Volume 5, Number 2 February, 2014

Accountable Care NEWS

# Insurance, Entitlements, and Charity Care

## The Business Case for Addressing the Health of Highly Vulnerable Populations

***By Douglas A. Hastings***

Responding to the health care needs and costs of the overlapping populations of those who are clinically at-risk or socially disadvantaged remains a fundamental moral and financial challenge in the United States. Among others, these populations include the frail elderly; the homeless; dual eligibles; low income individuals, especially within racial and ethnic minorities and rural Americans; at-risk young children; the mentally ill or cognitively impaired; and those with multiple or complex chronic conditions. For example, many beneficiaries who are dually eligible for Medicare and Medicaid are both economically disadvantaged (86% have incomes below 150% of the federal poverty level) and in poor health (60% have multiple chronic conditions). [1]

Despite these challenges, it is with this highly vulnerable group that payment reform and coordinated care efforts have the biggest opportunity to improve quality of lives, lower costs, and reduce disparities. This is the natural extension of population health management, and is gaining greater attention as an important component of a value-based health care system. Progress will require coordinated federal, state, and private sector efforts—and legal support both through legislation and reduction of legal barriers—but the benefits to society and to these highly vulnerable individuals will be significant.

By most accounts and according to most observers, we are in the midst of a potentially transformational change in the U.S. health care system. There are many precedents and arguable starting points for what we are now experiencing, but one meaningful place to start is the Institute of Medicine's publication in 2001 of *Crossing the Quality Chasm*[2]. In providing the underlying rationale for moving away from fee for service payments and fragmented care, the Chasm report defined quality in a broad way that continues to resonate today, through six aims: care that is safe, effective, efficient, patient-centered, timely, and (importantly) equitable.

The concepts in the Chasm report (and its progeny) also largely served as the framework for the payment and delivery reform sections of the Affordable Care Act in 2010 and the articulation of the Triple Aim as an important theme in implementing the ACA—better care, better health, lower costs. Since the passage of the ACA, we have seen expansion of pay-for-performance and value-based payment programs, and the introduction of accountable care, bundled payments, and population health management into the U.S. health care vocabulary, along with the formation of hundreds of ACOs and similar organizations.

All of this, of course, has played out in the context of evidence that the U.S. health care system costs far more but provides less quality, by various measures, than those of most other developed nations. Also increasingly understood is the extraordinary total expenditures, both in dollars and by percentage, for the care of the most needy and vulnerable of us, as well as the significant and unremitting cost pressures we face going forward as the baby boomers age. These dynamics drive up the cost of insurance and care for all, not just the highly vulnerable.

More recently, there is beginning to be more mainstream recognition of the importance of the connecting medical care and costs with community health and wellness. In January 2014, The Robert Wood Johnson Foundation published a new study, *Time to Act: Investing in the Health of Our Children and Communities*, which may prove to be as galvanizing to population health as the Chasm report was to coordinated care.

The report was the work of a committee co-chaired by economists Mark McClellan and Alice Rivlin. As the introduction to *Time to Act* states: "Our nation is unhealthy, and it is costing us all through poorer quality of life and lost productivity. Health in America is worse than in other developed nations on more than 100 measures….To become healthier and reduce the growth of spending on both public and private medical care, we must create a seismic shift in how we approach health and the actions we take. As a country, we need to expand our focus to address how to stay healthy in the first place. This will take a revolution in the mindset of individuals, community planners and leaders, and health professionals. It will take new perspectives, actors, and policies, and will require seamless integration and coordination of a range of sectors and their work. This shift is critical for both the health and economic well-being of our country." [3]

**Insurance, Entitlements, and Charity Care...***continued*

Among the data cited in the RWJF Report are the following: [4]

- Nationally, nearly one in three children is overweight or obese.
- As many as three in four Americans ages 17 to 24 are ineligible to serve in the U.S. military, primarily because they are inadequately educated, have criminal records, or are physically unfit.
- Poor health results in the U.S. economy losing $576 billion a year, with 39 percent, or $227 billion, of those losses due to lost productivity from those who are ill.
- Medicare would save billions of dollars on preventable hospitalizations and re-admissions if every state performed as well as the top-performing states in key measures of health.
- More than one-fifth of all U.S. children live in poor families, and nearly half of Black children live in particularly unhealthy areas of concentrated poverty.
- Nearly a fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activities.

Earlier, in 2011, the American Hospital Association published *Caring for Vulnerable Populations*, [5] which, among other recommendations, encouraged hospitals and health systems to develop community partnerships with public health departments and other community organizations and to provide non-health care services, such as transportation.[6] The ACA requirement of hospitals to conduct community needs assessments fits well into this new paradigm, and should be seen as an endorsement of the connectivity between medical care and community services to vulnerable populations.[7]

The work of Jeffrey Brenner in Camden, New Jersey, originally highlighted in Atul Gawande's "The Hot Spotters" article in *The New Yorker* provides evidence of the phenomenal quality and cost savings results that can come from aggressively working with the poor, homeless and other super-utilizers in the community outside of the acute setting.[8] Brenner found, as he has commented elsewhere, that 1% of the city's population generated 30% of hospital inpatient and emergency room expenses and 20% were responsible for 90% of inpatient and ER costs.

Joanne Lynn, now with the Center for Elder Care and Advanced Illness, is a nationally-known geriatrician and health services researcher with a long-time focus on the frail elderly. Joanne commented to me recently that most baby boomers will be frail and needy in their later years, and that the line between "entitlement" and "charity" is thin and easily crossed. Joanne's comment led me to the realization that given the realities and direction of health care in the U.S., the differences between commercial insurance, entitlements and charity care, perceived and real, are shrinking.

To achieve the six aims of quality, or the Triple Aim if you prefer, *Time to Act* recommends investing in early childhood development for all children, revitalizing neighborhoods and fully integrating health into community development, and incenting health care professionals and institutions to broaden their missions from treating illness only to helping people lead healthy lives. *Caring for Vulnerable Populations* emphasizes, among other actions, regular comprehensive assessments of each individual's life circumstances, home visits, day-center models, and cultural competency and equity of care standards.

All of this requires creating outreach mechanisms to the community to get the health care system more oriented to "health" and to bring all individuals within the reach of the system if we are ultimately to manage its cost. And it must be understood that such outreach is not a one-way street. These mechanisms must not only bring all individuals within the reach of the health care system, but also actively engage those individuals in the process of becoming healthier, regardless, or in spite of, their circumstances.

The U.S. has a mixed public and private health care system for powerful historical reasons. Both sectors necessarily will need to be involved in and collaborate on this transformation. Product and service opportunities for businesses, non-profit organizations, and government agencies providing goods and services in this context will need to recognize the differing social and clinical needs of population or customer segments, such as healthy, acutely ill, chronic conditions but normal function, stable but seriously disabled, frail with dementia, etc.9 And while better health for all is the goal, focused attention on the overlapping social and clinical needs of highly vulnerable populations is the most critical component in managing overall costs going forward. As a nation, we truly will do well by doing good.

*Doug Hastings is Chair Emeritus of Epstein Becker & Green, PC in Washingtn, DC. He may be reached at dhastings@ebglaw.com.*

## Insurance, Entitlements, and Charity Care...*continued*

### References:

1. Valerie A. Lewis, et al. “The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles,” Health Affairs 31 (2012): 1778.
2. National Research Council. Crossing the Quality Chasm: A New Health System for the 21st Century (Washington: National Academies Press, 2001).
3. RWJF Commission to Build a Healthier America. *Time to Act: Investing In the Health of Our Children and Communities* (RWJF Commission to Build a Healthier America, 2014) 5.
4. RWJF Commission to Build a Healthier America. 10.
5. American Hospital Association. *Caring for Vulnerable Populations* (Chicago: American Hospital Association, 2011).
6. American Hospital Association. 22.
7. *See* I.R.C. § 501(r)(3), added to the Internal Revenue Code by section 9007(a) of the Patient Protection and Affordable Care Act, enacted March 23, 2010, Pub. L. No. 111-148.
8. Atul Gawande. “The Hot Spotters,” *The New Yorker Magazine* 86 (2011): 40.
9. Joanne Lynn, et al. “Using Population Segmentation to Provide Better Health Care for All: The “Bridges to Health” Model,” *The Milbank Quarterly* 85 (2007): 185-208.

 