noted that "malnutrition is involved in 12 percent of non-maternal, non-neonatal hospital stays—$42 billion each year in healthcare spending."[122] One private health system in Chicago saved $3800 per patient by screening for malnutrition and providing follow-ups, referrals, and nutrition coupons.[123] Food insecurity among children has been associated with childhood asthma, behavioral and social-emotional problems, birth defects, developmental risk, iron deficiency anemia, decreased physical activity, low birth weight, lower bone density (among boys), lower physical functioning, mental health problems, more frequent colds, untreated dental caries, and other health problems.[124] Food insecurity in adults has been associated with arthritis, asthma, cancer, chronic kidney disease, chronic lung disease (e.g., chronic obstructive pulmonary disease), heart disease, depression, diabetes, functional limitations, hepatitis, high blood pressure, insomnia, less physical activity, obesity,

118. MARMOT REVIEW TEAM, *supra* note 114, at 9.

119. *Water and Sanitation*, CENTERS FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ncezid/dpei/aip/water-sanitation.html (last visited Dec. 15, 2018).

120. *Id.* (mentioning dental cavities and severe infections in the spinal fluid as related to lack of in-home water and sanitation services).

121. Craig Gundersen & James P. Ziliak, *Food Insecurity and Health Outcomes*, 34 HEALTH AFF. 1830, 1830 (2015) ("In 2013 almost fifty million Americans (14.3 percent) were food insecure.").

122. Azar, *supra* note 9.

123. *Id.*

124. HARTLINE-GRAFTON, *supra* note 55, at 4 fig.1; Gundersen & Ziliak, *supra* note 121, at 1830 (noting that food insecure children are "at least 1.4 times more likely to have asthma, compared to food-secure children").

stroke, pregnancy complications, suicidal ideation, osteoporosis, peripheral artery disease, and other health problems.[125]

Another social determinant of health that can negatively impact health and cost is poverty and/or the financial burden associated with illness and healthcare, which can often lead to poverty. The association of financial distress with poor health seems obvious and is well accepted.[126] The financial challenges associated with costly medical care often lead to depression, anxiety, and noncompliance which can translate into costly hospital readmissions, emergency room visits, and additional health care costs.[127] The stress of financial consequences of a significant illness can take a toll on patients' health leading to foreseeable negative health outcomes like stress, depression, and decreased quality of life—which some have termed "financial toxicity."[128] Unfortunately, financial burden and "toxicity" have not traditionally been treated in standard medical practice.[129]

Patients often have to borrow money and go into debt to finance their necessary medical treatments. For example, 54% of cancer patients have problems affording their treatment with 40% depleting their savings, and 34% borrowing money to pay for treatment.[130] Eventually, 30% of cancer patients have to deal with bill collectors.[131] Nearly half of cancer patients in a recent survey said that "nonmedical issues relating to their cancer were unmet by their [doctors]." This included over one-third (35%) whose

125. HARTLINE-GRAFTON, *supra* note 55, at 4 fig.1; Gundersen & Ziliak, *supra* note 121, at 1830 ("[F]ood-insecure seniors have limitations in activities of daily living comparable to those of food-secure seniors fourteen years older.").

126. *See, e.g.*, MONICA FAWZY BRYANT & JOANNA FAWZY MORALES, CANCER RIGHTS LAW: AN INTERDISCIPLINARY APPROACH 94 (2018) (observing that cancer patients' earnings decrease by almost 40% within two years of diagnosis and can take up to five years to rebound for survivors; also noting that caregivers are negatively impacted financially with families often losing over 40% of their income when a child is diagnosed with cancer; additionally noting the particular financial devastation for young adults diagnosed with cancer because they are often in low paying jobs and paying off student debt).

127. *See, e.g.*, Jennifer Mellace, *The Financial Burden of Cancer Care*, 10 SOC. WORK TODAY, Mar.–Apr. 2010, at 14, 15 (2010), http://www.socialworktoday.com/archive/032210p14.shtml (noting that two-thirds (66%) of cancer patients with financial challenges suffer from anxiety or depression).

128. *See, e.g.*, BRYANT & MORALES, *supra* note 126, at 94 ("In 2013, researchers coined the term 'financial toxicity' to refer to the financial side effects induced by the cost of cancer treatment." (quoting S. Yousuf Zafar & Amy P. Abernethy, *Financial Toxicity, Part I: A New Name for a Growing Problem*, 27 ONCOLOGY 80 (2013))).

129. *See* S. Yousuf Zafar et al., *Population-Based Assessment of Cancer Survivors' Financial Burden and Quality of Life: A Prospective Cohort Study*, 11 J. ONCOLOGY PRAC. 145, 145–49 (2015).

130. BRYANT & MORALES, *supra* note 126, at 282–83.

131. *Id.* at 283.

"nonmedical issues were wholly unaddressed."[132] Notably, 14% of those same cancer patients said they believed their doctors "wanted to assist with nonmedical issues but did not have enough information or experience to do so."[133] Even the most financially responsible patients have problems with medical debt, with over one-third of the forty-three million Americans who have medical debt negatively impacting their credit reports having no other negative items on their credit reports.[134] Low income families are especially vulnerable.[135]

Failure to address poverty or financial distress results in even higher costs to the health care system and payors. Patients experiencing "financial toxicity" are more likely to be noncompliant with the treatment recommendations of their doctors, even when that treatment is "key to their recovery."[136] Approximately 20% of the U.S. population does not adhere to the therapeutic recommendations of their doctors, with lack of affordability being one of the primary reasons for this noncompliance.[137] Noncompliance puts chronically-ill patients (e.g., diabetics, heart or lung disease patients) at risk for costly avoidable complications.[138] For example, the patient may choose to take a non-therapeutic, smaller or less frequent dose of his or her medications or may delay or not seek other therapeutic recommendations (e.g., physical therapy).[139] Although low-income individuals are more affected, even high-income individuals sometimes make similar choices—possibly reflecting the anxiety or depression associated with "financial toxicity."[140]

132. Fleishman et al., *supra* note 15, at 2123.

133. *Id.*

134. BRYANT & MORALES, *supra* note 126, at 282.

135. Beck et al., *supra* note 103, at 836 ("Low-income families are likely to experience >1 health-related social problem, including substandard housing, income instability, food insecurity, and inadequate access to health care.").

136. BRYANT & MORALES, *supra* note 126, at 94, 283.

137. Minal R. Patel et al., *Social Determinants of Health, Cost-Related Non-Adherence, and Cost-Reducing Behaviors Among Adults with Diabetes: Findings from the National Health Interview Survey*, 54 MED. CARE 796, 796 (2016) ("Lack of affordability is one of the primary reasons why patients do not adhere to therapeutic recommendations (20% of the U.S. population), and this problem is especially concerning among those who manage a chronic condition.").

138. *Id.* ("Cost-related non-adherence (CRN) to treatment plans may put chronically-ill patients at risk for avoidable complications.").

139. *Id.* ("CRN may include taking a smaller or less frequent dose of medications, delaying or not fulfilling therapeutic recommendations, and borrowing medicines from others.").

140. *Id.* ("Some low-income individuals report continuing to take their medication as prescribed despite serious cost pressures, while some high-income individuals or those with generous insurance coverage may engage in CRN despite manageable out-of-pocket costs.").

Health care costs can lead to poverty, and poverty increases the risk of disease (e.g., drug resistant bacterial colonization, diabetes, renal failure, immunodeficiency, nursing home residence, among many others).[141] Poverty can lead to bankruptcy, which is associated with increased mortality in cancer patients—with bankrupt cancer patients being around 80% more likely to die than patients who do not file for bankruptcy.[142] One sign of poverty is "dual enrollment" in Medicare and Medicaid.[143] Dual enrollment has been linked to higher Medicare spending per beneficiary, mostly due to higher costs after dual enrollees leave the hospital in "post-acute care settings."[144] Dual enrollees are more likely to have "poor cognitive and physical function, and to lack caregiver support at home and thus require institutional care."[145] Poverty also leads to other issues related to the home environment (e.g., homelessness and food insecurity) that are discussed separately above, but may have roots in the "financial toxicity" discussed in this section.

2. Payors Are Aware of SDH-Related Costs and Are Already Increasingly Willing to Proactively Pay to Address Them

The federal government is already beginning to recognize the potential savings associated with innovative ways to address SDH. Secretary Azar recently confirmed that HHS believes "we could spend less money on healthcare—and, most important, help Americans live healthier lives—if we did a better job of aligning federal health investments with our investments in non-healthcare needs."[146] As noted above, Azar and the CMMI are looking at innovative holistic solutions including the possibility, for example, of flexibility in government programs to "pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food."[147] The government may recognize significant savings because there is:

141. HHS REPORT TO CONGRESS, *supra* note 35, at 103.

142. Scott D. Ramsey et al., *Financial Insolvency as a Risk Factor for Early Mortality Among Patients with Cancer*, 34 J. CLINICAL ONCOLOGY 980, 980 (2016) ("The adjusted hazard ratio for mortality among patients with cancer who filed for bankruptcy versus those who did not was 1.79 (95% CI, 1.64 to 1.96).").

143. HHS REPORT TO CONGRESS, *supra* note 35, at 104 (describing "dual enrollment as a proxy for individual poverty").

144. *Id.* at 141, 153.

145. *Id.* at 153.

146. Azar, *supra* note 9.

147. Porter, *supra* note 19 (noting that the government is "actively exploring how we could experiment with actually paying for non-health services, like housing and

> [C]ompelling evidence that [on a state level] a combined intervention of stable, affordable housing along with supportive services can pay off in reduced utilization of crisis and inpatient services, resulting in better health care outcomes for individuals with complex needs who are homeless, and improved management of costs for Medicaid.[148]

In addition, "supportive housing programs for chronically homeless individuals have been shown to reduce hospital and emergency department visits and result in significant per-person savings."[149]

Azar especially plans to use the Medicare Advantage ("MA") program to try innovative ways to address SDH and drive down health care costs because MA is a "flexible, accountable, individual-driven system," in which the providers often "hold the risk for their patients and they compete for their patients' business [giving them] an incentive to offer benefits that are both appealing to their members and that will bring down health costs—*whether those benefits are traditionally thought of as health services or not*."[150] Soon MA plans will be allowed to pay for health-related benefits like transportation and home-health visits. In 2020, MA will be able to pay for "home modifications, home-delivered meals, and more."[151] Azar says, "Paying for outcomes means paying for the right inputs—*whether they are healthcare services or not*."[152] So, why not pay for attorneys' fees to help treat SDH?[153]

In addition, CMMI launched the Accountable Health Communities payment model, which automatically screens high utilizers of healthcare services for some SDH—including food insecurity, domestic violence, transportation issues, and housing and utility needs—during their doctor visits.[154] Instead of a "one-size-fits-all" approach, "navigators" are assigned to patients in need to "help determine what resources are available in the community to meet the patient's needs."[155] Unsurprisingly, private sector entities—like ACOs and Medicaid MCOs—have already shown "significant interest" in this payment model because those entities will get to keep some of the savings if the model

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nutrition—an integrated, individually driven approach to health and human services on a scale that has never before been tried in the United States").

148. NARDONE ET AL., *supra* note 51, at 11.
149. SPENCER ET AL., *supra* note 10, at 1.
150. Azar, *supra* note 9 (emphasis added).
151. *Id.*
152. *Id.* (emphasis added).
153. *See infra* Section III.
154. *See* Azar*, supra* note 9.
155. *Id.*

decreases costs.[156] "Health insurance providers recognize that the social determinants of health must be addressed in order to prevent and treat health care conditions."[157]

Further, even beyond ACOs and MCOs, health insurers are already beginning to recognize the potential savings related to improving housing conditions of their insureds. Some "[h]ealth insurance providers design housing solutions to fit the needs of the people they serve. . . . [by offering] safe and affordable housing options that improve health and ultimately reduce costs."[158] Multiple insurance companies are providing housing assistance by fighting homelessness—including transitional housing services, crisis services, substance abuse help, education, and employment.[159] In one Medicaid program in Indiana, eligible members have already spent over seventeen thousand nights in short term transitional housing. As a result, "[i]npatient stays at hospitals and skilled nursing facilities among individuals in the program have declined by 40 percent. . . . result[ing] in an $872 monthly average cost decrease per participant."[160] Insurers are also working on making homes healthier.[161] Still others work with case managers and provide assistance with behavioral and/or substance abuse care.[162] One health plan found medical cost savings averaging $6384 per patient by integrating permanent supportive housing for homeless special needs patients.[163]

III. ATTORNEYS ARE OFTEN THE BEST "PROVIDERS" TO TREAT SDH AND SHOULD BE INCLUDED ON THE HEALTHCARE TEAM

Attorneys are often the best "providers" to "treat" SDH to improve health outcomes and have been doing so by providing free legal services in some situations already—including Medical Legal Partnerships and other free legal arrangements. The health care system should not rely upon goodwill and charity from the legal community to address important SDH that have major implications for patients, providers, and payors—including financial gains for providers and payors. Attorney

156. *Id.*
157. AHIP, *supra* note 96, at 8 (explaining how "[h]ealth insurance providers understand the direct connection between housing and overall health" and are looking to find partners and "collaborate across sectors" with those who can help provide their members with more options).
158. *Id.* at 1.
159. *Id.* at 5–8 (offering several examples including AmeriHealth Caritas District of Columbia, Anthem Indiana Medicaid, and CareOregon, among others).
160. *Id.* at 6 (describing Anthem Indiana Medicaid's Blue Triangle Program).
161. *See, e,g.*, *id.* at 6 (describing such efforts by Kaiser Permanente).
162. *Id.* at 5–7 (describing efforts by Kaiser Permanente, MVP Health Care, and others).
163. *Id.* at 7–8 (describing UPMC Health Plan).

services in health care should be reimbursed with other health care providers, and new Current Procedural Terminology codes should be developed to facilitate reimbursement and to provide reimbursement models that fit within the current health care delivery system. Attorneys and the legal profession as whole have much to gain by embracing new models and getting involved proactively in health care delivery.

A. Attorneys Can "Treat" SDH Like Finances, Housing, Employment, and Other Issues, and By Doing So, Can Positively Impact Health and Health Care Costs

Attorneys can help "treat" patients' finances, home environment, employment needs, as well as many other SDH issues that will directly and tangibly impact health care outcomes and costs.

1. Treating Patients' Finances

While an attorney may not be able to "cure" poverty, early intervention might help prevent some patients from descending into poverty because of their medical bills. Attorneys can help prevent bad outcomes associated with "financial toxicity" by intervening before the situation reaches the "toxic" point. Depending upon the circumstances, there are a multitude of ways an attorney may be able to assist, but only a few examples will be covered here.

First, attorneys can help patients deal with debt and creditors during times of illness and help patients understand their rights as consumers thereby decreasing associated financial distress. Educating patients regarding their rights under the Fair Debt Collection Practices Act and assisting patients in dealing with aggressive creditors (e.g., perhaps with something as simple as an attorney letter to the creditor reminding them of the legalities) could have a significant impact on patients' mental state (and outcome of care) in dealing with the financial burden of serious illness.[164] Protecting patients' credit scores by helping them understand how to deal with discrepancies on their reports can also help, along with ensuring that creditors abide by the Fair Credit Reporting Act.[165] Special

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164. 15 U.S.C. §§ 1692–1692p (2012); *see* BRYANT & MORALES, *supra* note 126, at 308 ("The FDCPA prohibits debt collection companies from using 'abusive, unfair or deceptive practices' to collect past due debts. . . . Debt collectors cannot harass individuals, meaning individuals cannot be contacted at inconvenient times or places (e.g., before 8:00 a.m. or after 9:00 p.m., walking out of work) and collectors cannot use threatening or profane language in their communications.").

165. 15 U.S.C. § 1681 (2012); *see* BRYANT & MORALES, *supra* note 126, at 288–89 ("The [FCRA] is a federal law that provides consumers with various protections. . . . [such as,] individuals must be told when information in their credit report is used against them," and

rules, favorable to the debtor, may even apply if dealing with student loans.[166]

When all else fails, attorneys can help patients survive the bankruptcy process—sometimes literally survive, since cancer patients filing for bankruptcy are about 80% more likely to die.[167] There is little doubt that medical costs contribute to a significant percentage of Americans' bankruptcies with the number of bankruptcies dropping almost in half since the ACA was enacted.[168] Even insured patients are at risk of bankruptcy.[169] Attorney intervention might improve health outcomes among these financially distressed patients—especially if bankruptcy could be avoided.

Second, attorneys can help address financial exploitation of patients by scammers—especially involving the elderly. Financial exploitation through the "illegal or improper use of an elder's funds, property, or assets" can have devastating health consequences.[170] Over five million Americans are "financially exploited every year by scammers" and the elderly are additionally "suffering at the hands of greedy, desperate or drug addicted relatives and friends, among others."[171] Seniors may lose as much as $36.5 billion each year according to one financial services firm, but others suggest that even these numbers are "grossly underestimated" because only one in forty-five cases gets reported to authorities.[172] Attorneys can help recognize, protect, and prosecute perpetrators of financial exploitation of vulnerable patients—especially

providing free credit reports from each of the three federal credit bureaus along with a procedure in case of disputed accuracy).

166. BRYANT & MORALES, *supra* note 126, at 295–96 ("Federal student loans also have a system to forgive certain types of loans if an individual qualifies as having a total and permanent disability . . . ." (footnote omitted)).

167. *See* Ramsey et al., *supra* note 142.

168. Allen St. John, *How the Affordable Care Act Drove Down Personal Bankruptcy*, CONSUMER REP. (May 2, 2017), https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/.

169. *See* Margot Sanger-Katz, *Even Insured Can Face Crushing Medical Debt, Study Finds*, N.Y. TIMES (Jan. 5, 2016), https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html.

170. *See* JEFFREY HALL ET AL., CTR. FOR DISEASE CONTROL & PREVENTION, ELDER ABUSE SURVEILLANCE: UNIFORM DEFINITIONS AND RECOMMENDED CORE DATA ELEMENTS 14–15, 19 (2016), https://www.cdc.gov/violenceprevention/pdf/EA_Book_Revised_2016.pdf; *see also* Nick Leiber, *How Criminals Steal $37 Billion a Year from America's Elderly*, BLOOMBERG (May 3, 2018, 4:00 AM), https://www.bloomberg.com/news/features/2018-05-03/america-s-elderly-are-losing-37-billion-a-year-to-fraud (repeating statement of Elizabeth Loewy, former attorney at the Manhattan District Attorney's office: "[T]hese crimes [are] killing people.").

171. Leiber, *supra* note 170.

172. *Id.*

the elderly. The Elder Abuse Prevention and Prosecution Act adds new legal options to address this problem.[173]

Third, patients need help understanding their health insurance policies, and attorneys are often the best professionals to help patients sort through the legalese of complex policies to understand their options under the policy. Studies have shown that over 50% of patients cannot accurately calculate their expected hospital bills, and 75% do not understand their out-of-pocket expenses.[174] Further, two-thirds of patients do not remember having costs explained to them during treatment, and this lack of communication may lead to unnecessary financial distress if equally effective, viable, and less expensive treatments are overlooked.[175]

Hospital-based attorneys could help patients understand their health insurance coverage by helping medical staff understand the policies, by training hospital personnel to assist patients with insurance issues, and/or by personally reviewing the terms of health insurance policies with patients directly and answering questions. Attorneys may also be able to help patients understand the appeal process for their insurance plan when a claim is denied, and help protect patients' rights under their health insurance plans by assisting with appeals of unjust insurance denials that often overwhelm patients in their time of greatest need.[176] For example, one provider attributes an on-site attorney with obtaining coverage for a stroke patient for necessary physical therapy after losing employer-based coverage.[177]

Actively engaging patients in their care by providing cost information is a fundamental component of the ACA's patient-centered care and may

173. Elder Abuse Prevention and Prosecution Act, Pub. L. No. 115-70, § 1, 131 Stat. 1208 (2017).

174. Mira Norton, Liz Hamel & Mollyann Brodie, *Assessing Americans' Familiarity with Health Insurance Terms and Concepts*, HENRY J. KAISER FAMILY FOUND. (Nov. 11, 2014), https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/; *Patient Survey: Financial Hardship Associated with Cancer*, CANCERCARE (Apr. 2017), https://media.cancercare.org/publications/original/349-financial_hardship.pdf?149075790 ("Before treatment began, only one-quarter of patients said they had a full understanding of the out-of-pocket costs they would incur.").

175. BRYANT & MORALES, *supra* note 126, at 283 ("66 percent of respondents said they did not remember having the costs explained to them either before or during treatment.").

176. *See id.* at 70 ("Many individuals assume that their insurance company has accurately assessed their coverage, accept the denial of coverage, and then try to find a way to pay for the medical care themselves.").

177. KATE MARPLE, NAT'L CTR. FOR MED. LEGAL P'SHIP AT GEORGE WASH. UNIV., USING THE LAW TO INFORM EMPOWERED PATIENT CARE IN AUSTIN: THE STORY OF PEOPLE'S COMMUNITY CLINIC'S EVOLVING MEDICAL-LEGAL PARTNERSHIP WITH TEXAS LEGAL SERVICES CENTER 4 (2018), https://medical-legalpartnership.org/wp-content/uploads/2018/09/Using-the-Law-to-Inform-Empowered-Patient-Care-in-Austin.pdf.

even lower healthcare costs.[178] Hospital-based attorneys serving as patient advocates by interacting directly with patients may be able to provide an effective way to engage and inform patients of their options and expected costs under complex insurance policies. This in turn, may lead to patients making more informed decisions, avoiding "financial toxicity," and possibly driving down the cost of health care.

Fourth, attorneys can help prevent "financial toxicity" by helping patients maintain or find health insurance coverage during or after a life-altering disease by educating them and assisting them with their options, navigating the complex health insurance market and government programs (e.g., Medicaid, Medicare, veterans benefits). For patients who may lose their employer-sponsored health insurance as a result of their illness causing job loss, early attorney intervention and patient education may make a difference in patients' ability to remain insured. Several laws help provide continuity of coverage including HIPAA (e.g., prohibits discrimination for pre-existing conditions when the patient moves from one group plan to another),[179] COBRA (e.g., allows qualified beneficiaries to continue their health coverage for up to 1.5 to 3 years after a qualifying event),[180] state COBRA (e.g., many states have state COBRA laws that are "more protective than the federal law"),[181] Special Enrollment Periods (SEPs) under the ACA or Medicare (e.g., patient may be eligible for enrollment in Medicare or a health insurance plan under the ACA due to a qualifying event),[182] and other options.

For uninsured patients, attorneys may be able to help the patient find free care or qualify for affordable insurance. Specifically, "uninsured individuals may have new options for access to health insurance coverage, and without exposure to those options, they may be left confused, paying too much, or completely uninsured and unable to access

178. Zafar et al., *supra* note 129, at 149 ("Engaging patients in their care and providing cost information is not only a fundamental component of patient-centered care, but it might lower costs of care.").

179. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, § 702, 110 Stat. 1936 (1996).

180. Consolidated Omnibus Budget Reconciliation Act of 1895, Pub. L. No. 99-272, Title X § 10001(k), 100 Stat. 82 (1986).

181. BRYANT & MORALES, *supra* note 126, at 83.

182. *See, e.g.*, *Special Enrollment Period (SEP)*, CENTERS FOR MEDICARE & MEDICAID SERVICES (June 28, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/SEP-Overview_Webinar_Final.pdf (stating that SEPs can "provide a pathway to coverage" to "consumers who experience a qualifying event"; attorneys' special knowledge of these rules may help patients avoid loss of coverage where a patient may not recognize that a "qualifying event" has occurred or that SEPs are available).

health care."[183] Under the ACA, patients may qualify for subsidies if they earn between 138 and 400% of the federal poverty level, making health insurance affordable for some (especially if they are facing a costly illness).[184] If the patient's income is below 138% of the federal poverty level, they may qualify for Medicaid in expansion states, with individual qualification requirements varying in non-expansion states. If the patient has been disabled and received Social Security Disability Insurance benefits for twenty-four months, he or she may qualify for Medicare coverage.[185] In addition, certain diseases—like amyotrophic lateral sclerosis and end-stage renal disease—may qualify patients for Medicare.[186]

In some cases, free or reduced cost care may be available through the 140 Hill-Burton Act facilities obligated to provide a "reasonable volume" of free or reduced cost services.[187] After an application process, Hill-Burton free care may be available to patients with income below the federal poverty line, and reduced cost care may be available to patients with income up to double the federal poverty line (triple for nursing home care).[188] Patients can apply even after the medical bill has been sent to collections.[189] In addition, other types of free clinics are available in some locations.[190]

Finally, there are simply too many ways that attorneys can help patients avoid "financial toxicity" to list them all here. For example, attorneys may be able to assist patients in setting up legal fundraising efforts online (and navigating relevant taxes),[191] setting up a power of

183. BRYANT & MORALES, *supra* note 126, at 3.

184. *Federal Poverty Level (FPL)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ (last visited Dec. 15, 2018).

185. *Id.*; *Medicare Eligibility for Those Under 65*, MEDICARE INTERACTIVE, https://www.medicareinteractive.org/get-answers/medicare-basics/medicare-eligibility-overview/medicare-eligibility-for-those-under-65 (last visited Dec. 15, 2018).

186. *Medicare Eligibility for Those Under 65, supra* note 185.

187. HEALTH RES. & SERVS. ADMIN., HILL-BURTON FREE AND REDUCED-COST HEALTH CARE (Mar. 2018), https://www.hrsa.gov/get-health-care/affordable/hill-burton/. Hill-Burton Act facilities initially provided reduced cost services in return for government loans and grants, which were provided between 1946 and 1997. Even since the funding has been discontinued, about 140 facilities are still obligated to provide free or reduced cost care. *Id.*

188. *Id.*

189. *Id.*

190. *See generally* NAT'L ASS'N OF FREE & CHARITABLE CLINICS, http://www.nafcclinics.org (last visited Dec. 15, 2018).

191. *See* BRYANT & MORALES, *supra* note 126, at 316–17 (describing how patients can use online fundraising for health care).

attorney for financial affairs for an incompetent patient,[192] or helping with prescription medication assistant programs like NeedyMeds or RX Hope.[193] In addition, assistance or information might be provided to appropriate patients regarding programs like the Medicare Savings Programs, Programs for All-Inclusive for the Elderly (PACE), prescription drug assistance programs, State Health Insurance Assistance Program (SHIP), Children's Health Insurance Program (CHIP), high risk pools, federal employees health benefits program, military-related health insurance (Tricare, Veterans' health care), Indian Health Service (IHS), and others.[194] Further, attorneys may be aware of laws like oral chemotherapy parity laws or the Women's Health and Cancer Rights Act that affect particular patient populations.[195] It is unlikely other professionals will be able to provide the same level of service (or even be aware of potential solutions regarding these issues) that a health care attorney can provide.[196]

2. Treating Patients' Home Environment

Patients' home environment—including housing, food, and utilities—plays a major role in health outcomes, readmission risk, and overall health. The connection between health outcomes and home environment is well established.[197] "People spend more time in their homes than in any other location," and this can have a negative health effect if the housing is poor.[198] The elderly, the chronically ill, and the immunocompromised are particularly vulnerable because they spend the

192. *Id.* at 265 (noting that incapacitated individuals may need to have someone handle nonmedical decisions and that "[a] power of attorney for financial affairs is a legal document where an individual . . . names a trusted adult . . . who is authorized to make financial decisions" for that person).

193. *See id.* at 316.

194. *See, e.g.*, *id.* at 46–49.

195. *See id.* at 68 (observing that forty-three states plus D.C. and Puerto Rico have enacted oral chemotherapy laws that vary, "but generally insurance companies are required to treat and cover oral chemotherapy similarly to the way they would cover IV chemotherapy, which may reduce the out-of-pocket expenses incurred by patients").

196. *See* Fleishman et al., *supra* note 15, at 2123 ("In a recent survey of cancer patients . . . nearly half of the individuals surveyed said that non-medical issues relating to their cancer were unmet by their oncologists, including 35% who said nonmedical issues were wholly unaddressed and another 14% who said they believed their oncologists wanted to assist with nonmedical issues but did not have enough information or experience to do so.").

197. *See, e.g.*, Bashir, *supra* note 52, at 733; Beck et al., *supra* note 103, at 832; Gold, *supra* note 104, at 70.

198. Gold, *supra* note 104, at 60.

most time indoors and are often culturally isolated and alone.[199] In addition, children are particularly vulnerable to defects in the home environment.[200]

Attorneys can have significant impact on patients' health by protecting patients' rights in their home environment. There are too many ways that attorneys can help improve patients' home environment to list them all here, so these are only a few examples. Attorneys can sometimes help prevent homelessness, address substandard housing, prevent foreclosure/eviction, prevent utility shut-off, and assist with food security—all of which can have a significant impact on health outcomes and readmission rates.

First, attorneys can work to protect patients from becoming homeless in the first place by helping prevent evictions and foreclosures. Evictions of patients may be prevented in some cases if the patient's legal rights—like due process—are protected, which is often not the case.[201] Eviction hearings are common. For example, Baltimore courtrooms evict 6000 to 7000 households annually, New York City handles 300 to 400 eviction decisions per day, Chicago handles more than 31,000 eviction cases annually, and Milwaukee evicts over 16,000 people annually.[202]

In Chicago, the average length of eviction proceedings is *one minute and forty-four seconds*, and 95% of tenants are not represented by an attorney.[203] In nearly all jurisdictions, once evicted, tenants often find it difficult to acquire new housing because a digital record is created that stigmatizes the evictee such that future landlords are less likely to rent to them.[204] For some tenants, "it is simply impossible to secure housing following an eviction proceeding and they are forced into homelessness."[205] In New York City, almost half of all families in homeless shelters are homeless due to eviction.[206]

The limited power of pro se tenants makes the power imbalance such that substandard housing can prevail, which leads to predictable poor

199. Bashir, *supra* note 52, at 733 ("[T]he culture of isolation ensures that the persons who are most vulnerable to these diseases—infants, children, the elderly, the chronically ill, and the immunocompromised—are also those who spend the most time indoors and alone.").

200. Gold, *supra* note 104, at 70; *see also* Bashir, *supra* note 52, at 733 ("[O]ften life-threatening ailments disproportionately affect children of color and children from low-income families.").

201. *See* Gold, *supra* note 104, at 60.

202. *Id.* at 62.

203. *Id.* at 64.

204. *Id.* at 63.

205. *Id.* at 69.

206. *Id.* ("An estimated 47% of all families in New York City homeless shelters are homeless as a result of eviction.").

health outcomes that negatively impact the overall health care system.[207] A hospital-based attorney might be able to affect homelessness by helping protect evicted patients' basic due process rights.[208] As one researcher noted, "[e]ncouraging hospitals to work with community partners for the purpose of addressing the housing needs of their patients is consistent with [the goal of addressing SDH]."[209] Furthermore, according to one study, hospital "[d]ischarge to the streets or shelter versus other living situations [is] associated with increased risk for readmission"[210]—so, if an attorney can help a patient find an alternative to homelessness, the readmission risk decreases. Attorney assistance with assessment of complex government housing options is needed where, "[o]ften, federal and state resources are narrowly defined for specific populations with strict eligibility requirements."[211]

Second, attorneys can help protect patients from substandard housing issues that may be creating illness and so result in poor health outcomes. Legal services like ordinance enforcement, patient advocacy, and connection to resources can have a significant effect on patient outcomes related to substandard housing.[212] New or pre-existing symptoms are often exacerbated by home surroundings related to "[s]ick-building syndrome" and "building-related illness."[213] Substandard housing or "sick" buildings have been "shown to contribute to asthma, developmental and behavioral pathology, elevated lead levels, injury, and transmission of infectious diseases."[214]

Enforcement of landlord-tenant law can play a role in improving health outcomes. For example, in most states with a warranty of habitability included in their landlord-tenant laws, the warranty is violated by factors that worsen asthma severity like contamination of the home with mold, cockroaches, rodents, and dust.[215] However, most

207. *See id.* at 67–68. In showing the limited power of tenants, one tenant is quoted as saying, "[m]y landlord has a very bad reputation. He will sue you for anything. I don't want to do anything if it means I won't be able to find a good place to live after this." *Id.* at 68.

208. *See id.* at 63–64 (discussing violations to due process rights).

209. Christopher Cheney, *How Housing with Supportive Services Can Cut Hospital Utilization*, HEALTHLEADERS (Oct. 1, 2018), https://www.healthleadersmedia.com/clinical-care/how-housing-supportive-services-can-cut-hospital-utilization (noting that Medicare-eligible beneficiaries living in housing with supportive services used less hospital services).

210. Doran et al., *supra* note 49, at 767.

211. AHIP, *supra* note 96, at 8.

212. *See generally* Beck et al., *supra* note 103, at 831.

213. *Id.* at 832.

214. *Id.*

215. Mary M. O'Sullivan et al., *Environmental Improvements Brought by the Legal Interventions in the Homes of Poorly Controlled Inner-City Adult Asthmatic Patients: A Proof-of-Concept Study*, 49 J. ASTHMA 911, 911 (2012).

tenants do not have the resources to hire an attorney to remedy their housing issues.[216] Legal assistance with "fixing leaks, exterminating pests, or providing a different apartment" have been shown to be "highly effective" in decreasing the number of emergency department visits and hospital admissions, as well as decrease the need for systemic steroids, of adult asthma patients in sub-standard housing.[217] For example, one Medical-Legal Partnership ("MLP") made a significant difference in a case of substandard housing by identifying pest infestations and water damage that were going unaddressed in a portfolio of buildings owned by a single financially distressed landlord.[218] Eventually, the mortgage company ended up owning the buildings.[219] There were outstanding violations of city code and outstanding orders issued by the relevant health and building departments.[220] Legal advocates helped the tenants organize a tenant association and "helped tenants to work with the mortgage company . . . to identify and prioritize repairs [to] respond to city code standards while limiting blight and displacement."[221]

Third, attorneys can advocate for patients' rights under the Fair Housing Act. The Fair Housing Act prohibits discrimination against people who are disabled or those associated with someone with a disability.[222] A disability or "[h]andicap" is defined as "a physical or mental impairment which substantially limits one or more of such person's major life activities."[223] Reasonable accommodations are required and may include allowing a service animal in spite of a no pet policy, allowing a tenant to have a live-in aide who is not on the lease, or reserving a parking spot for a tenant with a mobility impairment.[224] A reasonable modification is a physical change that allows the disabled person to fully use the premises,[225] such as widening the doorway, installing grab bars in bathrooms, lowering kitchen cabinets, and adding a ramp. In private, unsubsidized housing, the tenant is generally responsible for the expense of these modifications. In subsidized housing,

216. *Id.*
217. *Id.*
218. *See* Beck et al., *supra* note 103, at 833–34.
219. *Id.* at 833.
220. *Id.*
221. *Id.*
222. 42 U.S.C. §§ 3601–3619 (2012).
223. *Id.* § 3602(h)(1).
224. *See id.* § 3604(f)(3); *Section 504: Frequently Asked Questions*, HUD.GOV, https://www.hud.gov/program_offices/fair_housing_equal_opp/disabilities/sect504faq#_Reasonable_Accommodation (last visited Dec. 15, 2018).
225. 42 U.S.C. § 3604(f)(3)(A).

the landlord may be responsible.[226] The tenant may be required to restore the premises upon leaving.[227]

Fourth, attorneys can help protect patients' due process rights when utility companies threaten to shut off vital utilities—like heat, air, and water. Restoration of heat is particularly important during winter months because improvements in warmth leads to improvement in general, respiratory, and mental health.[228] "Constitutionally sufficient 'shut-off notice . . . (must) provide the customer with the information he needs to quickly and intelligently take available steps to prevent the threatened termination of service.'"[229] In some cases, this includes information regarding options for people in "genuine hardships or appropriate situations" where utility companies offer "mutually satisfactory agreement for payment" and supply credit counselors to help the person prevent shut-off.[230] If an attorney can intervene early and help prevent the shut off of vital utilities like heat in winter time, air conditioning in the summer time, and necessary water, then health outcomes will improve. Attorneys can also raise patient awareness and help with qualification for the Low Income Home Energy Assistance Program.[231] There are numerous other ways attorneys can help with utilities beyond the scope of this paper.

Fifth, attorneys can impact health outcomes by helping patients with food insecurity. One research team recently noted, "[u]nhealthful diet is one of the top contributors to poor health in the United States, and disparities in diet quality by socioeconomic status can contribute to the nation's health disparities."[232] As noted above, Secretary Azar cited

226. *Section 504: Frequently Asked Questions*, *supra* note 224.

227. 42 U.S.C. § 3604(f)(3)(A).

228. Hilary Thomson et al., *The Health Impacts of Housing Improvement: A Systematic Review of Intervention Studies from 1887 to 2007*, 99 AM. J. PUB. HEALTH (SUPPLEMENT) S681, S681, S690 (2009) ("Housing improvements, especially warmth improvements, can generate health improvements"—including general, respiratory and mental health).

229. Craft v. Memphis Light, Gas & Water Div., 534 F.2d 684, 687 (6th Cir. 1976) (alteration in original) (quoting Palmer v. Columbia Gas of Ohio, Inc., 479 F.2d 153, 166 (6th Cir. 1973)), *aff'd*, 436 U.S. 1 (1978).

230. *Id.* at 688 n.5.

231. For general information on the Low Income Home Energy Assistance Program, see *Low Income Home Energy Assistance Program (LIHEAP)*, U.S. DEP'T HEALTH & HUM. SERVICES: OFF. COMMUNITY SERVICES, https://www.acf.hhs.gov/ocs/programs/liheap (last visited Dec. 15, 2018).

232. Fang Fang Zhang et al., *Trends and Disparities in Diet Quality Among US Adults by Supplemental Nutrition Assistance Program Participation Status*, JAMA NETWORK OPEN, June 15, 2018, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2684625.

malnutrition involvement in 12% of some types of hospital stays costing $42 billion.[233]

The Supplemental Nutrition Assistance Program ("SNAP")[234] is "by far the largest and most important safety net program, providing monthly benefits to approximately 1 in 7 US individuals and representing more than half of the annual budget of the U.S. Department of Agriculture."[235] SNAP served over forty-two million people in 2017 and has an annual budget of $70 billion, which exceeds the combined budgets of the National Institutes of Health, Centers for Disease Control and Prevention, Food and Drug Administration, and Health Resources and Services Administration.[236] SNAP "substantially reduces the prevalence of food insecurity and thus is critical to reducing negative health outcomes."[237] SNAP is funded by the federal government and administered through state programs that are "expressly prohibited from imposing 'any other standards of eligibility as a condition for participating in the program.'"[238] In some cases, attorney assistance early in the process making the patient aware of the program and its rules could make a difference in whether or not the patient gets timely needed assistance. Other programs may also be available that could require monitoring by an attorney to keep patients and hospital employees aware and assist when needed (e.g., Women, Infants, and Children (WIC) supplemental nutritional services). Food insecurity may also be addressed by preventing "financial toxicity" in the first place.[239]

3. Treating Patients' Employment Needs

Attorneys can help patients make educated decisions regarding employment issues during times of poor health by informing them of their legal rights and helping to protect those rights.[240] Work can have significant health benefits—even beyond financial security. For example, work may provide effective coping strategies for those dealing with illness by helping the patient have a routine and providing a distraction

233. Azar, *supra* note 9 ("In fact, malnutrition is involved in 12 percent of non-maternal, non-neonatal hospital stays—$42 billion each year in healthcare spending.").
234. 7 U.S.C. § 2011 (2012).
235. Zhang et al., *supra* note 232.
236. *Id.*
237. Gundersen & Ziliak, *supra* note 121, at 1830.
238. Barry v. Corrigan, 79 F. Supp. 3d 712, 720 (E.D. Mich. 2015) (quoting 7 U.S.C. § 2014(b) (2012)), *aff'd sub nom.* Barry v. Lyon, 834 F.3d 706 (6th Cir. 2016); *see also* 7 U.S.C. §§ 2013, 2020(a), (d), (e) (2012).
239. *See* discussion *supra* Section II.B.1.
240. BRYANT & MORALES, *supra* note 126, at 93–96 (describing employment issues and options in cancer patients).

from the person's health issue, while also giving the patient a feeling of productivity and usefulness.[241] These psychological benefits can affect health outcomes like quality of life, therapy compliance, and symptom burden.[242]

Federal fair employment laws like the Americans with Disabilities Act ("ADA") and the ADA Amendments Act of 2008 ("ADAAA") provide protections for some patients recovering from illness.[243] The ADA applies to private employers with fifteen or more employees.[244] A review of the ADA and ADAAA is beyond the scope of this Article, but its requirements for "fair employment protections" and "reasonable accommodations" can be important to patients recovering from illness, but in danger of losing their jobs.[245] In addition to federal protections, patients may have rights under state fair employment laws that a hospital-based attorney could help protect.[246]

Helping patients understand their rights regarding leave time (e.g., under the Family and Medical Leave Act ("FMLA"))[247] for recovery from illness is another way attorneys can help limit the impact of unemployment on health outcomes. For example, additional leave time may be available as a "reasonable accommodation" under the ADA after the patient has exhausted his or her FMLA leave if it is for a definite amount of time and does not result in undue hardship on the employer.[248] In addition, some states have their own leave laws.[249]

Attorneys may also be able to help contracted employees understand their rights under the contract and the particular state's contract laws. Further, attorney review of companies' sick leave policies may be helpful. Finally, self-employed individuals may need special attention to legal obligations and needs.

In addition, if a person is no longer employable due to disability, early attorney intervention to get the qualification process started can be

241. *Id.* at 95 (noting that 65% of cancer survivors reported work was an effective coping strategy).

242. *Id.* at 94.

243. 42 U.S.C. § 12101 (2012); ADA Amendments Act of 2008, Pub. L. No. 110–325, 122 Stat. 3553 (2008); BRYANT & MORALES, *supra* note 126, at 99, 101.

244. BRYANT & MORALES, *supra* note 126, at 103.

245. *Id.* at 106–14; *see also The Job Accommodation Network (JAN) Mission: Practical Solutions – Workplace Success*, JOB ACCOMMODATION NETWORK, https://askjan.org/about-us/index.cfm (last visited Mar. 17, 2018) (providing "confidential guidance on workplace accommodations and disability employment issues").

246. *See, e.g.*, BRYANT & MORALES, *supra* note 126, at 117–18.

247. 29 U.S.C. §§ 2601–2654 (2012).

248. BRYANT & MORALES, *supra* note 126, at 129.

249. *See, e.g.*, CAL. GOV'T CODE § 12945.2 (West 2011); OR. REV. STAT. ANN. § 659A.156 (West 2013); WIS. STAT. ANN. § 103.10(3) (West 2012).

critical to health outcomes where the process can often take several years and the barriers can be high.[250] "Beneficiaries with disabilities and those in rural areas had higher odds of mortality"—perhaps reflecting increased difficulties with getting assistance in clearing these barriers.[251] Two-thirds of applicants for Social Security Disability Insurance are initially denied and must appeal, and the average wait time for a hearing is 596 days with a judge's decision taking an additional 78 to 120 days.[252]

Some states have short term disability programs that can be leveraged.[253] Obviously, the quicker this process gets started, the quicker it will be resolved—so a hospital-based attorney would be in a unique position to impact health outcomes by helping start the process early, even if he or she did nothing more than connect the patient with a competent outside disability attorney as soon as it became apparent that one may be needed. In some cases, the process can be expedited with compassionate allowances, terminal illness, and quick disability determination—which may significantly affect health outcomes and readmissions to the hospital.[254]

So, there are many ways hospital-based attorneys can potentially make a difference in patients' employment prospects while dealing with illness/injury, and these differences may significantly affect health outcomes by keeping the patient employed with resultant physical, psychological, and financial benefits.

4. Treating Patients' Other SDH Issues

There are too many different scenarios where attorney intervention to address the SDH results in improved health outcomes to list them all here. Some examples include: (1) issues related to domestic relations/abuse, (2) education rights, (3) qualifying for veterans' benefits, (4) assistance for caregivers, (5) substance abuse treatment, (6) criminal law issues (e.g., expungement), (7) medical marijuana, (8) minority issues, among others. At the very least, making patients aware of free attorney services can sometimes impact health outcomes, such as alerting patients to resources like Legal Aid, lawhelp.org, lawhelpinteractive.org, local MLPs, law school legal clinics, prepaid legal services, and certified lawyer referral services. All of these interventions

250. *See, e.g.*, 20 C.F.R. § 404.1505(a) (2012).
251. HHS REPORT TO CONGRESS, *supra* note 35, at 155.
252. BRYANT & MORALES, *supra* note 126, at 156–57.
253. *Id.* at 182 (describing how the FMLA can work with paid leave options and disability insurance).
254. *See id.* at 177–79.

have the potential to improve health outcomes including reduction of hospital readmissions.

B. *Attorneys Should Be Included Proactively and Paid as Healthcare Treatment Team Members to Address SDH*

Attorneys are needed and have already been successfully incorporated into some health care delivery teams by providing free legal services, but could access more patients before crises occur if they are proactively and routinely included as paid members of health care delivery teams. In addition, routine inclusion will break down barriers and enhance health care providers' understanding of the advocacy role attorneys can play helping to overcome the adversarial stereotype often applied to attorneys by health care professionals (e.g., seeing attorneys as "ambulance chasers").[255] Instead of relying on the goodwill of attorney organizations to provide free legal services to patients, mechanisms should be put in place to properly reimburse attorneys for services provided, which will benefit patients, providers, and payors financially.

1. Attorneys Are Needed and Have Been Incorporated Successfully into Health Care Teams Already

Legal needs abound in health care settings. For example, in a recent study, researchers found that almost three-fourths (73%) of patients in orthopedic outpatient clinics had legal needs affecting their recovery.[256] Health care providers are well aware of the legal issues that affect their patients' care, but often do not have an outlet to address these types of concerns.[257] On-site attorneys can make a difference. One provider gives the example of a stroke patient who needed multiple types of therapy, but did not have insurance after losing employer sponsored health insurance when he could not work; the provider attributes an on-site attorney with helping the patient get the insurance coverage (e.g., including appeals to denied public benefits) and therapy needed—ultimately leading to a much improved outcome (and likely long-term reduction in costs) for the patient.[258] The provider emphasized

255. *See* Fleishman et al., *supra* note 15, at 2123 ("Traditionally, an historical and outdated tension between physicians and attorneys over contentious malpractice litigation discouraged their collaboration.").

256. Frank Griffin et al., *The Law and Social Determinants of Health: A Clinical Study of Orthopedic Outpatients*, J. HEALTH & BIOMEDICAL L. (forthcoming 2019).

257. MARPLE, *supra* note 177, at 4 ("'As a provider, I've always been aware of these kinds of legal issues that affect my patients' care,' said Ms. Trulson [RN], 'But I didn't have an outlet to address them . . . .'").

258. *Id.*

the importance of having an attorney on-site so "there is a continuous flow between the health and legal services that's designed to optimize health and well-being," noting that when the patient is referred outside the clinic for legal services, the follow-up is not as good.[259]

Elderly patient groups "have long embraced the input of legal teams in estate planning as well as in conservatorship and guardianship issues."[260] In addition, formalized incorporation of medical-legal teams "are often housed on-site in pediatric ambulatory centers," and legal advocacy is being taught as a core competency in some pediatric and psychiatric physician training programs.[261] Training for physicians is important because providers have limited time and "don't want to waste time on things that won't result in something meaningful for our patients."[262]

Support is growing in the medical community for increased interdisciplinary approaches to health care as outlined by Secretary Azar's comments noted earlier; for example, the American College of Physicians "supports increased interprofessional communication and collaborative models that encourage a team-based approach to treating patients at risk to be negatively affected by social determinants of health."[263] Legal services—like mostly charitable Medical Legal Partnerships ("MLP")—have been shown to positively impact health outcomes. For example, a three-year study of one rural MLP showed that the hospital made a 319% return on its investment in MLP services by recovering dollars for clinical services that were previously unable to be reimbursed before the MLP helped patients become insured, and the patients consequently experienced a range of social benefits (including for example, social security benefits, family law services, and end of life guidance) likely also decreasing future health care costs.[264] So, patient advocate attorneys can improve patients' health care outcomes and provide financial benefits to hospitals and payors.

Examples of charitable legal services benefiting patients, providers, and payors abound. For example, LegalHealth, which was the "first fully

259. *Id.*

260. Fleishman et al., *supra* note 15, at 2123.

261. *Id.*

262. MARPLE, *supra* note 177, at 12.

263. Hilary Daniel et al., *Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper*, 168 ANNALS INTERNAL MED. 577, 578 (2018), http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american.

264. James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-up Study*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 705, 705, 709–10 (2012).

staffed free legal services program" seeking to "make legal intervention a component of cancer care" by providing free legal services to patients, and training "health care professionals on the legal issues affecting their patients."[265] "[L]awyers [were] stationed in the same clinical area[s] where cancer treatment is provided," and patients were referred after prescreening by a traditional health care provider—sometimes by literally walking the patient over to the lawyer's nearby office.[266] Providers recognized that "[l]egal problems for patients with cancer . . . must be addressed to maintain quality of life during and after cancer treatment and to promote continued access to care."[267] LegalHealth today has a "staff of 49 lawyers and paraprofessionals" who "provide free legal assistance to low-income New Yorkers with serious health problems within hospitals across New York City."[268] "In 2017, LegalHealth handled over 8,300 new matters for patients referred by physicians, social workers, and community-based health organizations," including issues like "[i]mmigration, public benefits and housing."[269]

Another example is the MLP at People's Community Clinic at George Washington University as part of its broader SDH strategy.[270] The CEO noted, "[i]f you're being patient-centered, you're going to follow that patient out into the community to help with things that can't otherwise be addressed through medical treatment." [271] Value is particularly noted "in using legal expertise to inform clinical processes so that the health center is as safe and as empowering a place for its patients to receive care as possible."[272]

Charitable pro bono legal services like legal aid and MLPs are an important part of the solution to SDH, but simply cannot meet the demand for legal help to address SDH—especially in impoverished areas. For example, in rural America, approximately ten thousand to twelve thousand impoverished rural residents are present for every rural legal-aid attorney.[273] For perspective, about half of those seeking legal services through programs funded by the Legal Services Corporation are turned away annually and if legal aid attorneys worked fifty-two weeks per year for forty hours per week and could completely meet clients' legal

265. Fleishman et al., *supra* note 15, at 2124.
266. *Id.*
267. *Id.* at 2123.
268. *About LegalHealth*, LEGALHEALTH, https://legalhealth.org/about-us/ (last visited Dec. 15, 2018).
269. *Id.*
270. MARPLE, *supra* note 177, at 12.
271. *Id.*
272. *Id.* at 13.
273. Teufel et al., *supra* note 2, at 97.

needs in one hour each (they cannot), only 40% of demand would be met.[274]

2. Attorneys Provide Valuable Services to the Health Care System for Which They Should Be Paid, Which Will Increase Availability of Services and Positively Impact SDH

The healthcare delivery system should not rely on free legal services to provide necessary care for SDH that directly benefit providers and payors. Attorneys should be paid for these valuable services. The government is exploring experimentation with paying for non-health services "*on a scale that has never before been tried in the United States*."[275] In order to routinely incorporate attorneys in health care delivery teams, payment mechanisms need to be in place similar to other health care providers. For example, in 2016, "CMS updated the Medicaid managed care rule to encourage Medicaid [MCOs] to assist beneficiaries with nonmedical concerns that are essential for improving health outcomes and lowering costs," but spending has not been "accounted for in the development of Medicaid reimbursement rates."[276]

One way payors could pay for attorney services to address the SDH would be to support creation of Current Procedural Terminology ("CPT") codes to pay attorneys for an initial SDH consultation and follow-up visit (e.g., similar to new and established office visit codes for physicians like 99203 and 99213).[277] CMS is trying to improve care coordination already by introducing new CPT billing codes to reimburse and incentivize clinicians for "asynchronous telehealth services, chronic care physiologic monitoring, e-consults . . . and virtual check-ins between patients and clinicians."[278] CMS is interested in incentivizing "transitional care management, chronic care management, advanced care planning, care planning for cognitive impairment . . . and integrated behavioral health."[279] As noted above, attorneys could provide services to help with

274. *Id.*

275. Azar, Remarks, *supra* note 18 (emphasis added) ("We are actively exploring how we could experiment with actually paying for non-health services, like housing and nutrition—an integrated, individually driven approach to health and human services on a scale that has never before been tried in the United States.").

276. Shrank et al., *supra* note 5, at 2197.

277. *CPT (Current Procedural Terminology)*, *CPT Overview*, AMA, https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology (last visited Mar. 17, 2019).

278. Joshua M. Liao et al., *Medicare's Approach to Paying for Services that Promote Coordinated Care*, JAMA NETWORK (Dec. 13, 2018), https://jamanetwork.com/journals/jama/fullarticle/2719034.

279. *Id.*

coordination and ensure better results for many of these issues where SDH are involved. New fee-for-service codes are seen as "important complements to the implementation of alternative payment models," like value-based payment. [280]

ICD-10 already is recognizing SDH with Z-codes like Z59.5 Extreme poverty, Z59.6 Low income, and Z59.4 Lack of adequate food.[281] Attorney-visit CPT codes should be generated to allow attorneys to be reimbursed by payors for their time in treating these largely heretofore untreated SDH that significantly drive the cost of American health care.

To be clear, I am not suggesting that CPT codes be created for open-ended hourly billing. Instead, as for physician reimbursement, CPT codes should pay for a "New Patient SDH Legal Assessment Visit" and an "Established Patient SDH Legal Follow-up Visit." Also, just as with physicians, Relative Value Units could be assigned to determine the pay scale for these two codes.[282] The codes should include enough time for an attorney to write a letter explaining patient rights and perhaps a letter or two to particular entities (e.g., perhaps a housing authority, landlord, or a drug treatment facility). While I think that simply assessing and providing some initial advice to patients concerning their rights regarding SDH will be cost effective for a payor, I doubt that paying for a full legal treatment with hours of open-ended attorney billing would be cost effective. Instead, for many SDH, the consulting attorney may simply point the patient in the direction of another attorney or provide the services for a fee to the patient, who is now aware of his or her legal rights and options. However, it is possible that over time, additional attorney CPT codes may prove cost effective depending upon the SDH diagnosis being treated as more expertise in SDH treatment evolves. Attorneys have proven that they can be productive and appreciated advocates forming collaborative relationships in health care that benefit patients, providers, and payors.[283]

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280. *Id.*

281. HITEQ CTR., *supra* note 92.

282. NAT'L HEALTH POLICY FORUM, THE BASICS: RELATIVE VALUE UNITS (RVUS) 1 (Jan. 12, 2015), https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf.

283. Fleishman et al., *supra* note 15, at 2126 ("As oncology care is evermore provided in an ambulatory setting, oncology treatment teams are forced to confront family and financial issues that may expedite or impede patient treatment. An on-site, specialized attorney can intervene to address these issues before a crisis develops that interferes with cancer treatment.").

IV. CONCLUSION

Social determinants of health are non-medical conditions that can produce or undermine health and include basic human needs like economic status, education, employment, housing, nutrition, and social integration—many of which can have strong influences on health and may be treatable by attorney intervention. Unfortunately, SDH have historically been ignored by the current health care system to the detriment of patients, providers, and payors, but that is changing. CMS is looking for innovative ways to treat patients holistically to address SDH, including paying for services "whether they are healthcare services or not."[284] Insurance companies are already beginning to follow.

The legal profession has much to gain by getting more involved in health care as patient, provider, and payor advocates. Likewise, the health care industry has much to gain by utilizing legal expertise to address SDH. Continued failure to address SDH will negatively impact providers and payors under emerging value-based payment models that decrease reimbursement based upon hospital readmissions, hospital-acquired conditions, and other quality measures largely affected by SDH outside the reach of traditional medical care. The legal profession can help "treat" SDH like home environment (including housing, utility, and food security), employment issues, poverty, landlord tenant issues, financial distress, debtor/creditor issues, resolution of insurance/immigration/criminal/military status, and many other treatable SDH.

Payors are becoming increasingly aware of the need to pay for SDH care in order to bring down health care costs and improve outcomes "whether those benefits are traditionally thought of as health services or not."[285] In many circumstances, attorneys are the best providers to treat SDH and have demonstrated the ability to improve health outcomes and lower health care costs through charitable operations like medical-legal partnerships. Instead of relying on the goodwill of attorney organizations to provide free legal services to patients, the health care delivery system should include reimbursement mechanisms to pay attorneys for this valuable service. Pro bono legal services simply cannot meet the demands required to adequately address SDH to optimize health care costs and outcomes.[286] Often, on-site attorneys treating SDH may prove to be cost effective team members providing tangible benefits to patients, providers, and payors.

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284. Azar, *supra* note 9.
285. *Id.*
286. *See supra* text accompanying note 274.

HHS is exploring innovative options in "paying for non-health services . . . on a scale that has never before been tried in the United States,"[287] and insurance companies are beginning to follow suit. It is time for attorneys to embrace health care advocacy roles for patients and providers and for the health care industry to welcome attorneys onto health care delivery teams. The legal profession and the health care industry will both benefit from the development of payment mechanisms (like new CPT codes) that incentivize attorneys to engage in new roles treating social determinants of health.

287. Azar, Remarks, *supra* note 18.