REMODELING THE MEDICAL HOME: INTEGRATING SAFETY NET SERVICES WITH HEALTHCARE DELIVERY

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I. INTRODUCTION

After a long and acrimonious debate, President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. In doing so, he achieved something that had eluded presidents, both Democratic and Republican, since the passage of Medicare and Medicaid in 1965.

Yet will the reform actually work? Will healthcare reform lead to better health outcomes while cutting costs? To answer these questions, one must look to how reform will be implemented. A cornerstone of the reform bill is the provision of comprehensive primary care by physician led teams.[1] These teams are charged with coordinating a patient's medical care, including both preventive and chronic care, to improve health outcomes.[2] This is also known as the patient centered medical home.[3]

For low-income patients, however, it is not just their medical care that needs coordination. Instead, the entire safety net needs coordination. Utilizing safety net services is a full-time job. For example, in Los Angeles, an individual living at or below the Federal Poverty Line, who relies on public transportation, has to go to one

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1311(g)(1)(B), 2717(a)(1)(A), 3502 et seq. (2010) [hereinafter Patient Protection and Affordable Care Act]. This is also known as the patient centered medical home; *see also* MATHEMATICA INC., SUMMARY: MEDICAL HOME MODELS 1 (2008) (defining the medical home as being "intended to encourage a population-based, proactive and planned approach to care, whereby care is coordinated across various providers to facilitate the provision of recommended services, eliminate redundancies or unnecessary care, and engage patients.").

2. *See, e.g.*, Patient Centered Primary Care Collaborative, Joint Principles of the Patient Centered Medical Home (2007), http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home (last visited Apr. 15, 2010).

3. *See, e.g.*, Patient Protection and Affordable Care Act, *supra* note 1, at § 3502 et seq.; *see also* Medical Home Initiatives for Children With Special Needs Project Advisory Committee, *The Medical Home*, 110 PEDIATRICS 184, 184 (2002) (defining the medical home as providing accessible, continuous, comprehensive, family centered, compassionate, and culturally effective care through a team led by a primary care physician).

place for healthcare, another place to enroll for food stamps, and a third to turn in paperwork to remain eligible for these benefits.

This is a system set up for failure: a system that simultaneously spends money on outreach for enrollment while erecting administrative barriers to enrollment and retention.[4] It makes little sense to create programs that are theoretically designed to help low-income individuals but are practically difficult to access, unless the purpose is to clear our collective conscience while spending as little money as possible.[5]

Coordinating medical care while ignoring the safety net will cause health reform to fail for our most vulnerable population, the poor, because "[h]ealth is more a function of lifestyles linked to living and working conditions than of healthcare."[6] In other words, the socioeconomic determinants of health that the safety net focuses on potentially play a larger role than medical care in determining a person's health and health outcomes. Thus, coordinating healthcare

4. *See, e.g.*, Elisabeth Mason & Julie Kashen, *Out of the Desert: An Integrated Approach to Ending Child Poverty*, *in* BIG IDEAS FOR CHILDREN: INVESTING IN OUR NATION'S FUTURE 25, 25-26 (2008), *available at http*://www.firstfocus.net/Download/3-MasonKashen.pdf (discussing the difficulty in applying for food stamps as a case example and how over $65 billion in benefits are left on the table by low-income families annually); Sheila Zedlewiski et al., Urban Inst., *Is There a System Supporting Low-Income Working Families?* vi (Feb. 2006), *available at* http://www.urban.org/UploadedPDF/311282_lowincome_families.pdf (reporting that "about 5 percent of all low-income working families with children younger than 18 receive all three benefits (Medicaid, food stamps, and help paying for child care)").

5. *See, e.g.*, LEGISLATIVE ANALYST'S OFFICE, MOVING FORWARD WITH ELIGIBILITY AND ENROLLMENT PROCESS IMPROVEMENTS (MAY 2010), *available at* http://lao.ca.gov/reports%5C2010%5Cssrv%5Celigibility%5Celigibility_050310.aspx (discussing how "the number of persons who are eligible but not enrolled in Medi-Cal alone is at least 500,000" and how "[a]n increase in enrollment in Medi-Cal and CalWORKs may not be in the state's interest at this time."); *see also* GAO, MEANS-TESTED PROGRAMS INFORMATION ON PROGRAM ACCESS CAN BE AN IMPORTANT MANAGEMENT TOOL 12 Tbl. 5 (MAR. 2005) (finding that food stamp participation for all eligible households in 2001 was 46-48% of eligible households and Medicaid participation for all eligible households in 2000 was 66-70% of eligible households); KATIE PARKER COHEN, TACHC POL'Y PAPERS, OUTSTATIONED ELIGIBILITY WORKERS AT FQHCS: A LOOK AT COST-EFFECTIVENESS 5 (OCT. 2006) (reporting that in Texas between September 2003 and June 2006, 98,000 children were dropped from Medicaid and CHIP because of restrictive policy changes).

6. David R. Williams et al., *Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities*, 14 J. PUB. HEALTH MGMT. PRACTICE S8, S8 (2008); *see also* CHILDREN'S DEF. FUND, IMPROVING CHILDREN'S HEALTH: UNDERSTANDING CHILDREN'S HEALTH DISPARITIES AND PROMISING APPROACHES TO ADDRESS THEM (2006) (analyzing many of these health care disparities and finding a strong linkage to the socioeconomic determinants of health); Randye Retkin et al., *Medical Legal Partnerships: A Key Strategy for Mitigating the Negative Health Impacts of the Recession*, 22 THE HEALTH LAW 29, 29-30 & notes 5-33 (discussing how the connection between socioeconomic status and health is well established and how the recent recession has highlighted the need for safety net benefits).

delivery without also coordinating other safety net services is a formula for failure.

However, during the current economic downturn, political leaders are either proposing to increase enrollment and renewal barriers to cut costs and increase churning,[7] or they are considering eliminating public benefits programs altogether.[8] Meanwhile advocates are doing all they can to save existing programs. No one is talking about safety net coordination as the demand for safety net services steadily increases.[9]

This article takes a critical look at how healthcare reform, with its mandate for medical services coordination, can incorporate safety net coordination to improve health outcomes. Specifically, the article will discuss how the medical home can be utilized to overcome existing public benefits enrollment and retention barriers to increase efficient access to public benefits.[10]

II. SAFETY NET FRAGMENTATION: THE PUBLIC BENEFITS LANDSCAPE SINCE 1996

Critics may question whether safety net coordination is actually

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7. *See, e.g.*, PAMELA FARLEY SHORT ET AL., THE COMMONWEALTH FUND, CHURN, CHURN, CHURN: HOW INSTABILITY OF HEALTH INSURANCE SHAPES AMERICA'S UNINSURED PROBLEM 1-2 (2003) (defining churning as instability of health coverage and advancing the idea that churning disproportionately affect low-income Americans, minorities, and young adults); *see also* GEORGETOWN UNIV. HEALTH POL'Y INST. CTR. FOR CHILDREN AND FAMILIES, PROGRAM DESIGN SNAPSHOT: PAPERLESS INCOME VERIFICATION 3 (MAR. 2009) (defining churning as the process where individuals remain eligible for a program despite becoming disenrolled and then reenroll in the same program in a few months).

8. *See, e.g.*, WESTERN CENTER ON LAW & POVERTY, THE GOVERNOR'S PROPOSED BUDGET WOULD DECIMATE MEDI-CAL AND HEALTHY FAMILIES AS WELL AS OTHER SERVICES FOR POOR CALIFORNIANS (Jan. 12, 2010), http://lists.familyvoicesofca.org/pipermail/fvca-familyvoicesofca.org/attachments/20100114/e57e1908/attachment-0001.pdf (last visited Apr. 15, 2010) (describing Governor Schwarzenegger's proposed cuts to California's public benefits programs).

9. *See, e.g.*, Victoria Colliver, *Newly Uninsured Up 50% at Community Clinics*, S.F. CHRONICLE (Sept. 9, 2009), *available at* http://articles.sfgate.com/2009-09-09/news/17205360_1_clinics-strain-insurance (reporting that California's 800 community clinics and health centers have reported on average a 50 percent increase in newly uninsured patients in 2009 as a result of the downturn in the economy); Kevin Sack, *Rate of Enrollment in Medicaid Rose Rapidly, Report Says*, N.Y. TIMES, Oct. 1, 2009, *available at* http://www.nytimes.com/2009/10/01/health/policy/01medicaid.html (finding that the recession is driving up enrollment in Medicaid at higher than expected rates); Charles Abbot & Russ Blinch, *One in 10 Americans Gets Help from U.S. to Buy Food*, REUTERS, Apr. 2, 2009, *available at* http://www.reuters.com/article/idUSTRE5314B320090402. *But see* LEGISLATIVE ANALYST'S OFFICE, *supra* note 5 (discussing application simplification but recommending against it because the administrative costs saved would be wiped out by the increased costs of eligible individuals enrolling and receiving benefits).

10. *See, e.g.*, *supra* note 4.

needed. Do people actually have trouble accessing public benefits? Since those eligible for benefits are unemployed, do they not have time to chase down the benefits if they want them? Such critiques reveal a misunderstanding of how public benefits operate and of who is eligible for these benefits. Although this is not an article about welfare reform, a background on public benefits in America frames the discussion of why the integration of safety net services with healthcare delivery is so essential.

A. PRWORA's Effect on the Receipt of Public Benefits

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) attempted to fix welfare by "put[ting] an end to welfare as we have come to know it."[11] As enacted and implemented it accomplished this goal. According to the U.S. Department of Health and Human Services, the number of families receiving welfare dropped by 44 percent between August 1996, when the legislation passed, and September 1999.[12] By March 2003, there had been a 59.5 percent decline in the overall Temporary Assistance for Needy Families (TANF) rolls since the passage of PRWORA.[13] This change was partially due to a booming economy, but it was also due to the effective measures instituted to discourage people from applying.[14]

PRWORA's effects, however, spread far beyond simply welfare to many other public benefits. Prior to PRWORA, eligibility for Medicaid, food stamps, and Aid to Families with Dependent Children (AFDC) were linked. Thus, individuals applying for one would automatically be checked for eligibility for these other

11. Governor Bill Clinton, The New Covenant: Responsibility and Rebuilding the American Community, Remarks to Students at Georgetown University (Oct. 23, 1991).

12. ROBERT WOOD JOHNSON FOUND., SUPPORTING FAMILIES AFTER WELFARE REFORM: ACCESS TO MEDICAID, SCHIP, AND FOOD STAMPS (Feb. 2007), *available at* http://www.rwjf.org/reports/npreports/sfw.htm.

13. KENNETH J. NEUBECK, WHEN WELFARE DISAPPEARS 45 (2006).

14. *See, e.g.*, *id*. at 46 (finding that "[a]lmost all critics of the PRWORA stressed the healthy state of the U.S. economy in explaining the steady decline in the TANF rolls . . . some critics suggested that the especially rapid rate of this decline was in part a function of states' practices of division which, encouraged by PRWORA were aimed at keeping potential TANF recipients from joining the rolls in the first place."); *cf. id.* at 47 (finding that supporters of PRWORA argue that "most lone mothers were unwilling to work and preferred to laze along at home on public assistance rather than to take outside employment . . . [and] the decline in the rolls was proof that the laziness premise was correct.").

programs. PRWORA de-linked eligibility/application for these programs.[15] Furthermore, under PRWORA, when an individual's eligibility for one program ends, the recipient is often improperly terminated from other safety net programs.[16] Thus, individuals who lose welfare/TANF often also lose Medicaid or food stamps although they remain eligible for these other programs.[17] Between 1995 and 1998, the number of families receiving food stamps decreased by 30 percent, with the percentage of poor children benefiting from food stamps dropping from 88 percent to 70 percent despite about two-thirds of the families still being eligible for this benefit.[18] On the other hand, between 1996 and 1998, 1.25 million eligible children lost healthcare coverage under Medicaid, caused mainly by welfare reform.[19]

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15. HEALTH DIV. CHILDREN'S DEF. FUND, KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID AND THE UNINSURED, OUTREACH STRATEGIES FOR MEDICAID AND SCHIP: AN OVERVIEW OF EFFECTIVE STRATEGIES AND ACTIVITIES 6 (Apr. 2006) [hereinafter KAISER], *available at* http://www.kff.org/medicaid/upload/7495.pdf. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") changed Medicaid eligibility by severing the automatic link between eligibility for cash assistance and Medicaid, making outreach and enrollment much more difficult. *Id*. As a result, Medicaid enrollment dropped after PRWORA. *Id*.

16. ALVIN L. SCHORR, WELFARE REFORM FAILURE & REMEDIES 37-41 (2001) (finding that in addition to de-linking the programs, many TANF workers failed to let recipients know that they might be eligible for these other programs); *see also* JULIE DARNELL & CHARLES NAGATOSHI, MATHEMATICA POLICY RESEARCH, INC., STATE OF CONNECTICUT IMPROVING FOOD STAMP, MEDICAID, AND SCHIP PARTICIPATION: STRATEGIES AND CHALLENGES FINAL REPORT (2002) (discussing the problems of welfare reform resulting in improper disqualification when eligibility for one program expired).

17. KENNETH J. NEUBECK, *supra* note 13, at 55-59; *see also* ALVIN L. SCHORR, *supra* note 16, at 40 (finding that in many states computer programs automatically dropped people from Medicaid when they lost welfare and that; this was not fixed when PRWORA was implemented); CITIZENS FOR MISSOURI'S CHILDREN, HEALTH CARE COUNTS: BARRIERS TO MC+ COVERAGE FOR ST. LOUIS CHILDREN 6 (1999) (discussing how many children lost Medicaid as a result of welfare reform although they were eligible for Medicaid). *But see e.g.*, MARILYN R. ELLWOOD & KIMBALL LEWIS, THE URBAN INST., ON AND OFF MEDICAID ENROLLMENT: PATTERNS FOR CALIFORNIA AND FLORIDA IN 1995, 1-3 (1999) (reporting that in California both before and after welfare reform when the welfare case load decreased, so did Medicaid enrollment). It should be noted that California maintained the linkage between Medicaid and cash aid. Thus, this study suggests that even if linkage were maintained, a decrease in the receipt of cash aid leads to a decrease in the number of eligible individuals enrolled in Medicaid.

18. ALVIN L. SCHORR, *supra* note 16, at 37.

19. LEIGHTON KU & BRIAN BRUEN, THE URBAN INST., THE CONTINUING DECLINE IN MEDICAID COVERAGE 5 (1999); *see also* JOEL BLAU & MIMI ABRAMOVITZ, THE DYNAMICS OF SOCIAL WELFARE POLICY 391 (2007) ("Although Medicaid is supposed to provide health care to poor people, only 40 percent of the total population in poverty actually received Medicaid."); MARILYN R. ELLDWOOD & KIMBALL LEWIS, *supra* note 17, at 1-3 (finding that a decrease in receipt of cash aid led to a decrease in receipt of Medicaid despite individuals remaining eligible for Medicaid).

PRWORA has thus further fragmented the American public benefits delivery system that was already highly uncoordinated.[20] Unsurprisingly, since PRWORA, there has been a decline in the number of eligible individuals who receive public benefits.[21]

B. Are Families Better Off Under PRWORA?

As welfare rolls decreased, did former beneficiaries find jobs that left them better off? The data show that in fact, TANF rolls continued to fall even as poverty rates rose.[22] In fact, "welfare reform has adversely affected child and family well-being in various ways, even as political elites maintain a remarkable consensus that it has been a success."[23] Such cognitive dissonance is absurd: those who claim PWORA has been a success ignore the actual effects on children and families. Instead, they measure success solely by looking at the drops in numbers of families receiving assistance. On balance, one could say that TANF is a success because it cut the welfare rolls, but it has been a failure because it has increased poverty.[24]

PWORA's failure reflects two historical problems:[25] failure to

20. EDWARD T. JENNINGS, JR. & NEAL S. ZANK EDS., WELFARE SYSTEM REFORM, COORDINATING FEDERAL, STATE, AND LOCAL PUBLIC ASSISTANCE PROGRAMS 4 (1993) (finding that "[t]he multitude of regulations, procedures, definitions, and terms used in federal public assistance programs has contributed to an assistance system that is fragmented, uncoordinated, and difficult to administer.").

21. KENNETH J. NEUBECK, *supra* note 13, at 49 ("Because many families are failing to receive TANF's cash benefits as well as benefits from other government programs for which they may be eligible, the nation's poverty rate is higher than it otherwise would be. The stereotype equating being impoverished with being on welfare is not based in reality, especially today. One study found that mothers poor enough to qualify for cash welfare benefits were far more likely to receive such benefits in the early 1990s than in the years immediately following passage of the PRWORA.").

22. *See, e.g.*, *id*. at 47-48 (finding that from 2000-2003 the U.S. poverty rate rose from 11.3 to 12.5 percent while TANF rolls continued to decrease).

23. *Id*. at 44; *see also* PUB. POLICY INST. OF CAL., RESEARCH BRIEF: MANY WELFARE RECIPIENTS LACK THE BASIC SKILLS NEEDED TO SUCCEED IN THE WORKPLACE 1 (1999) (discussing how the decline of welfare rolls does not translate into welfare recipients' success in finding jobs and achieving financial independence or a higher quality of life).

24. *See, e.g.*, JOEL BLAU & MIMI ABRAMOVITZ, THE DYNAMICS OF SOCIAL WELFARE POLICY Reference 43 (2d, ed. 2007).

25. *See, e.g.*, CHARLES NOBLE, WELFARE AS WE KNEW IT: A POLITICAL HISTORY OF THE AMERICAN WELFARE STATE 8 (1997) (reporting that as a percentage of GDP, the United States spent less than one third the amount its peers in the Organization for Economic Cooperation and Development (OECD) did for education, training and relocation services for displaced workers); *see also* HANS P. JOHNSON & SONYA M. TAFOYA, PUB. POLICY INST. OF CAL., THE BASIC SKILLS OF WELFARE RECIPIENTS: IMPLICATIONS FOR WELFARE REFORM VI-VII &19-23 (1999) (finding that "[w]elfare recipients have substantially lower basic skills than other adults . . . For

focus on job training and job creation. The 1996 reform's fatal flaw was that it failed to ensure that there were enough jobs paying a living wage available for those moving off welfare.[26] In fact, "almost one out of every four jobs—29.4 million—fails to keep families above poverty."[27]

It is thus not surprising that under PWORA, many former welfare recipients took jobs that made them worse off than before.[28]

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example, the average welfare recipient in California has difficulty following simple directions to perform a single mathematical operation (such as addition) using numbers easily located in the text.").

26. *See, e.g.*, FRANCES JULIA RIEMER, WORKING AT THE MARGINS: MOVING OFF WELFARE IN AMERICA 232 (2001) (finding that "[w]ithout an emphasis on good jobs, success in moving off welfare becomes a hollow phrase."); *see also*, Sandra K. Danziger & Sheldon Danziger, *Will Welfare Recipients Find Work When Welfare Ends?, in* WELFARE REFORM: AN ANALYSIS OF THE ISSUES 43 (Isabel V. Sawhill ed., 1995) (recounting that jobs are scarce: for example, in Harlem, there were fourteen applicants for each job opening filled at four fast food franchises, and seventy-five percent of rejected applicants continued to search for work but were unemployed a year later).

27. WORKING POOR FAMILIES PROJECT, STILL WORKING HARD, STILL FALLING SHORT 2 (2008), *available at* http://www.workingpoorfamilies.org/pdfs/NatReport08.pdf; *see also* HANS P. JOHNSON & SONYA M. TAFOYA, *supra* note 25, at 38 (finding that "[e]ven when persons with the basic skills and sociodemographic characteristics of welfare recipients do find work, their earnings often are not enough to lift them out of poverty. Over the course of an entire year, welfare counterparts in California who worked earned an average income of $12,400, and over half did not have sufficient earnings to life a family of three out of poverty.").

28. *See, e.g.*, MARIA CANCIAN ET AL., INSTITUTE FOR RESEARCH ON POVERTY, BEFORE AND AFTER TANF: THE ECONOMIC WELL-BEING OF WOMEN LEAVING WELFARE 13 & Tbl. 7 (2000) (finding that in Wisconsin, 63.7% of families had less income after leaving welfare and less than 4% were above 150% of the Federal Povery Level); *see also* Joel Wilgoren, *After Welfare, Working Poor Still Struggle, Report Finds*, N.Y. TIMES, Apr. 25, 2002 (discussing how across states, despite different approaches to welfare reform, consistent themes emerged. For example, "salaries below the federal poverty line of $14,630 for a family of three, and trouble paying routine bills were common." Additionally, "[h]alf the former recipients in some states said they were unable to buy food, pay rent or pay utility bills, and a similar number reported their phone service being cut off for more than 24 hours. Several studies found that 1 in 10 former recipients had been evicted or become homeless."); *but see* DAVID T. ELLWOOD, THE BROOKINGS INST., CHILDREN'S ROUNDTABLE REPORT NO. 2: THE PLIGHT OF THE WORKING POOR 2-3 & Fig. 3 (1999) (asserting that with the expansion of public benefits programs welfare reform should lead to families being better off and how by working "such a mother can now pull her family above the poverty line, if not far above it."). The theoretical modeling and calculation made by David Ellwood reflects his failure to account for the actual availability of jobs for current and former welfare recipients. *See, e.g.*, *supra* notes 21-27. It is thus not surprising that despite theoretical modeling showing that former welfare recipients should be better off under PRWORA, the majority are not. *See, e.g.*, *infra* notes 29-32.

Furthermore, while some former beneficiaries may have made more money than they were receiving on welfare, these jobs came with higher costs: Jobs often required long commutes, resulting in long hours, high transportation costs, and increased childcare costs. Coupled with the loss of benefits, many were worst off than before. *See, e.g.*, JOEL BLAU & MIMI ABRAMOVITZ, *supra* note 24, at Reference 43 (reporting, for example, that sociologists found "recipients spent an average of $876 a month, $311 more than they received from welfare and food stamps . . . When they secured a regular paying job, their income did rise to $1,243 a month, but

Families that have left welfare and are working still struggle to make ends meet: more than one quarter work mostly at night; over half struggle with arranging childcare; one-third skip meals or cut down the size of meals; and many have trouble with mortgage, utility, or rent payments.[29] Others go without shelter, food, or necessary medical care.[30] Thus, by most measures, it is clear that families leaving welfare face unrelenting financial pressures.

Overall, despite the apparent drop in welfare rolls, all of this data show that PWORA failed to address poverty. Rather, it simply did not improve people's standard of living.[31] A majority of these individuals lost critical benefits and were worse off than before the passage of PRWORA. The current recession has highlighted these

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unfortunately, by the time they totaled up the cost associated with working-clothing, transportation, and child care-their standard of living had actually declined."); *see also* JOEL BLAU & MIMI ABRAMOVITZ, *supra* note 24, at 296 ("Another group . . . represents the official 'successes.' These are the people who average about $7 an hour in the typical post-welfare job and with intermittent employment typically earn less than $10,000 annually. By the first standard, they are employed, productive citizens; by the second, they are still unquestionably poor. Furthermore, as they are now working harder outside the home, they may well be less able to raise a family and take care of their children. Indeed, in the aftermath of welfare reform, researchers have noticed a sudden spike of 600,000 more children (and 200,000 additional urban African American children) living in no-parent families.").

29. *See, e.g.*, PAMELA LOPREST, THE URBAN INST., HOW FAMILIES THAT LEFT WELFARE ARE DOING: A NATIONAL PICTURE 1 (New Federalism: Nat'l Survey of America's Families, Series No. B-1, 1999).

30. *See, e.g.*, JOEL BLAU & MIMI ABRAMOVITZ, *supra* note 24, at 296 ("Most studies have found two distinct groups of recipients who have left welfare. By any standard, one group has clearly done worse . . . In 1999, for example, 47 percent of the families that recently left welfare for full-time, full-year employment experience one or more critical hardships, such as going without food, shelter, or necessary medical care. Despite improving economic conditions of the late 1990s, this figure represents a 10 percent increase over just two years earlier."); *see also* Sheldon Danziger et al., *Does It Pay to Move from Welfare to Work?*, 21 J. OF POL'Y ANALYSIS & MGMT. 671 (2002) (finding that although families were less likely to go without food or shelter, they were more likely to go without needed medical care). Food insecurity has also dramatically increased. *See, e.g.*, ALVIN L. SCHORR, *supra* note 16, at 39 (according to the United States Conference of Mayors, there was an 18% and 17% increase in emergency food requests across the country in 1999 and 2000, respectively); *see also id.* (reporting that Second Harvest, the largest distributor of donated food in the United States, estimated that from 1997 to 2002, "there would be a shortfall of food equivalent of three meals a day for three million people for an entire year."); Food Research and Action Center, Food Hardship: A Closer Look at Hunger Data for the Nation, States, 100 MSAs, and Every Congressional District 3 (2010) (finding that the recent recession has only increased food insecurity, as "nearly one in five U.S. households has been struggling with hunger and inability to purchase needed food sometime over the past year [(2009)].

31. *See, e.g.* Peter Edelman & Barbara Ehrenreich, *Why Welfare Reform Has Failed*, THE WASHINGTON POST, Dec. 6, 2009, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/12/04/AR2009120402604.html (describing how caseloads have shrunk through discouraging enrollment using diversion without regard for actual need).

effects, as "the number of homeless Americans is up by 61 percent since the recession began in December 2007 [and] the number of people living in poverty increased by 2.5 million during the first year of the recession."[32]

III. CURRENT COORDINATION OF HEALTHCARE DELIVERY WITH THE SAFETY NET

With such fragmentation, it is not surprising that coordination should be a leading concern for American social policy today. "National commissions [have] identified the proliferation of uncoordinated programs as the sources of severe problems affecting the well-being of children, infant mortality, and the delivery of public assistance."[33] Given the negative impact fragmentation has on health,[34] healthcare reform cannot focus on coordination of medical care and ignore the rest of the safety net. Failure to integrate safety net services into healthcare delivery will cause healthcare reform to fail for our most vulnerable population.

A. The Role of Social Workers

Currently, the coordination of healthcare delivery with the rest of the safety net is rudimentary, often tenuously linked together through the social work staff in the healthcare setting.[35] Providers are acutely aware of social and socioeconomic problems at an

32. *Id*.

33. WELFARE SYSTEM REFORM, *supra* note 20, at 3.; *see also id.* at 4-5 (finding that "[t]he current operating practices also have high costs. Agencies perform redundant or overlapping tasks, offering similar services to the same target groups of beneficiaries. Layers of unnecessary bureaucracy move excessive paperwork. Computer systems do not communicate with each other. Commitment of funds to these administrative activities means fewer dollars allocated for aiding the disadvantaged.").

34. *See, e.g.*, Barry Zuckerman et al., *Medical-Legal Partnerships: Transforming Healthcare*, 372 THE LANCET 1615, 1615 (Nov. 8, 2008), *available at* http://www.medical-legalpartnership.org/sites/default/files/page/Medical-Legal%20Partnerships%20—%20Transforming%20Healthcare.pdf (finding that "safety nets are now so complex and unwieldy that many parts of the net are rendered inaccessible, and the disregard of laws and regulations, such as those to protect against unhealthy environments, can result in adverse effects on health.").

35. *See, e.g.*, Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 225 (Jul. 2004), *available at* http://pediatrics.aappublications.org/cgi/reprint/114/1/224 (explaining that "[t]raditionally, health care providers have turned to social workers and case managers to assist families with basic social needs. Social workers and case managers are the front-line experts in assessing family stability and finding appropriate community resources for low-income families . . . However, social workers and case managers sometimes have difficulty convincing programs to provide services to families or effectively addressing intended or unintended barriers to accessing social services.").

individual patient level, as the healthcare setting is where socioeconomic needs are incidentally identified by the healthcare provider.[36] The provider almost always automatically refers the patient to the social worker without further discussion[37] because the social worker is the traditional advocate for the non-biological needs of the patient.[38] Therefore, in most healthcare settings focused on serving the socioeconomically disadvantaged, the social work staff is over-extended.[39] Not surprisingly, many vulnerable patients fall through the cracks.

However, it should be noted that hiring additional social work staff without other changes is not a viable solution. Social workers can help ameliorate many socioeconomic problems by educating patients and helping them apply for public benefits programs. Nonetheless, patients still have to either make an extra trip to the

36. *See, e.g.*, *Id*. at 224-25 (discussing how social factors affect a child's health and how pediatricians come into contact with these problems); *see also* Barry Zuckerman et al., *From Principle to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCHIVES OF CHILD HEALTH 100, 100 (2007) [hereinafter *From Principle to Practice*] (asserting that "[w]hen evaluating and treating sick children, healthcare professionals frequently identify how inadequate food, hosing, safety, access to basic medication such as vaccines or other unmet basic needs contribute solely or partially to preventable medical illness and poor child health."). *Id*. (also asserting that "[d]octors and other healthcare providers are uniquely situated to intervene when children's basic needs are not being met. Not only do many children seen in child health settings for immunization and treatment of illness but also a focus on prevention includes identifying the non-medical determinants of child health . . . [T]he clinical is where medical providers routinely screen families for a variety of barriers to child health . . . . ").

37. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 224-25. (finding that many healthcare providers experience significant frustrations when they try to intervene with social problems and thus turn to social workers and case managers for assistance); *see also* Kevin Fiscella & Ronald M. Epstein, *So Much to Do, So Little Time: Care for the Socially Disadvantages and the 15-Minute Visit*, 160 ARCHIVES OF INTERNAL MED. 1843, 1843-45 (2008) (discussing the challenges of caring for socially disadvantaged patients under the traditional primary care model, as there is simply not enough time to address these issues); *From Principle to Practice*, *supra* note 36, at 100 (finding that "although child health professionals are often aware of the social context of the patients they serve, they generally do not have the capacity (knowledge, training, time, resources, etc) to effectively intervene in non-clinical arenas.").

38. *See, e.g.*, NAT'L ASSOC. OF SOCIAL WORKERS, NASW STANDARDS FOR SOCIAL WORK PRACTICE IN THE HEALTHCARE SETTING 20-23 (2005) (discussing social workers' role in addressing biopsychosocial, including the the sociocultural, sociopolitical, and socioeconomic issues in a patient's life through assessment, intervention and treatment planning, and case management).

39. *See, e.g.*, Fiona Jones et al., *Stressors and Strains Amongst Social Workers: Demands, Supports, Complaints, and Psychological Health*, 21 BRIT. J. SOC. WORK 443, 451-53 (1991) (finding that 99% of social workers surveyed found their job to be high pressure and that 74% responded that they had more work than they had time to do); *see also* Interview with Bryna Pauker, Social Worker, Hospital of St. Raphael, in New Haven, Conn. (Oct. 5, 2007) (confirming that the social work staff is overextended as they are called for any non-biologic problem encountered by the medical staff).

Department of Social Services (DSS) office to drop off the application or mail the application and await a response. This delays when the eligible individual can begin receiving benefits. Because benefits are important to a patient's health, it is crucial to have no delays in this process.[40]

B. Current Federal Outstationing Requirements: 42 U.S.C. § 1396a(a)(55) & 42 C.F.R. § 435.904

1. The Role of Outstationed Workers

Outstationed workers should be able to help with safety net coordination. Federal law requires outstationed DSS workers to "provide for receipt and initial processing of Medicaid applications from the designated eligibility groups at each outstation location,"[41] including Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals (DSH Hospitals).[42]

Outstationed DSS workers must help individuals complete the application, provide information about the application, obtain the required documentation to complete the application, and ensure that the application is complete.[43] On-site staff may, but do not have to, evaluate the application to determine eligibility.[44]

Currently, many states do not allow outstationed workers to process applications on-site; instead, these workers are there only for application assistance.[45] Moreover, most outstationed workers only conduct outreach or eligibility determinations for Medicaid and the State Children's Health Insurance Program (SCHIP) instead of for a broader range of safety net programs, despite the fact that DSS administers all of these programs.[46]

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40. *See, e.g.*, David R. Williams et al., *supra* note 6.

41. 42 C.F.R. § 435.904(d)(1) (2009); *see also* 42 U.S.C. § 1396a(a)(55) (2009).

42. 42 U.S.C. § 1396a(a)(55) (2009); 42 C.F.R. § 435.904 (2009).

43. 42 C.F.R. § 435.904(d)(2) (2009).

44. *Id*. at § 435.904(d)(3).

45. *Id*. at §§ 435.904(d)(2)-(3); *see also* Barbara E. Riley, Medicaid Eligibility Manual Transmittal Letter No. 27, §5101:1-38-04(C)(2) (Nov. 30, 2005) (providing instructions for outstationed workers who only assist with initial application processing and do not determine Medicaid eligibility) (on file with author).

46. *See, e.g.*, JULIE DARNELL & CHARLES NAGATOSHI, *supra* note 16, at xiii (relating how in Connecticut, DSS officials faced many problems in effectively promoting participation in Medicaid and food stamps together, as they faced "problems related to mixed messages about public assistance programs, diminishing resources, inconsistencies between state policy and the management information system, and lack of integration of computer systems supporting various

2. Outstationing is Not Happening

Despite the federal requirement for outstationing, a study looking at actual placements at FQHCs seven years after the passage of this legislation found that only 57 percent of these centers engaged in outstationing.[47] Another study showed that although three-quarters of DSH hospitals were aware of this requirement, only 79 percent of those three-quarters had outstationed workers.[48] These numbers clearly show that many of the FQHCs, DSH hospitals, and states ignore this legal mandate, meaning patients must go one place for healthcare services and another to apply for healthcare coverage. This results in an unnecessary and illegal fragmentation of the safety net as a result of poor enforcement of existing law.

IV. WHY DOES SAFETY NET COORDINATION MATTER? THE IMPACT OF SOCIOECONOMIC, LEGAL, AND ENVIRONMENTAL FACTORS ON HEALTH

If the socioeconomic determinants of health—socioeconomic, legal, and environmental factors—had little to no impact on health, it would not matter whether healthcare professionals cared or learned about these interventions. However, evidence indicates otherwise, because these factors have a significant impact on health and health outcomes.[49] By overlooking or ignoring these factors, healthcare professionals fail to look at their patients holistically. As a result, they cannot provide their patients the most appropriate medical treatment.

Traditionally, most socioeconomic determinants of health—ranging from providing adequate nutrition to ensuring safe neighborhoods—fell outside the scope of medical consideration and

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programs.").

47. Sarah Rosenbaum et al., *Medicaid Outstationing Enrollment Activities at Federally Qualified Health Centers: A Progress Report Seven Years After Enactment of Federal Law*, ABSTR. BOOK ASSOC. HEALTH SERV. RES. MTNG. 15: 140 (1998).

48. NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., STRATEGIES TO OPTIMIZE HOSPITAL MEDICAID ENROLLMENT: A BACKGROUND PAPER 11-12 (2000).

49. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 224; *see also* Nancy Adler et al., *Socioeconomic Inequalities in Health: No Easy Solution*, 269 JAMA 3140, 3140-41 (1993); Nancy Adler et al., *Socioeconomic Status and Health: The Challenge of the Gradient*, 49 AM. PSYCHOLOGIST 15 (1994); Jonathan S. Feinstein, *The Relationship Between Socioeconomic Status and Health: A Review of the Literature*, 71 THE MILBANK Q. 279 (1993); Randye Retkin et al., *supra* note 6, at 29 & notes 5-10 (explaining that the "connection between socioeconomic status and health outcomes is well-established."). *See generally, e.g.*, David R. Williams et al., *supra* note 6.

intervention. Instead, separate public programs were created to address these concerns from the perspective of fighting poverty and social decay. With the advent of the medical home[50] and medical legal community partnerships,[51] medicine is starting to take a closer look at the socioeconomic determinants of health.

Safety net programs address many of the socioeconomic determinants of health. A few examples will be highlighted here to illustrate the link between the socioeconomic determinants of health, safety net programs, and health outcomes.

A. Health Insurance

The most obvious of these factors linked to health is health insurance. For example, a Kaiser Family Foundation study found that "Medicaid enrolled children have better access to health services and are more likely to use these services than eligible uninsured children."[52] This finding is logical and expected.

The figures from this Kaiser study detail why health insurance coverage is so important, especially for children: compared to those enrolled in Medicaid, the eligible uninsured had a 25 percent higher chance of postponing care because of cost (41 to 16 percent), 13 percent higher chance of not filling a prescription because of cost (26 to 13 percent), and a 21 percent lower chance of having a well-child visit in the previous year (61 to 82 percent).[53] Additionally, uninsured children are six times less likely to have a usual source of care (24 to 4 percent).[54]

Uninsured children's lack of access to care is problematic, as these children will be sicker, have a lower quality of life, and place a greater burden on the healthcare system.[55] More alarming, however, is that uninsured children are also three times more likely to go

50. *See, e.g.*, Kevin Fiscella & Ronald M. Epstein, *supra* note 37, at 1846-47 (discussing the use of the patient-centered medical home to begin addressing the needs of socially disadvantaged patients).

51. *See, e.g.*, Barry Zuckerman et al., *supra* note 35 (introducing the idea of medical legal partnerships as a method of addressing the socioeconomic determinants of health).

52. MICHAEL PERRY ET AL., THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND CHILDREN OVERCOMING BARRIERS TO ENROLLMENT FINDINGS FROM A NATIONAL SURVEY 4 (2000).

53. *Id*. at Fig.2.

54. Paul W. Newacheck et al., *Health Insurance and Access to Primary Care for Children*, 338 NEW ENG. J. MED. 513, 515 (1998).

55. *See, e.g.*, PAMELA FARLEY SHORT ET AL., *supra* note 7, at 2.

without at least one needed service (22 to 6 percent) and six times as likely to go without needed medical care (6 to 1 percent).[56] Delaying medically necessary care has, unsurprisingly, a negative impact on health.

B. Food Insecurity & Housing

Health insurance is not the sole socioeconomic determinant of health. Food insecurity and housing instability are also large barriers to health among lower-income Americans. For example, one study found that both were associated with postponing needed health care and medications.[57] Both were also associated with increased emergency room (ER) usage and hospitalizations, indicators of poorer access to health and poorer health, respectively.[58] Additionally, housing instability was associated with poor access to care, as measured by not having a usual source of care.[59]

Food insecurity also leads to malnutrition. It is well documented that malnutrition has adverse effects on health. For example, one study showed that food insecurity is associated with increased hospitalization in infants and toddlers, with a dose-response relationship between the level of food insecurity and fair/poor health.[60] The same study showed that food stamps attenuated the link between food insecurity and poor health.[61]

Similarly, poor housing conditions have been linked to aggravations of asthma and other respiratory diseases, skin ailments, and other medical problems.[62] Greater housing insecurity also increases ER usage and lower overall health care utilization.[63]

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56. Paul W. Newacheck et al., *supra* note 54, at 515.

57. *See, e.g.*, Margot B. Kushel et al., *Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans*, 21 J. GEN. INTERNAL MED. 71, 74 (2006). Although this study does not prove that these factors cause poor health, it builds upon earlier studies that do.

58. *Id*. at 74-75.

59. *Id*. at 74.

60. *See, e.g.*, John T. Cook, *Food Insecurity is Associated with Adverse Health Outcomes Among Human Infants and Toddlers*, 134 J. NUTRITION 1432 (2004) . *See generally* Joseph R. Sharkey, *Risk and Presence of Food Insufficiency Are Associated with Low Nutrient Intakes and Multimorbidity among Homebound Older Women Who Receive Home-Delivered Meals*, 133 J. NUTRITION 3485 (2003).

61. *See, e.g.*, John T. Cook, *supra* note 60, at 1436.

62. *See* Barry Zuckerman et al., *supra* note 35, at 224.

63. *See, e.g.*, Thomas P. O'Toole, *Utilization of Health Care Services among Subgroups of Urban Homeless and Housed Poor*, 24 J. HEALTH POL. POL'Y & LAW 91, 102 (1999); *see also*

Overall, these findings help explain why food insecurity and housing instability lead to poorer health outcomes.

C. Income Support

By definition, lack of financial resources makes an individual poor. As already established, poverty leads to poor health outcomes because socioeconomic factors affect health outcomes.[64] Therefore, it should not be a surprise that many studies have shown that income support programs, which are intended to ameliorate the effects of poverty,[65] improve health outcomes.[66] These programs are the safety net programs previously discussed and include both social insurance programs, such as Social Security and unemployment insurance, as well as means-tested programs, such as TANF, SSI, food stamps, Earned Income Tax Credit (EITC), and housing subsidies.[67]

D. The Need for Coordination

The significant impact that these socioeconomic factors have on health point to the importance of safety net services, which address many of these factors. As a result of PRWORA, there is a large population eligible for public benefits that is not currently enrolled.[68] It is thus essential that these safety net services be coordinated for patients to improve health outcomes. How should this coordination be done?

V. A PROPOSAL FOR COORDINATION: REMODELING THE MEDICAL HOME – AN INTEGRATION OF SERVICES

Commercial vendors have responded to consumers' demands for convenience: shopping malls, banks in supermarkets and mini-marts at gas stations. The key feature of these services is that although

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David Wood & R. Burciaga Valedez, *Barriers to Medical Care for Homeless Families Compared with Housed Poor Families*, 145 AM. J. DIS. CHILD 1109. *But see* Lisa M. Duchon et al., *The Relationship of Residential Instability to Medical Care Utilization Among Poor Mothers in New York City*, 37 MED. CARE 1282 (1999).

64. *See generally* David R. Williams et al., *supra* note 6.

65. *See, e.g.*, ARLOC SHERMAN, CTR. ON BUDGET POL'Y AND PRIORITIES, PUBLIC BENEFITS: EASING POVERTY AND ENSURING MEDICAL COVERAGE 2-3 (2005) (finding that public income support cuts poverty nearly in half).

66. *See, e.g, id*. at 812-14 (discussing how various income support programs in the United States and around the world have led to better health outcomes).

67. *See, e.g.*, ARLOC SHERMAN, *supra* note 65, at 2.

68. *See, e.g.*, *supra* notes 16-19.

often ostensibly unrelated, they are co-located, allowing for one-stop shopping. Given that safety net services are theoretically intended to help those in need, they should be co-located with other needed services to allow for one-stop shopping. Since these services have a direct impact on health outcomes, they should be available at healthcare facilities.

A. Beyond Simple One-Stop Shopping: Integration

Co-locating the delivery of public benefits with the provision of healthcare by placing DSS workers who administer safety net services at DSH Hospitals and FQHCs is logical, because it allows healthcare providers to directly refer patients who need these services to an on-site specialist for any identified social problems.[69] In effect, it would make physicians ask about the socioeconomic determinants of health more routinely because they would feel empowered to address them directly and effectively.[70] In this way, both the social service agency and the healthcare team involved in a patient's care could work together to view that patient holistically.

Healthcare teams could then look beyond the traditional biological causes and pharmacological remedies to the underlying socioeconomic, legal, and environmental problems that are either causing or aggravating a patient's symptoms.[71] In doing so, they can design a treatment plan that incorporates the available social supports that allow a patient to be treated in the context of his or her community as opposed to an individual who has a malfunctioning biological process.

This co-location of services, coupled with a truly coordinated and working relationship between the healthcare and social services staffs, is an integration of the delivery of safety net services with the provision of healthcare. It moves beyond simply co-locating services,[72] as implemented by Medicaid outstationing, TANF's one-

69. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 225.

70. *Id*.

71. *See, e.g.*, James Krieger & Donna L. Higgens, *Housing and Health: Time Again for Public Health Action*, 92 PUB. HEALTH MATTERS 758, 758-60 (May 2002) (detailing how housing affects health).

72. *See, e.g.*, CHAUCEY LENNON ET AL., IMPROVING ACCESS TO PUBLIC BENEFITS HELPING ELIGIBLE INDIVIDUALS AND FAMILIES GET THE INCOME SUPPORTS THEY NEED 9 (2009) (citing the "One-Stop" model as an effective way to increase access to public benefits and social supports).

stop shopping work programs,[73] Delaware's State Service Centers,[74] and SingleStop's one-stop benefits programs.[75] It also goes beyond creating a coordinated, linked referral process.[76] Instead, integration makes the DSS staff part of the healthcare team. In effect, it re-models the patient centered medical home to include not only health care providers,[77] but also social service providers.[78] In doing so, it creates the relationships necessary to improve patient care and patient health outcomes by allowing patients to immediately enroll in safety net programs that both address immediate needs and have a longer term preventive effect.

B. Does Health Reform Support Re-Modeling the Medical Home?

The Patient Protection and Affordable Care Act,[79] discusses the creation of patient centered medical homes.[80] These medical homes are staffed by "an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary[.]"[81] If one reads the following "may"[82] as simply suggesting but not limiting members of

73. *See, e.g.*, THE NAT'L COMM'N. TO PREVENT INFANT MORTALITY, ONE-STOP SHOPPING: THE ROAD TO HEALTHY MOTHERS AND CHILDREN 13 (1991) (explaining that these one-stop centers are created to "accommodate the needs of pregnant women and their families, rather than leaving them to navigate through a maze of forms and services.").

74. *See, e.g.*, *Id* at 35; State of Delaware, Division for State Service Centers, http://www.dhss.delaware.gov/dssc/ (last visited Apr. 15, 2010).

75. *See, e.g.*, Elisabeth Mason & Julie Kashen, *supra* note 4, at 27-28 (describing the SingleStop model); *see also* Single Stop Shop, http://www.singlestopusa.com/ (last visited Apr. 15, 2010).

76. KINDA SERAFI & ANNE MARIE COSTELLO, CHILDREN'S DEF. FUND, COORDINATING NEW YORK'S MEDICAID AND FOOD STAMP PROGRAMS, MAKING IT EASIER FOR FAMILIES TO ACCESS THE BENEFITS THEY NEED 18 (2006) (describing a community based location for both health insurance enrollment and food stamp pre-screening as a more efficient option).

77. *See, e.g.*, Patient Protection and Affordable Care Act, *supra* note 1, at § 3502(b)(4) (defining the health team as an "interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.").

78. By extension, one could also argue that a lawyer should also be included in the re-modeled medical home, as lawyers can work very effectively as part of the healthcare team to address the socioeconomic determinants of health. *See, e.g.*, Barry Zuckerman et al., *supra* note 35. However, such a discussion is beyond the scope of this paper.

79. Patient Protection and Affordable Care Act, *supra* note 1.

80. *Id*. at § 3502 et seq. ("such team may include . . .").

81. *Id*. at § 3502(b)(4).

82. *Id*.

the medical home, a strong argument could be made for re-modeling the conventional conception of the medical home to include members from social service agencies.[83] However, even if one were to take a more restrictive reading of the "may"[84] as permissive but limiting, a strong argument could still be made for including members from social service agencies under the enumerated category of "social workers."[85]

Re-modeling the medical home is thus supported by the recently passed healthcare reform bill. It also builds upon current Medicaid law, which requires an eligibility worker be placed, or outstationed at FQHCs and DSHs.[86]

Re-modeling the medical home is patient-client centered, and has the goal of encouraging those who have a need to apply for and receive assistance. It champions individual need and strives to meet these needs through fully utilizing existing public benefits programs to improve healthcare outcomes. It coordinates care for both the purpose of preventive care and chronic disease management by integrating healthcare delivery with access to traditionally community-based safety net benefits. In doing so, the purpose and goals of incorporating workers from social service agencies are entirely with consistent the charge to medical home health teams as delineated by the Act:[87] by law, health teams must have a whole person orientation; provide coordinated and integrated care; expand access to care; collaborate with existing State and community based resources to coordinate disease prevention, chronic disease management; develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients; and serve as a liaison to community prevention and treatment programs.[88]

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83. Again, under such a reading the author would strongly advocate for lawyers to be included.

84. *See* Patient Protection and Affordable Care Act, *supra* note 1, at § 3502 et seq.

85. *Id*. at § 3502(b)(4).

86. *See* 42 U.S.C. § 1396a(a)(55) (2009); 42 C.F.R. § 435.904 (2009).

87. *See* Patient Protection and Affordable Care Act, *supra* note 1, at § 3502(c) et seq.

88. *Id*.

C. The Philosophical Underpinnings of Re-Modeling

1. Principles Motivating Integration

Re-modeling the medical home to integrate safety net benefits reflects a client-centered approach, creating synergy by allowing experts to take a holistic view of their client-patient's problems. It educates, empowers, and expands the healthcare team, allowing its members to better treat their client-patient by allowing them to assess the family holistically and then help the family apply for the appropriate social services, if appropriate. At the same time, this client-patient centered approach reduces both travel and waiting times, by co-locating these other services within a healthcare facility.

However, integration extends beyond merely making life easier or simpler for those families who need these benefits. Ease of application for safety net benefits determines whether an individual will actually receive and benefit at all from these programs.[89] Given the serious impact that socioeconomic, legal, and environmental factors have on healthcare outcomes,[90] integration is designed to maximize participation in public benefits programs.

Since families theoretically see providers on a regular basis and would at least see providers in a time of a health crisis, the healthcare setting makes sense as a point of contact for these families. Additionally, since those with lower socio-economic status have worse health outcomes, they may be more likely to be seen in the healthcare setting. Re-modeling the medical home thus ensures that those who need social supports the most would be captured by integration.

Furthermore, an integrated referral process would create a user-friendly environment for the client that de-stigmatizes the benefits, as they are recommended, and potentially even "prescribed" by a healthcare professional. Finally, integration saves overhead and operating expenses by allowing these experts to share a common space and support services. Thus, more money can be focused on client-patient services.

2. A Conceptual Shift Away from the

89. *See, e.g.*, CHAUCEY LENNON ET AL., *supra* note 72, at 3 (reporting that billions of potential dollars in public benefits programs are either unused or unclaimed).

90. *See supra* Part IV.

Historic Outlook on Public Benefits

Re-modeling the medical home to allow for integration does not intrinsically judge the value of public benefits programs or whether individuals are worthy of receiving them. Instead, it allows healthcare providers to work within existing laws and with established programs to "prescribe" another remedy for a patient to improve that patient's health outcome.

Unfortunately, in today's complex administrative state, success seems to be measured by reducing enrollment in public benefit programs rather than counting how many individuals and families are actually helped.[91] Adopting an integration of services in any setting, including the healthcare setting, thus requires a shift in ideology, from "undeserving poor"[92] to "harm reduction."

Harm reduction is a concept popularized in needle exchange programs that refrains from judging individuals, but instead meets individuals where they are at to reduce the harm they otherwise would suffer as a result of their condition.[93] Harm reduction programs are often used where individuals have a perceived, but not a real, choice over their condition because of other factors.[94]

In many senses, applying the concept of harm reduction to accessing public benefits is ideal, as it dispels the current perception that poverty is a choice. In using such an approach, it may lead to a normalization of poverty to the extent that the blame moves from the impoverished individual to societal factors not within the individual's control. This would then result in a very different

91. *See, e.g.*, *supra* Part II.B; *see also* Robert Rector, Statement Before the Committee on Ways and Means United States House of Representatives (Jul. 19, 2006) *available at* http://www.heritage.org/Research/Testimony/The-Impact-of-Welfare-Reform (citing as part of PRWORA's success the decrease of welfare caseloads from 4.3 million families to 1.89 million).

92. It should be noted that the United States treats its poor much less generously than other countries: "as a proportion of the average production worker's wages, the value of all benefits available to single-parent families is 222% higher in Sweden than in the United States, 184% higher in the Netherlands, and 41% higher in Austria." CHARLES NOBLE, *supra* note 25, at 8.

93. *See, e.g.*, Al Leshner, *By Now, "Harm Reduction" Harms Both Science and Public Health*, 83 CLINICAL PHARMACOLOGY & THERAPEUTICS 513, 513-14 (2008) ("[T]he Harm Reduction Coalition . . . defines it as a 'set of practical strategies that reduce negative consequences of drug use. . . .Harm reduction strategies meet drug users 'where they're at.''").

94. *See, e.g.*, *id*. at 514 (quoting Congressman Mark Souder of Indiana as saying that harm reduction is "an ideological position that assumes certain individuals are incapable of making healthy decisions . . . and that dangerous behaviors, such as drug abuse, therefore simply must be accepted by society and those who choose such lifestyles . . . should be enabled to continue these behaviors . . . Often, however, these lifestyles are the result of addiction, mental illness, or other conditions that should and can be treated rather than accepted as normal, healthy behaviors.").

perception of safety net programs.

Furthermore, it should be noted that living on welfare is a far cry from what some critics view as a comfortable, if not a lucrative existence.[95] Additionally, very few poor families with young children rely exclusively on public assistance: 59.6 percent (1,272,000) have earnings but no public assistance, 15.4 percent (328,000) are on both public assistance and earnings, 14.2 percent (302,000) live without earnings or public assistance, and only 10.9 percent (232,000) are on public assistance but no earnings.[96]

Many individuals choose to stay on public assistance not out of laziness or a desire for a free ride but rather because the alternate options are simply untenable. These individuals simply cannot find jobs that will make ends meet.[97] Although their gross income may be higher after taking a low paying job, many of these individuals find that they are actually worse off after deducting transportation expenses and losing healthcare coverage.[98] This problem is a systemic one that requires a hard look at job training programs, the availability of suitable jobs with a living wage, and other such factors beyond the scope of this article.[99]

Finally, even if one feels that poor individuals are truly undeserving, the goal should not be to decrease access to public benefits by arguing against re-modeling the medical home to support the integration of safety net benefits. It does not make sense to pass a program assisting individuals in need and then spend the approved funding on throwing up barriers to accessing these benefits. These funds should be used to facilitate access to public benefits programs.

If one finds these individuals undeserving, one should be focused on cutting back the eligibility levels for these programs or getting rid of them entirely, and not on denying access once the program is implemented. Throwing up barriers to accessing these programs is simply a waste of tax dollars and creation of unnecessary government bureaucracy.

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95. *See, e.g.*, JASON DEPARLE, AMERICAN DREAM 283 (2004).

96. JOEL BLAU & MIMI ABRAMOVITZ, *supra* note 24, at 295.

97. *See supra* Part II.B; *see also* ALVIN L. SCHORR, *supra* note 16, at 31-33.

98. *See, e.g.*, JASON DEPARLE, *supra* note 95, at 283-84; KENNETH J. NEUBECK, *supra* note 13, at 49-52 (giving both examples of such cases as well as aggregate statistics for all those affected by these changes).

99. *See, e.g.*, *supra* notes 25-27.

3. Benefits for Patients

For client-patients/potential beneficiaries, integrated benefits delivery overcomes several barriers. First, it avoids the stigma of going to a DSS or other public benefit agency's office.[100] Second, it both saves time and avoids transportation complications.[101] Third, it allows for advocates to work directly with the eligibility workers to ensure optimal outcomes for patients' health. Furthermore, proper prevention avoids costly and unnecessary emergency care and hospitalizations, resulting in a net savings for both patients and the system as a whole.[102]

D. How Does A Client-Patient Enroll for the Appropriate Benefits?

1. An Overview of the Integrated Process

From the medical perspective, re-modeling the medical home to integrate safety net benefits with healthcare delivery involves a seamless referral system facilitating enrollment for benefits and receipt of benefits. Upon identifying a socio-economic need, the healthcare team would refer the individual to an on-site eligibility worker for enrollment into the appropriate public benefits program. Of course, the healthcare team would provide the necessary medical documentation.

A social worker would work with the eligibility worker, the healthcare team, and the beneficiary to ensure proper enrollment into the identified public benefits programs. Enrollment not only addresses immediate, emergent needs, but also has a preventive health effect by providing the patient-client with benefits that impact long-term health outcomes. Such a system not only allows for these referrals to become a tool for the medical provider, but also makes a patient's application for safety net programs much easier, thereby

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100. *See, e.g.*, GENEVIEVE KENNEY & JENNIFER HALEY, THE URBAN INSTITUTE, WHY AREN'T MORE UNINSURED CHILDREN ENROLLED IN MEDICAID OR SCHIP? 4 (2001); MICHAEL PERRY ET AL., *supra* note 52, at 14.

101. MICHAEL PERRY ET AL., *supra* note 52, at Tbl.1 (finding that 35% of respondents did not apply because they had trouble with transportation).

102. *See, e.g.*, Margot B. Kushel et al., *supra* note 57, at 74-5; *see also* Anna Aizer & Jeffrey Grogger, *Parental Medicaid Expansions and Health Insurance Coverage*, (Nat'l Bureau of Econ. Research, Working Paper No. 9907) (2003), *available at* http://www.nber.org/papers/w9907 (finding that the increase in Medicaid coverage led to fewer preventable hospitalizations among eligible children).

lowering the transaction costs of applying for these benefits.[103]

2. Immediate Eligibility Determination & Presumptive Eligibility

Under the regime of a re-modeled medical home, DSS would continue to outstation eligibility workers at DSH hospitals and FQHCs. DSS staff would be trained so that they are knowledgeable and able to assist individuals who are applying for all the safety net programs that are offered, instead of only Medicaid.[104] This way, one interview can be conducted to determine eligibly for all of the benefits.[105] Ideally, a single application could also be filled out for all of these programs.[106]

However, information and help in completing the application is not enough. Many of those referred to the program would be under many stressors and timing will have an important effect on their health.[107] Thus, the law or its implementing regulations should mandate that on-site workers make an immediate eligibility determination.

In the past, such a determination was difficult, as clients at the outstation often did not have all the information DSS workers needed.[108] However, in today's electronic world, with the aid of a

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103. *See, e.g.*, THOMAS Z. FREEMAN & MICHAEL WEINSTEIN, THE NEW DEMOCRATIC LEADERSHIP COUNCIL, HELPING AMERICANS HELP THEMSELVES: TOWARD A NATIONAL SINGLE STOP POLICY AND MORE EFFICIENT, MORE EFFECTIVE POVERTY FIGHTING 6-8 (Mar. 2010) (discussing the barriers preventing access to public benefits).

104. This is not difficult and has been done in the past. Variations are becoming increasingly prevalent. *See, e.g.*, KATHLEEN MALLOY ET AL., MATHEMATICA POL'Y RESEARCH, INC., STATE OF INDIANA: STRATEGIES FOR IMPROVING FOOD STAMP, MEDICAID, AND SCHIP PARTICIPATION xii-xiii, 28-29 (2001) (reporting that Indiana used "integrated caseworkers" who were trained to understand eligibility requirements, application process, and benefits structure of Medicaid/SCHIP, food stamps, and TANF who could then conduct a combined interview for all the programs together. This offers a sort of "one-stop shopping" for all of these benefits.); Elisabeth Mason & Julie Kashen, *supra* note 4, at 27-28 (describing the SingleStop model where a non-profit helps clients apply for various public benefits programs during one visit); Social Interest Solutions, California: One-e-app, https://www.socialinterest.org/solutions.aspx?lm_linkid=2_6# (last visited Apr. 16, 2010) (describing a system that screens for a wide variety of public benefits programs in California).

105. *See* KATHLEEN MALLOY ET AL., *supra* note 104.

106. *See, e.g.* Social Interest Solutions, California: One-e-app *supra* note 104.

107. *See, e.g.*, KATIE PARKER COHEN, *supra* note 5, at 4 (asserting that "Medicaid eligible clients typically enter the FQHC at a time a need for healthy services arises.").

108. *See, e.g.*, 100% CAMPAIGN, MODERNIZING ENROLLMENT THROUGH PAPERLESS INCOME VERIFICATION: *A SMART APPROACH TO COVERING MORE UNINSURED CHILDREN ELIGIBLE FOR MEDI-CAL AND HEALTHY FAMILIES* 1 (OCT. 2004) (reporting that 68% of applications come to Healthy families with missing information).

computer connected to the central DSS database via the internet, making an eligibility determination should not be difficult, as much information can be obtained from electronic systems.[109] If all the necessary information were available, the DSS worker should be legally required to make an immediate decision about the case.

If all of the necessary information were not available, an immediate decision should be made utilizing a modified presumptive eligibility regime. This means that the DSS worker should be required to make an initial determination based upon a simple application supplemented by an on-site interview and signed affidavit about income, assets, and residency. If the income, assets, and residency requirements appear to be met, then the DSS worker should find the applicant presumptively eligible. The necessary information then could be verified later through a more comprehensive electronic search of state and federal databases.[110] For those whom electronic verification is not available, benefits would be continued with a stipulation that the necessary documentation be submitted within sixty days in person or by mail.[111]

The benefit of such a system would be to allow needs to be met

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109. Previously, lack of such a linkage was a huge barrier for allowing outstationed DSS workers to make eligibility determinations on-site. However, this was at the turn of the century. Today, with new computer systems and high-speed internet readily available, such a task should be relatively easy. *See, e.g. id*. (discussing paperless enrollment strategies); LEGISLATIVE ANALYST'S OFFICE, *supra* note 5, (discussing how current automation systems in California do "not fully harness currently available technology (such as the scanning of documents needed to verify program availability and allowing applicants to submit such information via the Web.)"); *see also* KATHLEEN MALLOY ET AL., *supra* note 104 (reporting that the "lynchpin to Connecticut's public assistance system is the Eligibility Management System (the EMS). Installed in 1989 and substantially upgraded since, the EMS supports the state's TFA, Food Stamp, and Medicaid (HUSKY A) programs, in addition to other assistance program. For these programs, the EMS completes eligibility calculations; generates alerts, notices, and letters; takes actions at prescribed times; produces management reports; calculates overpayments and tracks their collection; generates EBT and HUSKY cards; and interfaces with CitiBank to update clients' cash assistance and food stamp accounts. Using the EMS, the eligibility workers are able to process applications and redeterminations for the different programs, individually or simultaneously."); ROBIN DION ET AL., MATHEMATICA POL'Y RESEARCH, INC., STATE OF MAINE: STRATEGIES FOR IMPROVING FOOD STAMP, MEDICAID, AND SCHIP PARTICIPATION FINAL REPORT 10 (Dec. 2000) (reporting that Maine uses a computer system where all of the data collected from the client to help make an eligibility determination).

110. *See, e.g.*, DANIELLE HOLAHAN & ELISE HUBERT, UNITED HOSP. FUND OF NY, LESSONS FROM STATES WITH SELF-DECLARATION OF INCOME POLICIES 3 (Sept. 2, 2004), *available at* http://www.uhfnyc.org/publications/237565 (finding that "[e]leven of the 12 states surveyed conducted procedures to verify self-reported income information using a combination of federal and state databases available to state agencies.").

111. *But see id*. at 6-9 (finding that higher error rates occurred when income verification was done after an eligibility determination).

immediately if the patient appears to be eligible. This avoids unnecessary, preventable harm to the patient's health[112] by allowing enrollment at the time of referral with verification afterwards. Of course, if a participant were deemed to have grossly misrepresented his or her financial situation, reimbursement would be required and penalties would ensue.[113] These penalties could be both financial and criminal. However, the purpose of the penalty is not to deter those at the margin from applying. Thus, those within a certain income range, even if later deemed ineligible, should be allowed to keep those benefits without penalty. This line of reasoning reflects a reversal from the traditional American reasoning behind welfare and public benefits. It errs on the side of helping the needy individual, as deemed by a medical expert, instead of focusing excessively on fraud prevention.

The availability of mail-in applications and renewals would not be eliminated.[114] Instead, an integration of the delivery of public benefits with the provision of healthcare is an additional way for individuals to enroll in the appropriate public benefits programs. By being properly trained and equipped, these DSS eligibility workers would ensure that the delivery of public benefits is integrated into the healthcare setting and the practice of medicine. They can be comprehensive resources for not only beneficiaries but also providers.

E. Nuts & Bolts: How to Re-Model the Medical Home

This section looks at how safety net services would be integrated

112. *See, e.g.*, *supra* note 107 (finding that Medicaid eligible clients usually arrive at FQHCs when they have medical needs).

113. From states that do allow for self-declaration of income, error rates appear to be low if proper procedures are in place. *See, e.g.*, HEALTH MGMT. ASSOCS., SELF-DECLARATION OF INCOME OPTIONS FOR CALIFORNIA 5-6 (MAY 2006) (finding that Arkansas, Connecticut, Georgia, Michigan, and Wisconsin have all implemented a self-declaration of income policy successfully); *see also* DANIELLE HOLAHAN & ELISE HUBERT, *supra* note 110, at 6-8 (finding low error rates existed for most states that offered self-declaration and that higher error rates only occurred when income verification was done after an eligibility determination or no third-party income verification was done.").

114. Mail-in application and renewals present an unseen barrier. For example, in Missouri where there are high illiteracy rates, mailings do little good; there is need for more face-to-face outreach and application assistance. CITIZENS FOR MISSOURI'S CHILDREN, *supra* note 17, at 13. Outstationing at hospitals and clinics allow for more face-to-face outreach and application assistance. Other suggested outstationing locations include CBO offices, schools, Head Start programs, early childhood programs and childcare agencies, WIC clinics, family resource centers and churches. *Id*. at 15-16.

into the medical home.

1. Included Public Benefits Programs

Public health insurance (Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare); food stamps; cash assistance (TANF, General Relief (GR), unemployment insurance (EDD), State Disability Insurance (SDI), Supplemental Security Income (SSI), and Title II Benefits (OSDI)); Women, Infants, and Children (WIC); and childcare programs[115] all should be available through DSS workers in the re-modeled medical home.[116] As previously discussed, these benefits have a direct impact on health outcomes.[117] The goal is to enroll and keep individuals and families in these programs as long as they are eligible through the re-modeled medical home.

Housing is also a major concern. However, unlike these other public benefit programs, housing assistance in California is extremely limited, leading to long waiting lists. Outstationing housing authority workers or deputizing DSS workers after they have received proper training would still cut down on transaction costs for patients. However, the ability to offer immediate assistance would be much more limited, unless more funding is pumped into housing assistance programs.[118]

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115. Childcare is a vital and underutilized resource. *See, e.g.*, David Super, Public Welfare Law 4 (2006) (unpublished coursepack, on file with author and on Blackboard) ("During TANF's first five years, many states failed to spend their block grant monies and, in particular, failed to provide enough day care. Ten hours of additional work will further strain this limited day care capacity, especially as states seeking to meet the caseload workfare quota may be forced to shift money out of day care and invest it in make-work programs."); Marcia K. Meyers & T. Heintze, *The Performance of the Child Care Subsidy System: Target Efficiency, Coverage Adequacy, and Equity*, 73 SOC. SERV. REV. 34, 54 (1999) (noting that smaller public benefits programs such as child care for working parents often have lower uptake because qualified individuals are not aware about them). Childcare can be especially crucial during a time of crisis such as an illness. Making this benefit available through the healthcare setting may alleviate strains upon the family and should be made available on a temporary basis, as defined by a period of illness. Of course families that would otherwise qualify because of work should have this benefit extended on a permanent basis.

116. EDD, SDI, SSI, Medicare, and OSDI are normally administered by agencies other than DSS. These agencies should train and deputize DSS workers to take applications for these programs and make the proper determinations. Alternatively, these other agencies could also outstation workers and make them part of the medical team. Administration by different agencies contributes to the fragmentation of the safety net.

117. *See supra* Part IV.

118. This is true unless housing can be covered for certain individuals (eligible children) through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program that requires medically necessary services to be covered. One could make an argument that housing is

Without increased funding for benefits, an outstationed housing authority worker or deputized DSS worker would provide basic advice regarding housing conditions and finding affordable units. They could also help clients apply and be put on the wait list for low income subsidies and Section 8 Rental Vouchers.

Given the lack of ability to provide immediate assistance, outstationing housing authority workers or deputizing DSS workers, while still beneficial, would be less efficacious.

Although the subsequent discussion will be focused on integrating DSS workers, it is applicable to eligibility workers from other agencies, should a county, a state, or the federal government decide to outstation them as well.

2. Social Service Agency Obligations

Integration of safety net services with healthcare delivery is not necessarily budget-neutral.[119] Since the 1996 welfare reforms, both budgets and benefits have been slashed.[120] Programs across the nation, including those in California are facing even further cuts.[121] For integrated services to truly work, DSS must ensure that the offices at healthcare facilities are properly staffed and resourced.[122] Since re-modeling the medical home is supported by the healthcare reform legislation,[123] there is a potential funding stream for DSS workers from patient centered medical home funds.

In the ideal case, there would be at least two DSS workers at each healthcare facility so that they could spend part of their time at the home office and the rest of their time at the outstation. This ensures that the workers are up-to-date on the latest office policies and remain connected with the rest of the office.

In general, however, workers do not need to be in the office; for

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medically necessary to treat certain health conditions and that there is no alternative treatment. This, however, goes beyond the scope of the current article and will be the topic of a future article.

119. DSS could take existing workers and relocate them to healthcare facilities. Such a proposal would be budget neutral from a personnel perspective. However, given how overburdened with cases these workers are, this is not an ideal solution. Ideally, DSS should hire new workers to staff healthcare facilities.

120. KAISER, *supra* note 15, at 17.

121. *See, e.g.*, *supra* note 4.

122. Whether existing staff should be outstationed or new staff should be hired is beyond the scope of this article.

123. *See supra* Part V.B.

example, in California, beneficiary eligibility is tracked and determined electronically.[124] Beneficiary application and determination can also be done electronically.[125] Of course, the potential for false data entry and errors still exists and proper mechanisms must be put in place to avoid these problems and ensure quality.[126] A further look at current DSS accountability procedures and administrative structures is needed to see what special modifications are needed or if current structures are efficacious and should be adopted.[127]

3. Healthcare Facility Obligations

For outstationed workers to be integrated into the healthcare team, the healthcare facility would have to provide office space and necessary amenities, if not also a portion of these workers' salaries. Urban hospitals would most likely benefit financially from the integration of a healthcare worker, as they serve a large number of uninsured patients. By hosting these eligibility workers, they will see an immediate return in terms of some reimbursement for services they render[128] as well as potential long term decreases in both

124. *See, e.g.*, MEDICAID INST. AT UNITED HOSP. FUND, REFORMING NEW YORK'S MEDICAID ELIGIBILITY PROCESS: LESSONS FROM OTHER STATES 13-14 [hereinafter REFORMING NEW YORK] (discussing how counties in California use computer systems to determine eligibility and then upload this information into the state's Medi-Cal eligibility system).

125. *See, e.g.*, 100% CAMPAIGN, *supra* note 108 (discussing how California could shift to paperless enrollment and verification).

126. In fact, one report on current outstationing recommends "greater oversight of on-site workers by the responsible agency . . . [as well as m]onitor[ing] individual workers performance and investigate if denials seem to be excessive or workload is not up to standards." NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., *supra* note 48, at 19. However, placing the workers in the healthcare setting leads automatically to greater oversight: The rest of the team will have a vested interest in their patients and will automatically serve as advocates their patients. Furthermore, the integrated DSS worker may feel a greater sense of responsibility and this may lead to a higher quality work.

127. It should be noted that each state has its own eligibility system. *See, e.g.*, MEDICAID INST. AT UNITED HOSP. FUND, *supra* note 124, at 8 (listing reasons for why each state's eligibility policy is different, including "the history of each state's health and human services system development, the state's traditional division of labor between state and local government entities in the human services arena, and how the state finances Medicaid administrative activities.").

128. KISHA MERCHANT, NATIONAL CTR. FOR HEALTH WORKFORCE ANALYSIS, PROMOTING CHILDREN'S ACCESS TO HEALTH INSURANCE BY POSTING OUTSTATIONED WORKERS: SOME NORTH CAROLINA EXPERIENCES 12 (2003); *see also* NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., *supra* note 48, at 11.(finding that "[p]roviders have a strong incentive to assist individuals to apply for any programs that might cover all or some of the costs of care, including Medicaid, SCHIP, and state indigent care programs. Making outstationing work should be a prime strategy for any hospital trying to optimize revenues. The major challenge is convincing patients who could otherwise receive "free care" from safety net providers to undertake the

inappropriate emergency room visits and avoidable hospitalizations.

FQHCs have less to gain because of the lower reimbursement rate for outpatient services. However, given their high volume, the additional benefits on their patients' health, and their role and potential reimbursements as these patients' care coordinators, the burden on FQHCs could be minimal or even incentivized, depending on the specifics of the program design.[129]

4. Provider Education & Interaction with Outstationed Workers

a. The Need for Healthcare Provider Education

Why do healthcare providers not do more to address socioeconomic, legal, and environmental factors, if these factors have such a significant impact on health outcomes? In part, this failure to engage more in depth with the socioeconomic determinants of health is because traditionally, providers have been trained to focus on the biomedical aspects of care.[130] Although many individuals—such as pediatricians—look at the broader family and social context, they generally do not have the proper, knowledge or the necessary resources to appropriately intervene.[131] Such powerlessness makes providers reticent to ask about socioeconomic determinants of health.[132] Ironically, however, healthcare professions are perhaps the best suited to identify these problems, given the significant role they play in affecting healthcare outcomes.[133]

Providers have traditionally relied on social workers to close this gap. However, eligibility rules have become more complicated and focused on preventing fraud rather than helping needy individuals.

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application process, which is why the process needs to work as smoothly as possible from the applicant's point of view if it is to succeed."); RACHEL KNIGHT, THE MED. LEGAL P'SHIP FOR CHILDREN, HEALTH CARE RECOVERY DOLLARS: A SUSTAINABLE STRATEGY FOR MEDICAL-LEGAL PARTNERSHIPS? (2008) (discussing financing medical-legal partnerships through a portion of the dollars recovered by helping uninsured patients qualify for Medicaid/SCHIP).

129. *See, e.g.*, KATIE PARKER COHEN, *supra* note 5, at 3-5 & Tbl. 4 (describing how outstationed workers are financially beneficial for Federally Qualified Health Centers).

130. Alexander R. Green et al., *Integrating Social Factors Into Cross-cultural Medical Education*, 77 ACAD. MED. 193 (2002).

131. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 225; *see also From Principles to Practice*, *supra* note 36, at 100.

132. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 225.

133. *See supra* Part IV.

With constant changes in regulations, social workers have become less effective patient advocates than before.[134] In response, some hospitals have incorporated lawyers into their healthcare staff or have partnered with legal aids to better advocate for their patients.[135] While a step in the right direction, these partnerships are not enough to ensure optimal patient care. Both lawyers and social workers still have to work with DSS to resolve enrollment and retention problems. Integration of a DSS worker into the medical home is thus a logical next step to ensure appropriate access to available safety net benefits.

Providers must be educated about the availability of safety net services to address the socioeconomic determinants of health before they would be willing to actively screen for these problems and make the appropriate referrals.[136] Theoretically, providers should at least be familiar with Medicaid, as they often have to interact with it. In reality, however, medical training teaches very little about public benefits.[137] Thus, provider education will be necessary.

b. How to Educate the Rest of the Healthcare Team

A benefit of integrated services is having the DSS worker become a member of the healthcare team. Having the DSS worker as a member of the healthcare team not only allows for a built-in referral source, but it also allows for regular dialogue between the DSS worker and the rest of the healthcare team. This dialogue allows the outstationed worker to provide the necessary education and information not only to patients, but also to the rest of the healthcare team. It builds trust by giving providers an understanding of whom and for what they are referring their patients.

Through working with the DSS workers, healthcare providers could become true advocates for their patients: Armed with knowledge about public benefits programs, providers could conduct

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134. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 227.

135. *See, e.g.*, *Id*. at 224 (detailing the medical legal collaborative model); *see also* Medical Legal Partnership for Children, Site List, http://www.medical-legalpartnership.org/mlp-network (last visited Mar. 2008) (listing of all medical-legal collaboratives in North America).

136. *See, e.g.*, Barry Zuckerman et al., *supra* note 35, at 225 (discussing how physicians are "reticent to ask families about income supports, housing conditions, or access to adequate food supplies because they are unsure what to do with the responses."

137. *See, e.g.*, Malcolm Cox & David Irby eds., *American Medical Education 100 Years after the Flexner Report*, 355 NEW ENG. J. MED. 1339, 1342 (2006) (finding that for medical training, "more emphasis should be placed on the social, economic, and political aspects of health care delivery.").

a great deal of the advocacy required to qualify individuals for public benefits programs. In reality, however, providers are strained for time.[138] Thus, by making the DSS worker a member of the healthcare team, the provider could be asked to provide focused support when necessary. In this way, the provider serves as a specialist for the rest of the healthcare team, including both the social worker and the DSS worker.

In addition to experiential learning, a formal educational curriculum should be instituted to help providers become fluent in addressing the socioeconomic determinants of health.[139] Such education could occur through presentations coupled with feedback sessions, refresher presentations, and in-depth case discussions. Such presentations, feedback sessions, and discussions should be conducted by the outstationed DSS worker in cooperation with the social work staff.

c. Feedback to the Rest of the Healthcare Team

Feedback from the DSS worker to the rest of the healthcare team is very important and would consist of several parts. First, the DSS worker should let the rest of the healthcare team know that they received the referral and that they are helping the client-patient through the process. This allows for continuity and the provider can then follow up with the client-patient at his or her next visit. Second, the DSS worker should inform the rest of the healthcare team as to the disposition of the process and answer any questions they might have. Third, the DSS worker should conduct refresher presentations, focusing on the details of different benefits while clarifying any problems seen with referrals. In doing so, the DSS worker would not only help streamline the process, but he/she will also educate the rest

138. *See, e.g.*, Michael D. Burdi & Laurence C. Baker, *Physicians' Perceptions of Autonomy and Satisfaction in California*, 18 HEALTH AFF. 134, Exh. 2 (1999) (finding that in 1996 30.4% of young primary care physicians in California felt that they were not able to spend sufficient time with their patients, increased from 17.5% in 1991. Similarly, in 1996, 29.3% of young primary care physicians in California felt that they were not able to carefully review patient's' medical histories and test results, up from 7.4% in 1991).

139. Broadly speaking, this educational curriculum would address all six areas of core competencies set out by the Accreditation Council for Graduate Medical Education (ACGME). *See* Outcome Project—General Competencies, http://www.acgme.org/outcome/comp/compMin.asp (last visited May 4, 2010). The six areas are patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

of the healthcare team and help them become better patient advocates.

Feedback allows the rest of the healthcare team to integrate social services into healthcare delivery. This allows the healthcare team to then begin looking at their patients more holistically. The training provided as a result of integration, coupled with the actual integration of services, would empower providers, giving them a clear way to ameliorate these problems. Providers could then empower their patients.

5. Incentivizing Providers to Take Advantage of Integrated Services

Under a framework of service integration, a regime of immediate eligibility for patients would further empower the healthcare team. Integration would allow providers to prescribe immediate remedies for identified social problems that are negatively impacting their patients' health.[140] Providers could then better treat their patient's socio-economic problems and avoid the current approach of overmedicating patients. This overmedication occurs when providers feel powerless to treat the underlying causes or aggravating factors of clinical symptoms and instead prescribe medications to treat the symptoms.

Skeptics find that providers—especially their primary care providers—are highly pressed for time and are thus unlikely to engage and address these other problems.[141] If this is true, how does one get providers to buy-in and actively use integrated services?[142]

In reality, however, this concern may be misplaced.[143] Anecdotally from across the country, providers have been excited to learn about public benefit programs from lawyers in medical-legal partnerships, as it allows them to treat their patients better.[144]

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140. For example, immediate access to food stamps would remedy malnutrition for a child and immediate eligibility for Medi-Cal would allow access to medically necessary medications.

141. *See, e.g.*, note 138. B*ut see* Thomas Bodenheimer, *Primary Care in the United States: Innovations in Primary Care in the United States*, 326 BRITISH MED. J. 796, 796-98 (2005) (discussing innovations such as primary care teams to assist primary care physicians in solving a patient's problems).

142. Penalties seem counterproductive, as they would likely be looked upon with resentment; penalties not only impose a requirement but also call into question the provider's motives.

143. *See, e.g.*, Thomas Bodenheimer, *supra* note 141, at 796-98 (discussing primary care physicians innovating so that they can meet all of their patients' needs).

144. *See, e.g.*, NEW ENGLAND REG'L MED.-LEGAL NETWORK, THE MEDICAL-LEGAL

Furthermore, integrated services help providers treat the problems they often identify but cannot remedy. Therefore, one would expect that healthcare providers would be happy to refer patients to DSS workers who are part of the medical team. Such a prediction is not surprising, as this addition to the medical team would help providers achieve better healthcare outcomes. It thus appeals to the providers' duty and goal of providing the highest quality of care possible for their patients, as mandated by the Hippocratic Oath.[145]

Finally, primary care providers come from a culture of referrals to specialists. Thus, a referral process fits easily within the practice of medicine and can be incorporated into the re-modeled medical home.[146]

6. Revisiting the Social History

Part of re-modeling the medical home is developing and implementing a socioeconomic determinants screen. This screen would be part of the social history taken at every healthcare visit and should be adopted as a clinical best practice/standard of care.[147] This way, healthcare checkups could be coupled with socioeconomic "checkups,"[148] ensuring continued eligibility for public benefits. Preventive screening for safety net benefits would save all parties involved from unnecessary confusion, excess paperwork, and the

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COLLABORATION: BEST PRACTICES & STRATEGIES FOR CAPACITY-BUILDING (2005) (discussing the best practices and examples of success of medical-legal partnerships); *see also* Barry Zuckerman et al., *supra* note 35, at 225-26; *see also* MLP Network, http://www.medical-legalpartnership.org/mlp-network (last visited Apr. 12, 2010) (showing the growth of medical legal partnerships to over 150 sites nationally). The author's experience at medical-legal community partnerships (MLCP) in both New Haven and Los Angeles, there has been no shortage of referrals. All members of the healthcare team have become enthusiastic referrers. Many have commented that the MLCP has allowed them to address problems that they normally encounter in the course of a normal healthcare visit. Based on this, one could reasonably surmise that a similar program allowing for the provision of social services that requires merely a prescription or referral on the providers' part would also be enthusiastically utilized.

145. HIPPOCRATIC OATH (stating "I will apply, for the benefit of the sick, all measures [that] are required.").

146. Of course, the referral process should be designed to be no more burdensome than a referral to any other specialty service.

147. *See, e.g.*, Chen Kenyon et al., *Revisiting the Social History for Child Health*, 120 PEDIATRICS 734 (2007) (discussing how the social history can be used more proactive in healthcare delivery). Furthermore, making such a screen a standard of care would also allow providers to request insurance reimbursement for conducting the screen.

148. Making such a screen a standard of care would also allow providers to request insurance reimbursement for the screen.

detriments of churning.[149]

7. Funding

For Medicaid and SCHIP, state budget shortfalls have already hurt efforts to increase outreach and enrollment. For example, in 2003 and 2004, total state budget shortfalls exceeded seventy-five billion dollars each year.[150] These deficits have resulted in states cutting back on outreach and instituting additional barriers such as waiting periods, caps on enrollment, increased premiums, and income/asset verifications.[151]

Unfortunately, the demand for safety benefits programs is generally counter-cyclical.[152] This means that at the same time states' budgets become tighter from an economic downturn, more individuals will need assistance from these programs.[153] It is therefore even more important to look for strategies to fund efforts such as outreach and the integration of services to ensure those individuals in need receive the proper services to keep them healthy.

There is a 50 percent federal financial participation reimbursement rate for outstationing.[154] Presumptively the rest comes from the state, as regulations say that the DSS must place these workers there. Some states pass this cost onto providers, as in

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149. *See, e.g.*, *supra* note 7 (Churning is where recipients move on and off of public benefits due to failure to renew benefits properly and changing economic conditions leading to changed eligibility for benefits).

150. KAISER, *supra* note 15, at 17.

151. *See, e.g.*, FAMILIES USA, STATE BUDGET CUTS: PRESERVING ENROLLMENT (DATE UNKNOWN) (discussing barriers instituted by states to limit enrollment in an attempt to limit Medicaid costs).

152. *See, e.g.*, LADONNA PAVETTI & DOROTHY ROSENBAUM, CTR. FOR BUDGET & POL'Y PRIORITIES, CREATING A SAFETY NET THAT WORKS WHEN THE ECONOMY DOESN'T: THE ROLE OF THE FOOD STAMP AND TANF PROGRAMS 4-8 (FEB. 2010) (discussing how the demand for both food stamps and TANF has increased due to the current recession. However, because of their differential funding structures, the programs have responded differently); VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE, AND POLICY IN THE MIDST OF A RECESSION: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2009 AND 2010, 5 (2010) (citing the recession as the main reason Medicaid spending and enrollment increased).

153. *See, e.g.*, Erik Eckholm, *As Jobs Vanish and Prices Rise, Food Stamp Use Nears Record*, N.Y. TIMES, Mar. 31, 2008, at A1 (finding that as the economy continues its decline in 2008, the projected number of Americans receiving food stamps will reach a record high of 28 million).

154. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL §§ 2913, 2975.1 (2008), *available at* http://www.cms.hhs.gov/Manuals/PBM/list.asp?listpage=2 (follow Publication #45: The State Medicaid Manual hyperlink).

Connecticut[155] and New York.[156] Providers appear willing to do this, as enrolling these patients in Medicaid allows for financial recovery of otherwise uncompensated care. This compensation makes hiring the additional employee a financially sound decision.

However, for the healthcare provider, funding a DSS worker to help client-patients access to a wide scope of services is less attractive from a financial standpoint, because the healthcare provider stands to gain very little directly if the individual qualifies for food stamps or welfare.[157] Thus, additional state or federal resources must be made available to encourage such a program in addition to the current 50 percent federal financial participation reimbursement rate.[158]

The recently passed healthcare reform legislation serves as the additional funding needed to re-model the medical home, as it pays primary care providers to serve as a medical home for patients.[159] The DSS worker is the ideal individual to carry out certain requirements of the medical home, such as conducting a full screen for socioeconomic problems that are negatively impacting the patients' health and then incorporating available community benefits/programs to address these factors. Thus, medical home funding through healthcare reform could pay for a DSS worker to be part of the medical home.

8. Enforcement

The Medicaid outstationing statute requires that DSS workers be

155. Telephone interview with an Outstationed DSS Worker from a New Haven, CT, DSH Hospital (Mar. 7, 2008).

156. *See, e.g.*, Federal Reimbursement for Outstationing Workers Under OBRA 90, 93 ADM-3 NY, 3-4 (N.Y. Office Of Children & Family Servs. Feb. 9, 1993), http://www.ocfs.state.ny.us/main/policies/external/1993/#ADM (follow "93-ADM-03" hyperlink).

157. *See, e.g.*, Jacob Alex Klerman & Amy G. Cox, *Informing, Enrolling, and Reenrolling CalWORKs Leavers in Food Stamps and Medi-Cal* 31 (RAND, Working Paper No. WR-732), *available at* http://ssrn.com/abstract=1539222 (finding that enrolling patients in food stamps at county hospitals provide no direct benefit to the hospital and therefore no direct benefit to the county). *But see, e.g.*, Randye Retkin et al., *supra* note 49, at 31 (finding that "[b]ecause public hospitals are mandated to provide care to all patients, regardless of ability to pay, immigration status and place of residence, they are seen as a safe place to go for help – even if the problem is not exclusively medical.").

158. It should be noted that since this article proposes outstationing these individuals at DSH hospitals and FHQCs, such a program would fall under the current outstationing guidelines and would not require a federal waiver, as specified under 42 U.S.C. § 1396a(a)(55) (2009).

159. *See* Patient Protection and Affordable Care Act, *supra* note 1, at § 3502 et seq.

placed at DSH Hospitals and FQHCs.[160] Given the number of DSH Hospitals and FQHCs without outstationed workers,[161] there is very little question that this mandate is not being enforced.

Private enforcement of many Medicaid requirements are difficult, especially given the limits placed on private enforcement under 42 U.S.C. § 1983 by *Gonzaga v. Doe*.[162] It is likely that the courts would find that a suit under § 1983 to enforce 42 U.S.C. § 1396a(a)(55) would not be viable as there is no language creating an individually enforceable legal right in this section. If this is true, the Department of Justice or the Center for Medicare and Medicaid Services (CMS) would have to enforce this particular provision of the Medicaid statute against the states.

One remedy would be to revise the current statute to include "rights creating language." This way, individuals who are harmed by a failure to comply can sue a state under 42 U.S.C. § 1983.[163] Of

160. 42 U.S.C. § 1396a(a)(55) (2009).

161. *See supra* notes 47 & 48.

162. 536 U.S. 273, 289 (2002).

163. The revised statute could be similar to 42 U.S.C. § 1396a(a)(55) (1) (2009).

A. Each individual patient at an established disproportionate share hospital or federally qualified health center has the right to see an on-site Department of Social Services (DSS) worker provided by the local DSS agency who will then:

1) Inform the individual patient about Medicaid/SCHIP, food stamps, cash/TANF, and childcare benefits.

2) Aid the individual patient in filling out the application, obtaining the needed documentation, and ensuring that the application is complete.

3) Conduct any necessary interviews and make an on-site determination if the application is complete.

4) Conduct an initial intake interview and grant presumptive eligibility if proper documentation is not available to complete the application and the it appears that the individual would be eligible but for the proper documentation.

a) The supporting documentation must be mailed back within thirty days of this grant of presumptive eligibility.

b) Civil and criminal penalties will attach as specified by the implementing agency if an applicant grossly misrepresents his or her situation.

B. If an individual's rights under this provision are violated, an individual may seek a judicial remedy under this provision against:

1) Both DSS and the healthcare facility for injunctive relief mandating access to an on-site worker at the healthcare facility.

2) DSS for payment of lost/back benefits without having to first exhaust all administrative remedies.

C. Consistent with parts A. & B. of this statute, DSS shall outstation fulltime workers (or the equivalent thereof) to serve each patient requiring their assistance in a timely manner.

Such a statute would create a right for individual patients to access public benefits with the help of DSS workers. It would also allow for individual enforcement of the rights guaranteed by this

course, revising the statute to include an independent individual cause of action would clearly allow for individual enforcement. Allowing for individual enforcement is desirable because, as based on experience, it is very difficult to interest the Department of Justice in bringing a suit to ensure access to public benefits.

Alternatively, CMS could impose financial penalties upon the state for violating the outstationing requirement. However, cutting off funding for Medicaid in part or in whole, is not a desired remedy, as it would decrease access to services.

Health reform offers an unique opportunity for enforcement, as it brings a new line of funding.[164] The law grants the Secretary (of Health and Human Services) the authority to use grants or contracts to establish medical homes.[165] If the Secretary were to require that outstationed DSS workers are required to be part of the medical home, then FQHCs and DSH Hospitals applying for this funding would be forced to comply.[166]

9. Program Evaluation: Evaluating an Integration of Services

What are the proper metrics to measure success for a re-modeled medical home that integrates services? Comparing the enrollment of families in programs with historical data and other sites that do not have such a program would be one metric. Success would show increased enrollment in benefits including Medicaid, food stamps, cash assistance, WIC, and childcare services.

A second measure would be the client-patient's overall health. These services should help improve the client-patient's overall health. Thus, improved health would be a measure of success. Third, a measure of the client-patient's stress level could be indicated. A re-modeled medical home should help lower the overall stress level of these individuals, especially during a time of crisis. Fourth, provider awareness of, knowledge about, attitude toward, and utilization of the referral process would be crucial to evaluation of the program. Overall, the correct metrics for evaluating this program

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statute since 42 U.S.C. § 1983 would give individuals a cause of action to enforce these rights§.

164. *See* Patient Protection and Affordable Care Act, *supra* note 1, at § 3502(a).

165. *Id*.

166. It should be noted that this requirement can be implemented at a subsidized rate, as Medicaid would pay for half the costs. However, since the Secretary also oversees Medicaid, it may be a zero sum game from HHS's perspective.

would look at health measures including health outcomes, utilization of public benefits, and the internal functioning of the healthcare team.

On the other hand, an improper metric would be looking at effects one might expect to see as a result of better health and use these effects to evaluate the success of the program. For example, using measuring a child's performance in school is a metric that should be avoided. While good health, nutrition, and improved living standards could be reasonably expected to have an effect on a child's performance in school, it is unclear whether this impact would be statistically significant. Targeted interventions such as educational assistance, increased school funding, and inter-district transfers would more directly lead to increased performance in school.

Similarly, one should not expect individuals to move off welfare or find jobs simply because they are now healthier or their family situation is more stable. Improved health could be expected to have an effect on the ability of the client-patient to find a job. Again, however, a job training, transportation assistance, or employment assistance program, would be expected to have a much more direct effect on whether an individual were able to find a job and leave welfare.[167]

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167. *See, e.g.*, Stephanie DeLuca, *Neighborhood Matters: Do Housing Vouchers Work?*, BOSTON REV. 20, 20-23, Jan./Feb. 2008, *available at* http://bostonreview.net/BR33.1/deluca.php (A look at the Moving to Opportunity program (MTO) implemented during the Clinton Administration, shows exactly why the proper metrics are important and why one must design a program to achieve specific goals. The MTO program involved giving families in low income neighborhoods vouchers to find new housing. The stipulations on using these vouchers were that these families could only move to neighborhoods in census tracts with 1990 poverty rates of less than ten percent. The designers of this program hoped that by moving these families out of high poverty neighborhoods, they would be able to find work, have children with improved results in school, and lift themselves out of poverty.

MTO was a program that expected one intervention, housing environment change, to have an impact on too many things. Moving a family out of a high poverty, crime ridden neighborhood can be reasonably expected to improve the safety of the family and potentially have some incidental effects on work and the children because of environmental influences. However, MTO did not provide transportation assistance, job training, employment assistance, and educational assistance. Thus, it is not surprising that families with vouchers to move out of poverty in MTO did not show a significant improvement when their ability to find and retain jobs, perform better in school, and move themselves off of welfare.

The metrics used to evaluate the success of MTO thus reflects unrealistic expectations for a program that focuses solely on one aspect of a family's life, where they live, expecting that by changing this one factor, significant gains should be found in all of these other areas. Not surprisingly, these expected gains were not observed.

As illustrated by the experiences of the MTO program, realistic expectations must be set for a

10. Additional Challenges to Integration

A remaining challenge is working within the fragmented public benefits system.[168] This challenge can be addressed in several ways.

a. Personnel

First, personnel training and qualifications need to be addressed.[169] Currently, DSS workers specialize in one program and work on eligibility for that program. DSS workers have to be retrained to be fluent across programs and be able to help clients with a variety of programs.

b. Application Simplification

Second, the application process needs to be simplified. Currently, applicants for different public benefits programs administered by DSS have to fill out several applications with largely overlapping information. A common application could be easily implemented with additional questions specifically for each program.[170]

c. Computer-Assisted Decision Making and Case Management

Third, a good computer program would counteract fragmentation by putting an applicant's information into a centralized system. Such a system would help workers make decisions immediately. Additionally, an improved program could automatically check eligibility across programs and alert the worker

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program of the integration of services. Correct metrics also must be used to measure whether these expectations are met. Otherwise, regardless of the outcome, the program will be deemed a failure.).

168. The system was not always so redundant and fragmented. Before the 1996 welfare reforms, those who qualified for Aid to Families with Dependent Children (AFDC) automatically also qualified for Medicaid and food stamps; in fact, one of the biggest concerns falling out from these reforms are that eligible families are no longer enrolling in Medicaid or for food stamps after they lost their welfare. *See, e.g.*, Janet Currie & Jeffrey Grogger, *Explaining Recent Declines in Food Stamp Program Participation, in*, BROOKINGS-WHATRON PAPERS ON URBAN AFFAIRS 203 (William Gale & Janet Rothenberg-Pack eds., 2001); SHEILA ZEDLEWSKI & SARAH BRAUNER, URBAN INSTITUTE, DECLINES IN FOOD STAMPS AND WELFARE PARTICIPATION: IS THERE A CONNECTION? (1999).

169. *See, e.g.*, JASON DEPARLE, *supra* note 95, at 230-63 (telling the story of the sheer incompetence of workers in the Milwaukee offices. These workers had low morale, took advantage of their clients, and were generally under-qualified for the position).

170. *See e.g.*, Social Interest Solutions, California: One-e-app, *supra* note 104 (describing a common application system starting to be used in California).

as to which the applicant may be eligible, facilitating a well-trained worker's job.[171] Finally, such a program would not automatically cut beneficiaries off from all benefits when eligibility for one is lost or expired.[172]

The challenge is designing an efficient, user-friendly computer system. This may require a complete system overhaul since many states' computer systems are extremely out-of-date.[173] Such an investment may be too large of an expenditure for many states. Thus, perhaps such a system would have to be designed federally and given to the states. Alternatively, a state could develop the system and then sell the license to other states at an affordable rate to recoup development costs.

If these three challenges could be addressed, they would help overcome the challenge of systems fragmentation and facilitate integration.

VI. WHY INTEGRATED SERVICES?

A. Why the FQHC & DSH Hospital as a Point of Service/Integration?

The healthcare setting, whether the DSH hospital or FQHC, is an ideal setting for the integration of public benefits delivery as it is a point of regular visits for low income individuals and families who are eligible but not enrolled for public benefits.[174] In urban and rural

171. *See, e.g.*, 100% CAMPAIGN, *supra* note 108 (discussing how California can use a paperless application system); *see also* KINDA SERAFI & ANNE MARIE COSTELLO, *supra* note 74, at 14 (describing the New York Department of Health's increased efficiency resulting from its electronic processing system); NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., *supra* note 48, at 19 (recommending enhanced computer systems to help outstationed eligibility workers stay current with latest changes and all available options. Additionally, it recommends that these systems could be developed into "automated application process to allow applications to be submitted electronically, to enable verification against other state databases, and to communicate about the status of applications."). *But see* JASON DEPARLE, *supra* note 95 (describing the archaic and difficult to learn data system used for welfare in Wisconsin); KATHLEEN MALLOY ET AL., *supra* note 104, at 28. (reporting that the Indiana system, ICES, does not automatically link eligibility determination for the different programs, requiring the worker to indicate which programs an applicant is applying for).

172. Some states have fixed this already. *See, e.g.*, *id*. at 23-26, 28 (reporting that Indiana has a system that automatically rechecks eligibility for other benefits when one is lost so that an individual is not thrown off all programs immediately).

173. *See supra* note 167; *see also* LEGISLATIVE ANALYST'S OFFICE, *supra* note 5 (discussing improvements that could be made to California's computer system).

174. *See, e.g.*, NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., *supra* note 48, at 11(finding that DSH hospitals and FQHCs are obvious places to outstation programs, since large

settings, FQHCs and DSH hospitals share the responsibility of providing non-emergent care for the low income and uninsured. The FQHC serves as a regular source of primary care for low income patients while DSH hospitals provide a source of usual care through its outpatient clinics. Additionally, the DSH hospital also provides primary care through its emergency room for those who cannot find individual or group practices to care for them.[175]

1. Prevention: Reaching an Otherwise Unenrolled Population

The medical home focuses on more than just care coordination. Because the medical home is based in the primary care setting, the medical home is also focused on prevention and early diagnosis. Re-modeling the medical home to include DSS workers is thus consistent with the goal of the medical home, as screening individuals for safety net benefits should be done not only in response to existing health conditions but also as a preventive measure to prevent poor health. Re-modeling the medical homes allows the health team to reach individuals before they are in crisis because of individuals' regular contact with their primary care providers/medical home.

Enrolling eligible individuals at FQHCs and DSH hospitals thus holds the dual promise of improving health outcomes while lowering healthcare costs by addressing the socioeconomic determinants of health before individuals or families are in crisis. The data support this assertion. In states where DSS workers have been outstationed at hospitals and clinics to assist individuals in applying for Medicaid, applications at the central DSS offices have not decreased.[176] In these states, outstationed workers are reaching a population not previously enrolled. This population was not coming to a DSS office to apply for services. Furthermore, the population that uses the emergency room as its usual source of care is obviously not plugged

proportions of their patients are uninsured); *see also* Randye Retkin et al., *supra* note 6, at 31 (discussing how "public hospitals and healthcare centers in New York City function both as a 'sanctuary' for people in high-need communities and as a gateway to other safety net organizations in the community").

175. Of course, the DSH hospital also provides acute care, emergency care, hospitalizations, and surgeries.

176. KISHA MERCHANT, *supra* note 128, at 13 (discussing how in North Carolina's NC Health Start, no decrease was seen in the DSS offices in Cabarrus and Forsyth counties).

into the system. Enrolling these individuals at DSH hospitals has the additional benefit of transitioning them to a regular source of primary care.

2. Patient/Clients Visit Healthcare Facilities Regularly

From the patients' perspective, both the DSH hospital and the FQHC are a natural point for the integration of healthcare and public benefits. The healthcare setting is a nexus of activity for both childless adults and families with an infant or child, whether well or sick.

For example, the American Academy of Pediatrics has laid out guidelines for both frequency and substance of well-child visits.[177] Thus, even a healthy infant or child will receive a series of well-baby/well-child visits based on this standard. Part of the well-child visit includes the social history, which includes questions about nutrition, housing, education, health insurance, and other socioeconomic determinants of health. Therefore, it makes sense to extend from asking about these factors to actually connecting children and families to the appropriate social services on-site.

In doing so, the healthcare professional can go beyond simply asking about social problems to "prescribing" remedies for them. Since the eligibility workers would be right down the hall, the barriers and delays associated with traveling to another location are eliminated. Parents do not have to find another time or arrange for transportation to go to the DSS office and can begin receiving benefits immediately if eligible. Thus, integration holds the promise of not only improving health outcomes but also increasing access to public benefits for healthy individuals. Such a system builds upon the preventive nature of the medical home: Early enrollment helps preempt potential problems, as it link a patient the to appropriate benefits before an eligible individual's health deteriorates.

3. Reaching Patient/Clients in a Time of Crisis

Realistically, however, a number of patients will only come to the DSH hospital or FQHC when in need of serious medical care.

177. Committee on Practice and Ambulatory Medicine, American Acad. of Pediatrics, *Recommendations for Preventive Pediatric Health Care,* 105 PEDIATRICS 645, 646 (2000).

Having public benefits eligibility workers on-site would allow the healthcare team to immediately address some of the socioeconomic stressors affecting the patient's health. The healthcare team could screen for urgent needs and then send the patient or the family down the hall to enroll for benefits to address these needs, instead of asking the sick individual or their family to go elsewhere to access these social supports. Thus, whether for a healthy or sick individual, it makes sense to integrate the delivery of healthcare and public benefits in the clinical setting.

4. Existing Law Supports Remodeling the Medical Home

Remodeling the medical home by stationing eligibility workers from DSS and other offices out at FQHCs and DSH hospitals builds upon the structure already in place at some of these institutions as a result of the Omnibus Reconciliation Act of 1990, as discussed above.[178] Furthermore, the Patient Protection and Affordable Care Act's places medical homes at primary care practices within the hospital service area of "State or State-designated entit[ies]."[179] The DSH hospital should be a "State or State-designated entity."[180] Thus, both FQHCs and DHS hospitals' outpatient practices should be included within those entities eligible for funds through the Patient Protection and Affordable Care Act.

These two pieces of legislation thus not only provide a legal framework supporting remodeling the medical home, but also provide two separate funding streams to support this effort.[181] As the focus of healthcare delivery moves away from insuring individuals to actually delivering coordinated services, FQHCs and DSH hospitals should take advantage of these laws to secure funding so that they can remodel the medical home and improve patient health outcomes.

5. Benefits of a Remodeled Medical Home

Integrating DSS eligibility workers into the medical home at the DSH hospital and FQHC serves several purposes. By centralizing eligibility, patients can participate in "one-stop-shopping" and sign

178. *See supra* Part III.B.

179. *See* Patient Protection and Affordable Care Act, *supra* note 1, at §§ 3502(A)&(B)(1)(A).

180. *Id*. at § 3502(B)(1)(A).

181. *See supra* Part V.E.7.

up for all necessary benefits while seeing the doctor.[182] This eliminates barriers of transportation and inconvenient hours. Additionally, integration takes away some of the stigma associated with signing up for public benefits. One study found that 54 percent of parents of eligible uninsured children would much more likely enroll at a doctor's office or clinic than at the DSS office.[183] Furthermore, in the healthcare setting, individuals are much more likely to be concerned about enrolling in some form of public benefits when they see the direct impact it is having on their health, as opposed to other settings where these individuals may have to be convinced about the benefits of signing up for these programs.[184]

On-site enrollment also facilities eligibility: The healthcare facility may have some of the necessary documentation on file.[185] The patient can take the documentation directly over to the eligibility worker instead of trying to track down sundry pieces of paper. Social workers at the hospital can work with the rest of the healthcare team, including the eligibility workers, to ensure that eligible clients will be able to enroll for the necessary benefits by assisting them track down the necessary documentation.[186]

Overall, the healthcare setting captures the direct impact of these public benefits on health. Providers are acutely aware of the effects that these benefits have on health. After proper training, providers

182. *See supra* Part V.A.

183. *See* MICHAEL PERRY, *supra* note 52. This study also found that parents would be 51% more likely to enroll their children at their school or daycare center and 40% more likely to enroll their child at a local community center. *Id.* This points perhaps to both stigma as well as the importance of co-location with other vital services, in facilitating ease of enrollment. *See also* Lea Nolan et al., *Enrolling Uninsured Children in SCHIP: Lessons Learned from Community Health Centers*, 26 J. AMBULATORY CARE MGMT. 51, 58-59 (2002) (finding that patients at health centers were more likely to apply when their physician or nurse brought up the subject of SCHIP/Medicaid and referred them to an outstationed worker or other outreach worker).

184. *See, e.g.*, NAT'L ASS'N OF PUB. HOSPITALS & HEALTH SYS., *supra* note 48, at 11 (finding that for Medicaid enrollment, "[o]utstationed enrollment programs are an important strategy for enhancing Medicaid enrollment, since they capture individuals at points-of-service when they are most likely to be concerned about enrolling in some form of health coverage (as opposed to other sites where people must be convinced of the benefits when they are healthy and not in need of care).").

185. *See supra* Part V.D.2. (although this paper argues of presumptive eligibility and the use of electronic systems, having additional documentation to supplement these processes should be helpful in ensuring that eligible individuals enroll in the appropriate programs).

186. *See supra* Part V.D.2. Beneficiaries often have trouble tracking down the necessary paperwork to complete an application. When patients have help from outreach staff or other trained experts, they are more likely to complete the application. Lea Nolan et al., *supra* note 183, at 54, 58.

can work with DSS workers to ensure true coordination of care, resulting in appropriate referral to benefits as identified through healthcare delivery. This coordination, coupled with co-location, results in a true integration of public benefits delivery into the practice of healthcare.

6. Critiques Dispelled

One argument against outstationing eligibility workers at hospitals is that the state should try to reach families before a time of crisis.[187] However, as shown above, in the urban setting the hospital is not only a trauma and crisis center but also a primary care anchor for many families.[188] It thus makes sense to house outstationed workers at these hospitals in addition to FQHCs. However, this paper by no means is arguing against also having such workers at schools, daycare centers, or other appropriately defined sites. Having workers at these sites would also help de-stigmatize the enrollment for public benefits while reaching children and families who were not previously enrolled.

However, in a world of limited resources, the healthcare setting, especially urban DSH hospitals and FQHCs are an ideal and logical place for outstationing eligibility workers; it creates synergies, empowers providers, and leads to better patient care. DSH hospitals and FQHCs are thus not simply a new outreach site for DSS. Making DSS workers part of the health team in the medical home increases care coordination and leverages existing laws as funding sources to improve health outcomes. There are therefore distinct benefits created by outstationing workers in this setting as opposed to any other.

B. Challenges & Barriers to Accessing Social Services

If the socioeconomic, legal, and environmental factors have such a profound impact on health, and thus also quality of life, why would anyone eligible for public benefit programs not apply? After all, those who qualify for these programs are low-income and pay nothing to receive these benefits; they just have to sign up.

This oversimplified characterization of the process leads to

187. CITIZENS FOR MISSOURI'S CHILDREN, *supra* note 17, at 4.

188. *See supra* Part VI.A.1-2.

many critiques of the low-income population. In the context of this article, two prominent ones are discussed below:

First, these individuals should know what they need. Thus, they should sign up for the appropriate programs on their own because healthcare professionals do not need to be involved at all. Second, considering that these programs are free, individuals who do not sign up for it either do not have an imminent need or are irresponsible and unwilling to assist themselves. Why should others go through the effort to sign these individuals up if they cannot take some basic level of responsibility for their own well-being?

A closer examination of why many needy people do not access seemingly helpful public benefits dispels these misconceptions. Several systematic studies have been done on why beneficiaries or patients often do not sign up for public benefits programs even if they qualify. They have all identified a series of overlapping factors that point to why the gap exists between one's initial expectations and actual beneficiary experiences.

For the indigent who qualify for social services, the public benefits system is a complex one that is difficult to understand and often hard to access. There are four major barriers that prevent beneficiaries from accessing benefits that they qualify for: informational, transaction costs, administrative failures, and stigma. Each of these will be discussed in-turn. These barriers work synergistically and reflect a series of hurdles standing in the way of application for and receipt of public benefits.

Co-locating and coordinating the application for and delivery of these benefits with that of healthcare addresses all four of these barriers. Integration is thus an ideal, although not exclusive, solution. Other reforms such as additional outreach, application simplification and/or combination, and presumptive eligibility would also help facilitate receipt of these benefits in an appropriate, timely manner. However, they work synergistically with integration and cannot be used as a substitute for integration. Integration creates a nexus between medicine, health, and public benefits that uniquely serves this population by overcoming all of these barriers and utilizing these services directly to improve the beneficiary's health. This care coordination has a dual focus on addressing urgent needs as well as delivering preventive care.

1. Lack of Knowledge and Information

The lack of information about these programs arises from several sources. At the most basic level, eligible individuals may not know about the program. Even if they do know about a program, the details are complicated, changing, and not well-publicized. Thus, many eligible families think that they are not eligible. One study found that knowledge gaps accounted for 32 percent of why families did not enroll in Medicaid/SCHIP.[189] For example, with health insurance programs, parents may be unaware of the availability of coverage, or they may know about the program, but not think they meet eligibility criteria. Grandparents raising their grandchildren may not know that they can apply for health coverage for their grandchildren, even though they are not the parent.[190] Another study reinforced these observations, finding that for the 12 percent of parents who did not try to enroll their children in Medicaid, 58 percent did not think their child would qualify, 56 percent did not know how or where to apply, and 50 percent found that the rules and regulations were too confusing and the forms were too complicated.[191] Additionally, 31 percent of respondents to another study believed that they could only apply for Medicaid at the welfare office and 26 percent were unsure.[192]

Other times, language and cultural barriers arise. Outreach and information is not always targeted at the proper communities using the appropriate language.[193] Thus, for many immigrant communities, eligible beneficiaries simply do not find out about these programs.[194]

Furthermore, under the current administrative state, public

189. This is broken down into three categories: Had not heard of Medicaid/SCHIP (12.4%), Did not inquire or apply because did not think child was eligible (17.7%), and Did not inquire or apply because lacked sufficient information about program (2.3%). GENEVIEVE KENNEY & JENNIFER HALEY, *supra* note 100, at 4.

190. DEBRA J. RINGOLD ET AL., FEDERALISM RESEARCH GROUP, MANAGING MEDICAID TAKE-UP, SCHIP AND MEDICAID OUTREACH: EFFORTS AND EVALUATION (2003).

191. MICHAEL PERRY ET AL., *supra* note 52, at 12.

192. KISHA MERCHANT, *supra* note 128, at Tbl.1.

193. *See, e.g.*, MICHAEL PERRY ET AL., *supra* note 52, at 7 (finding that only thiry-six percent of parents of Medicaid enrolled children and a quarter of eligible uninsured children say that they have ever talked to someone or received information from someone about enrolling in Medicaid); *see also* KISHA MERCHANT, *supra* note 128, at Tbl.1. (finding that "62% of parents who did not complete the application process and 58% of parents who did not attempt to apply though they made too much to qualify" while "74% of parents of uninsured children have not received information nor talked to someone about enrolling in Medicaid.").

194. KAISER, *supra* note 15, at 10-12.

benefits programs are fragmented: "Few programs are wholly self contained; most deal with only part of an individual's or family's needs. Many recipients continue to have trouble determining just what services are available to them much less take advantage of the full range of opportunities."[195] For example, before the welfare reforms of 1996, food stamps, cash, and Medicaid were linked. After 1996, when a family lost cash assistance, the agency administering all three programs did not always tell the recipient about their continued eligibility for food stamps or Medicaid, leading to loss of all three benefits instead of just one.[196]

Proper outreach targeting the eligible population would begin to solve these problems. Five steps are recommended for this process:

> Step 1: Identify and understand the potentially eligible population
>
> Step 2: Increase public awareness that the program exists
>
> Step 3: Increase understanding of eligibility for the program
>
> Step 4: Educate individuals about the program
>
> Step 5: Motivate individuals to take action to find out more about, or enroll in, the program.[197]

However, outreach is not a substitute for integration because outreach does not allow for on-site application. Furthermore, integration of DSS workers into the medical home allows for referrals tailored for that individual's needs. While outreach may allow and encourage more people to apply for these programs, it does not solve the other barriers that integration does. Thus, although outreach is a strategy that works synergistically with integration, it is not an alternative.

Of course redesigning public benefits programs may also help with the coordination problems. However, short of that, co-locating the services in the healthcare setting addresses the need for improved coordination. The healthcare team would be able to refer the patient

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195. WELFARE SYSTEM REFORM, *supra* note 20, at 4.

196. *See, e.g.*, ALVIN L. SCHORR, *supra* note 16, at 38 (describing how in Ohio, people who missed appointments received a letter telling them that they were dropped without receiving information about continued eligibility for TANF or Medicaid). In fact, eighty percent of those who left TANF were eligible for food stamps and Medicaid, but only half of these people received them. *Id.*; *see also supra* Part II.A.

197. BARENTS GROUP, LLC, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, REVIEW OF THE LITERATURE ON EVALUATION OF OUTREACH FOR PUBLIC HEALTH INSURANCE AND SELECTED OTHER PROGRAMS A-1 Tbl. 1 (2000).

for a range of services that the eligibility worker could help the patient apply for. This overcomes the fragmentation and administrative separation of various public benefit programs by forcing all them to be available and accessible in one location.

2. Transaction Costs (Administrative Hassles)

Knowledge about public benefits programs is not enough. An individual must be able and willing to apply for these programs. Given the fragmentation of these programs, not only is knowledge scattered, but the application process for these programs are also separate, often in different locations.[198] Additionally, although DSS administers food stamps, cash assistance, and Medicaid, different eligibility forms are often required for each, often with redundant information required.[199] Some have compared applying and remaining eligible for the various public benefit programs, while caring for a child or children, to holding a full-time job.[200]

Many eligible individuals, especially the working poor, do not have time or the means to sign up for much needed public benefits. As New York City Deputy Mayor for Human Services Linda Gibbs astutely commented:

[W]hat the poor have in common is that they are really struggling to make ends meet, that every day every decision is, 'Do I do this thing or do I do that thing?' It's not a matter of can I go to work and get health care; it's often a matter of trading it off.[201]

The costs of applying for public benefits are thus transactions costs that are borne by the applicant. Often these transaction costs,

198. *See, e.g.*, EDWARD T. JENNINGS, JR. & NEAL S. ZANK EDS., *supra* note 20, at 4 (finding that "[p]otential clients, typically with children in tow, bounce from agency to agency and travel from one end of town to the other in order to negotiate these systems.").

199. *See, e.g.*, CITIZENS FOR MISSOURI'S CHILDREN, *supra* note 17, at 6 (discussing how many children lost Medicaid as a result of welfare reform although they were eligible for Medicaid). This points to the need for intra-office coordination, as both programs are administered by DSS. Recipients need to be made aware of the changing requirements and the office should make an effort to keep those eligible informed and enrolled even if they lost one of the benefits; *see also* WELFARE SYSTEM REFORM, *supra* note 20, at 3-5 (discussing the fragmentation, redundancy, and inefficiency of applying for public benefits).

200. *See, e.g.*, THE NAT'L COMM'N TO PREVENT INFANT MORTALITY, ONE-STOP SHOPPING: THE ROAD TO HEALTHY MOTHERS AND CHILDREN 8 (1991) (finding that "Jolene made nine trips in six weeks to begin care and receive Medicaid eligibility.").

201. Ray Rivera, *In Mexican Town, Maybe a Way to Reduce Poverty in New York*, N.Y. TIMES, Apr. 24, 2007, *available at* http://www.nytimes.com/2007/04/25/nyregion/25antipoverty.html.

framed in the terms of opportunity costs, are high enough that families do not try to apply or do not complete the application process until it is absolutely necessary. For example, one study found that three-quarters of parents, with uninsured children, eligible for Medicaid work.[202] The same study also found that 67 percent of parents of eligible uninsured children have tried to enroll their children in Medicaid and 57 percent have been unsuccessful, with 21 percent unable to complete the process, 21 percent ultimately denied,[203] and 15 percent experienced numerous and reported problems in both completing the process and obtaining approval.[204]

There are a number of transaction costs, real or perceived, that made it difficult for applicants to start or complete the process. One study showed that for those who tried applying, costs included: difficulty getting all of the required papers (72 percent), the overall hassle of the enrollment process (66 percent), belief that the process was complicated and confusing (62 percent), and not having application materials available in the proper language (46 percent of Spanish speaking parents).[205] In comparison, for those who did not apply, 52 percent said applying takes too long, 44 percent stated the office was not open when they were able to go apply and 39 percent said it was too difficult to get to the office.[206]

Additionally, poor people can only suffer so much hassle and humiliation. In one survey, mothers who did not appeal decisions discontinuing daycare told interviewers: "They want to get rid of us and they are going to get rid of us. The devil with them!"[207]

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202. MICHAEL PERRY ET AL., *supra* note 52, at v.

203. *See* Administrative Failures, *infra* Part VI.B.3.

204. MICHAEL PERRY ET AL., *supra* note 52, at 7.

205. *Id*. at 9-10; *see also* KISHA MERCHANT, *supra* note 128, at Tbl.1 (finding that "41% of respondents found the Medicaid application too long/complicated", "72% of parents who did not complete the process cited the difficulty of getting all the required documentation as a barrier", and that "46% of Spanish speaking parents said they did not have the materials available in their language, . . .43% of participants believe that it is hard to find a translator to assist them in the enrollment process, [and] 62% of respondents said that immigrants were afraid to apply."); *see also* GENEVIEVE KENNEY & JENNIFER HALEY, *supra* note 100, at Tbl. 2 (finding that administrative hassle as the primary reason accounted for 9.5% of why low-income children were uninsured).

206. MICHAEL PERRY ET AL., *supra* note 52, at 13; *see also* KISHA MERCHANT, *supra* note 128, at Tbl.1 (finding that 35% of respondents did not apply because they had trouble with transportation); Erik Eckholm, *In Turnabout, Infant Deaths Climb in South*, N.Y. TIMES, Apr. 22, 2007, *available at* http://www.nytimes.com/2007/04/22/health/22infant.html.

207. ALVIN L. SCHORR, *supra* note 16, at 38.

Similarly, many left welfare because they were either "[u]nwilling to work for a welfare check or endure more pointless classes, the poor voted with their feet. Most simply left."[208] This goes to show that transaction costs not only prevent parents from applying but can also drive them from continuing with existing programs.

In sum, many patients simply have too much going on and do not enroll in safety net programs until they feel it is absolutely necessary. Integration cuts down on a number of these transaction costs by co-locating the service with healthcare services, allowing patients to apply when they come in to see their primary care providers. With the members of the healthcare team working cooperatively with the patient and the eligibility worker, many of these other transaction costs can be reduced. Of course, simplified forms, transportation subsidies, and longer hours will also address some of these transaction costs. However, the bottom line is how client-patients weigh these costs. Through integration the healthcare team can help frame the trade-off in a way that these other fixes never can: the harm to one's health.

3. Administrative Failures

Many of the transaction costs could be viewed as administrative hassles, which must be differentiated from administrative failures. Administrative failures are agency mistakes that prevent individuals from obtaining public benefits in a timely manner.

Leading this list are the incorrect denials of eligible individuals. One study found that 21 percent of those who applied where incorrectly denied.[209] Another found among eligible but uninsured children that 17.8 percent had been enrolled in the past year but were not enrolled at the current time and 11.0 percent of those who had applied for coverage were not enrolled.[210] This study shows that in addition to improper denials, the system is set up in a way that leads to churning: individuals will be enrolled, lose coverage, and then potentially re-enroll instead of remaining on these benefits continuously.[211] Sometimes, this is due to fluctuations in income,

208. Jason DeParle, *Bold Effort Leaves Much Unchanged for the Poor*, N.Y. TIMES, Dec. 30, 1999, at A1.

209. MICHAEL PERRY ET AL., *supra* note 52, at 8.

210. GENEVIEVE KENNEY & JENNIFER HALEY, *supra* note 100, at Tbl. 2.

211. *See* DEBRA J. RINGOLD ET AL., *supra* note 190.

other times it is due to lost or unreturned paperwork. The system is built as a rigid denial system rather than one that attempts to keep individuals enrolled.

Critics may argue about whether this is a true administrative failure as opposed to a procedural choice. Choosing to cut off potentially eligible individuals is indeed a choice, but is a failure in light of the stated goals of the programs: The purpose of public benefit programs such as Medicaid is ostensibly to help individuals. Agencies spend a great deal of resources on outreach and education, hoping to enroll eligible individuals in these programs.[212] The rigid and complex rules undermine this investment and work against the agencies' stated goals of increasing enrollment of eligible individuals. In this sense, the agencies' unnecessarily complex rules should be viewed as an administrative failure.

However, regardless of one's viewpoint, churning leads to gaps or loss of coverage for otherwise eligible individuals. Integration addresses this problem. Integration builds into the process an advocate, the health team. The health team has both an ongoing relationship with the patient and the eligibility worker, who are both members of the medical home, as well as a vested interested in ensuring patients receive the proper benefits. They can thus work with the patient through the process, serve as an advocate, and identify problems or errors. Of course, this requires training; however, such training is built into the development of a fully integrated system. Critics may argue that an improved computer system or changed policies may help avoid some of these problems. There is absolutely no doubt that both would help. However, human error still exists. The healthcare team would be there to serve as an advocate to work with both sides when such errors do exist even if a new computer system was put in place and agency policy were changed. Thus, integration again retains additional value even if these other changes were implemented.

4. Stigma & Fear of Public Charge

The degree to which the stigma around public benefits, especially welfare, dissuades eligible beneficiaries from applying is

212. As a legal services attorney, the author finds it a sad statement that lawyers are needed to advocate on behalf of poor families to keep them on families because the rules are so complex that DSS workers themselves often make mistakes.

debatable: There is definitely a stigma about welfare and it does dissuade some people from applying. However, this stigma is added to the other costs of applying and balanced against the benefits received.[213] Thus, it is difficult to quantify exactly how much of an effect stigma actually has.

One study found that of the parents who did not apply, 38 percent did not like having to go to the welfare office to apply, 42 percent feared that they would be treated badly by people at the enrollment office, and 37 percent didn't want their children to be Medicaid "recipients."[214] A second study found that 22 percent of the eligible uninsured did not need or did not want to enroll in Medicaid/SCHIP, in part because of stigma.[215] However, it is unclear how much easier the application process needs to be or how much higher a level of benefits must be provided for these recipients to overcome their adverseness to applying.[216]

Although the literature is unclear on the role of stigma, integration removes much of the stigma associated with public benefits. If the healthcare provider is recommending this treatment for the health of an individual, the welfare stigma should not attach. Additionally, to obtain these benefits, individuals do not have to go to the welfare office. Instead, they just go to a separate office in the hospital or clinic where they can see an eligibility worker. Thus, any deterrence that stigma might have is in a large extent removed by integrating these services into the healthcare setting. This way, the healthcare team could "prescribe" individuals the needed benefits instead of the individual seeking them out. The medicalization of the receipt of public benefits thus dissociates stigma from the receipt of public benefits.

Furthermore, many immigrants are deterred from applying for benefits because of concerns about public charge, the idea that

213. JANET CURRIE, CONFERENCE IN HONOR OF EUGENE SMOLENSKY IN BERKELEY (DEC. 12-13, 2003), THE TAKE-UP OF SOCIAL BENEFITS, 11-12 (rev. 2004).

214. MICHAEL PERRY ET AL., *supra* note 52, at 14.

215. Those parents who felt that their children did not need Medicaid/SCHIP coverage had children who were in better health and had fewer unmet needs compared to other low-income uninsured children. However, only 32% had received well-child care visits and only 51% had a dental visit within the past year. GENEVIEVE KENNEY & JENNIFER HALEY, *supra* note 100, at 4.

216. JANET CURRIE, *supra* note 213 (stating that studies have shown that transaction costs and stigma play a large role, as the larger the benefit, the more likely one was to take it up); *cf. id.* at 12-13 (finding that stigma may be overrated as even with the EBT card system, there was detectable effect on Food Stamp up take).

eligible family members receiving benefits may affect one's immigration status.[217] Having the health team educate patients about the myths and realities of public charge[218] and supporting patients in making an informed choice about the receipt of these benefits is an additional benefit of integrating DSS workers into the medical home.

5. Conclusions About Barriers

Stepping back, the system begins to look quite complex and inaccessible for a system designed to help people. Yet the benefits, when obtained, cannot be underemphasized, as they have such a profound positive impact on healthcare outcomes. What can be done to make these benefits more easily accessible to beneficiaries?

Many of the barriers discussed above can be addressed through beneficiary education followed by restructuring the delivery mechanisms of public benefits. Integration, as proposed in this article, allows for such outreach and restructuring within the healthcare setting. However, even if broader outreach and redesign were undertaken, remodeling the medical home to integrate healthcare delivery with increasing access to safety net benefits still adds an independent value, based on the expertise of the health team and the relationship that the rest of the team builds with the eligibility workers. Thus, regardless of broader administrative reforms to public benefit delivery, integration should be adopted to allow for better patient health and more effective treatment of patients by the health team.

VII. COORDINATION AND/OR CO-LOCATION: DOES IT WORK?

Integration makes sense in theory. However, skeptics may argue that proposals are always optimistic; they want concrete evidence that integrated services actually work, especially for a challenging population, such as the low income one seen at FQHCs and DSH hospitals. The outstationing experience, although limited in many aspects, provides a starting point for evaluation. Other programs that have coordinated and/or co-located social services

217. *See, e.g.*, NAT'L IMMIGRATION LAW CTR., IMMIGRANT-FRIENDLY HEALTH COVERAGE OUTREACH AND ENROLLMENT (2002), *available at* http://www.nilc.org/dc_conf/flashdrive09/Health-Care-Access-Reform/pb13_Immigrant-Friendly-App-Enrllmnt.pdf.

218. *See, e.g.*, U.S.C.I.S., A QUICK GUIDE TO 'PUBLIC CHARGE AND RECEIPT OF PUBLIC BENEFITS (1999), *available at* http://www.uscis.gov/files/pressrelease/Public.pdf.

should also be considered.

A. Outstationing: Has It Worked?

In the late 1990s and early 2000s, there was a great deal of talk around the idea of outstationing, which involved placing a DSS representative in a setting such as health centers and hospitals. As discussed previously, the Omnibus Reconciliation Act of 1990, required DSS to place outstationed workers at FQHCs and DSH hospitals.[219] Despite the limited requirements and high noncompliance, the data still showed that outstationing resulted in a greater uptake of Medicaid/SCHIP; enrollment at these sites did not decrease enrollment at previously existing DSS offices.[220] Since the goal of outstationing was to enroll those who were otherwise uninsured but qualified for healthcare coverage, this program showed that outstationing DSS workers at healthcare facilities was an appropriate way to reach out to a population that was otherwise falling through the cracks. Integration builds upon outstationing and thus should reach a similar population that is otherwise not accessing the appropriate public benefits

B. Select National Experiences: Programs for Women and Children

The National Commission to Prevent Infant Mortality (NCPIM) produced a report looking at one-stop shopping for pregnant women.[221] The goal of the proposal was to "accommodate the needs of pregnant women and their families, rather than leaving them to navigate through a maze of forms and services."[222] To operationalize this goal, NCPIM proposed coordinating health and social services so that there was a single point of entry anywhere in the system.[223] The report reviewed a number of programs qualitatively. They will be discussed here in turn.

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219. *See supra* Part V.A.4.

220. *See supra* note 177.

221. THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, ONE-STOP SHOPPING: THE ROAD TO HEALTHY MOTHERS AND CHILDREN 13 (1991).

222. *Id*. at 13.

223. *Id*.

1. The Baby Love Program

North Carolina implemented a program that used care coordinators who served as a link between services and acted as professional client advocates, helping women apply for Medicaid; secure transportation for clinic appointments; enroll in educations and job training programs; locate affordable housing; obtain food, clothing, and household furnishings; secure day care; stop using tobacco, alcohol and other drugs; and develop the skills that foster independence in utilizing health and social services.[224] The data from this program show that women in the program had a low birthweight rate 14 percent lower and an infant mortality rate 23 percent lower than women on Medicaid not receiving such services. A cost analysis found that each dollar spent on care coordination saved $2.44 in newborn care costs.[225]

The care coordination role is similar to a role that would be played by the rest of the health team (including the social worker) in cooperation with the outstationed eligibility worker. Outstationing has the additional benefit of allowing all members to focus on the patient-client's application and actual receipt of social services instead of working on overcoming the various barriers discussed previously. If care coordination could save $2.44 per dollar spent, integration has the potential to save much more, because integration can be viewed as facilitated care coordination due to the co-location and relationships built.

2. Delaware State Service Centers

The Delaware State Service Centers (SSCs) provide a

224. *See also id*. at 34 (describing the Tampa Hospital's Genesis Program, which placed an ambulatory care center with prenatal, postpartum, family planning, and gynecological care; well baby and child health care; nutritional counseling; health education; social services (social work staff); financial counseling; and on-site child care during the mother's visits. The staff conducts outreach, case management, and transportation assistance to and from appointments. The program also provided linkage to financial and social services counseling. No data could be found on the effect of these services on outcomes. The Genesis Program sounds very similar to the North Carolina Program described here.); *id.* at 32 (describing the Family Life Program, which is based at the Harvard Street Neighborhood Health Center in Dorchester, MA. This program has a day treatment center for substance abuse; prenatal care and classes; postpartum obstetric care; pediatric primary care; parenting education including child development, nutrition and parenting skills development; early intervention programs for young children; child care; transportation; and life skills training. Drug addicted pregnant women were sent here. As of 1991 four of five babies born were full-term and all five were normal, healthy, and drug-free. However, no further information could be found about this program.).

225. *Id*. at 33.

comprehensive co-location of all public benefits available in Delaware and are truly an impressive model. These locations also often provide prenatal care and well child care. Such a program comes very close to a true integration of the delivery of public benefits with that of healthcare provision. Unfortunately, it is not; instead the SSCs are a one-stop shop for an impressive, comprehensive array of social services, including certain public health ones such as immunizations, dental services, lead testing, WIC, prenatal care, and well child visits for children without health insurance.[226] The state service centers are therefore much like the PATH*Mall*, co-locating and coordinating these services under one roof without integrating these services with the delivery of healthcare.

To achieve true integration, State Service Centers need to be placed within or be physically connected to/next to a FQHC or DSH hospital to provide a full range of services. Initial studies of outcomes for these SSCs found that for the high risk women served, only 7 percent of deliveries were low birthweight. This was the same rate as all deliveries state-wide showing that this coordination did help those utilizing their services. However, these healthcare services provided are so limited in both scope and audience that if such a center were already being provided, as it is here, integrating it with FQHCs and DSH hospitals would be much more efficacious in terms of clients benefited and healthcare delivery improvement.

C. Relevant Los Angeles Area Experiences

1. Integrated Services for Homeless People in Los Angeles: The PATH*Mall*

The stated goal of this project, the People Assisting the Homeless Mall (PATH*Mall*) in Los Angeles, is to provide all the services that an individual needs to overcome barriers and access permanent housing.[227] It is premised on the same idea proposed here: the integration of access to social services to meet clients where they are at. By bringing the experts together under one roof to create a client centered approach, PATH*Mall* allows for easy access. This

226. *Id*. at 35; State of Delaware, Division for State Service Centers, http://dhss.delaware.gov/dhss/dssc/ (last visited May 4, 2010).

227. *See* PEOPLE ASSISTING THE HOMELESS, PATH MALL HANDBOOK 2 (2003).

idea is not novel, as we have many shopping centers, mega complexes, and malls across the country. It is just not done very often for poor people.

Physically, PATH*Mall* is a 40,000 square foot one stop shopping facility that houses nearly two dozen public and private social service agencies.[228] The services provided include a full-service employment agency, a substance abuse center, mental health care, a free health clinic, public benefits assistance, a community courts, and even a beauty salon. Bringing together these experts and services has created cooperation and synergy. Referrals could be made and walked over instead of becoming "lost to follow-up." Obviously, this saves the client a great deal of transportation time as well. The centralization at PATH*Mall* also allowed the agencies to link their case management, client tracking, and program outcomes so that together they could coordinate case management to better serve the clients.[229]

In its first year, "1,200 people receive[d] mental health assistance, 500 people f[ou]nd permanent employment, 850 people receive[d] health care, and over 6,000 people receive[d] free haircuts and manicures" through the PATH*Mall*.[230] It effectively changed thousands of people's lives by providing one service, centralization.

The PATH*Mall* demonstrates the importance of process and not just availability of services. It emphasizes that services must be designed to meet clients where they are at instead of creating services and criticizing clients for failing to access them. This follows the philosophy of harm reduction: the provided service must both be accessible (location and hours) and appropriate for client needs.[231]

2. The Sun Valley Medical Legal Community Partnership

At the Medical Legal Community Partnership in Sun Valley, Neighborhood Legal Services discovered that many eligible individuals were not enrolling in the food stamp program. Since there was already a WIC (Womens, Infants, and Children) Program

228. *Id*.

229. *Id*. at 6, 8-10.

230. *Id*. at 2-3.

231. *See supra* notes 93 & 94.

on-site, it made sense to bring food stamp enrollment on-site as well.

Through cooperation with the local Department of Public Social Services (DPSS), a food stamp eligibility worker now comes out to the Health Center at Sun Valley Middle School to enroll eligible individuals into the food stamp program. Eligibility determinations are made with the information collected on-site, saving beneficiaries an added trip to the local DPSS office. The program has been extremely successful, enrolling 75 families in less than a year, resulting in over half a million dollars of economic benefit for the local community.[232]

This project demonstrates that co-location in the healthcare setting reaches an otherwise eligible population not accessing these benefits. Additionally, it shows that DPSS can make eligibility determinations for programs outside of Medi-Cal based on information and applications processed by outstationed workers. However, this model falls short of true integration as the DPSS worker is not a member of the health team.

3. LAUSD

The Los Angeles Unified School District is piloting a "one-stop" application for safety net benefits through the use of One-e-App, which allows for application to a number of these programs.[233] Results of this approach are not yet available.

Other One-e-App pilots in California have shown benefits in process time efficiencies, applicant time efficiencies, time utilization for assistors and workers, error prevention, and total enrollment and retention.[234] However, many of these efficiencies are small, pointing to a need in not only allowing for a single point of entry but also to a

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232. Barbara Siegel & Dennis Hsieh, Neighborhood Legal Servs. of L.A. County, Poster Presentation at the 5th Annual National Medical-Legal Partnership Summit: Creative Partnerships for Systemic Policy Change (Mar. 26, 2010).

233. Social Interest Solutions, California: One-e-app, *supra* note 104 (listing included programs as Medi-Cal (Medicaid), SNAP (Food Stamps), CalWORKs (TANF), Healthy Families (S-CHIP), Healthy Kids, County Indigent Care Programs, Child Health and Disability Prevention Program (EPSDT), Kaiser Permanente Child Health Plan, Earned Income Tax Credit (EITC), Child Tax Credit, Supplemental Nutrition for Women, Infants and Children (WIC), CaliforniaKids (CalKids), California Low-Cost Auto Insurance Program (CLCA), California Alternate Rates for Energy (CARE), Low-Income Home Energy Assistance Program (LiHEAP), Free and Reduced-Cost School Lunches (via Express Lane Eligibility)).

234. *See, e.g.*, ERIKA ANGE ET AL., THE LEWIN GROUP, ASSESSMENT OF ONE-E-APP: A WEB-BASED APPLICATION AND ENROLLMENT APPLICATION FOR PUBLIC HEALTH INSURANCE PROGRAMS 45-79 (2008).

need in back-end program administration and rules simplification.

VIII. BEYOND INTEGRATION: THE HEALTHCARE MALL MODEL

Integration would be a dramatic improvement over what currently exists and would both improve patient health and the delivery of healthcare. An interesting concept to explore further, is creating a PATH*Mall* centered around a healthcare facility. Other important services, such as grocery stores, retailers of basic goods (such as a Walgreens or a Target), the Board of Education, the local Housing Authority, the local Department of Health, and others could set up offices at this location. Thus, a true "one-stop shopping" model for basic necessities and social services would all be co-located in the same complex with healthcare services.

However, these other services do not need to be integrated with the delivery of healthcare services as the DSS services in this proposal are; while these other services are often important to health, they can be navigated either alone or with the help of a social worker. The distinction here being that the other agencies listed do not have the ability to provide immediate access to services as those programs administered through DSS do. Housing programs, if properly resourced, would be the exception.

This healthcare mall complex would have positive externalities, as it would encourage regular utilization of healthcare and preventive care. Parents could drop the kids off at the doctor and run errands while their child is being seen. It might also integrate regular and appropriate healthcare visits into the culture in these communities, thereby preempting the inappropriate use of emergency rooms and avoidable hospitalizations.

Such a proposal is the subject of another paper and is mentioned here simply to show that while novel, a proposal for re-modeling the medical home to integrate the delivery of public benefits with the delivery of healthcare is by no means the limit. It addresses a very specific set of goals, which can then be expanded if further co-location of different services is explored.

IX. CONCLUSION

Overall, it is clear that socioeconomic, legal, and environmental factors have a profound impact on health. Safety net programs are designed to ameliorate the impact of these factors on low-income

individuals. Remodeling the medical home to integrate the delivery of these benefits with healthcare delivery creates a synergistic interaction that improves not only patient care but also health outcomes. At the same time, it makes it easier for patients to access these benefits and allows these programs to actually help those in need.

Remodeling the medical home is a patient-centered one that strives to meet patients where they are at. It directly addresses the informational, stigma, and transaction cost barriers to obtaining these services. Compared to alternatives, it is the most cost effective way to capture a needy audience while overcoming these barriers. In doing so, the remodeled medical home delivers coordinated preventive and long-term care that effectively and realistically meets its patients' needs.

For those looking to coordinate care, provide preventive care, improve chronic care management, increase the uptake of safety net programs, and/or improve healthcare outcomes, remodeling the medical home should be a priority as we work to implement health reform: Increased healthcare coverage without increased safety net coordination will lead to increased healthcare spending without a comparable improvement in health outcomes. Only by improving coordination of healthcare delivery with safety net services can we carry out the twin mandates of health reform–improving health outcomes while bending the cost curve.