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Medical-Legal Partnerships IN THE AGE OF THE Affordable Care Act

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Debbie, a low-income single mother, was unfocused and teary-eyed as her oncologist talked to her about her upcoming surgery for stage-four colon cancer.[1] She interrupted her doctor and said, "I just can't focus on this until I know my children will be taken care of if it doesn't work out."

Debbie's oncologist practices in a medical group linked to the Medical-Legal Partnership of Southern Illinois. The oncologist called in the attorney team to discuss Debbie's concerns with her. With Debbie's major surgery just days away, the attorney prepared a short-term agreement granting guardianship over Debbie's children to her best friend if she did not survive the procedure. The existence of the agreement greatly eased Debbie's mind. After the surgery was successful, the attorney met with Debbie again to prepare a last will and testament that more fully took up her concerns. She could not have afforded such legal assistance without Medical-Legal Partnership of Southern Illinois. Having these legal issues resolved allowed her to focus her energy where it was needed—overcoming cancer and getting well. The partnership's advocate also helped her apply for social security disability benefits.

Cases such as Debbie's are the heart and soul of medical-legal partnerships (MLPs), which integrate the legal and health care professions to improve the health and well-being of vulnerable populations.[2] With 137 hospitals, 145 health care centers, and 108 legal aid organizations using MLPs, this nationwide movement is transforming health care by making "legal care" a component of holistic, patient-centered care.[3] Legal care improves health outcomes by alleviating legal stressors occurring at individual, organizational, and community levels. Through MLPs, patients can receive services and advocacy; organizations can initiate and enforce policy changes; and legislators and other key stakeholders can be educated on the connection between law and health. MLPs can vary in the type and level of services offered, but all are interactive, participatory, and integrated; they are not merely a system of referrals between medical and legal providers.[4]

Legal care from MLPs benefits low-income patient-clients, health care providers, and legal aid organizations. We describe MLP benefits through examples from the National Center for Medical Legal Partnership and the Medical-Legal Partnership of Southern Illinois; the latter, a nationally recognized rural organization, celebrated its 10-year anniversary in 2012. In light of rising costs, poor health outcomes, and the

[1]All stories here are those of clients of the Medical-Legal Partnership of Southern Illinois; we have changed the clients' names to protect their confidentiality.

[2]Pamela C. Tames et al., *Medical-Legal Partnership: Evolution or Revolution?* 45 Clearinghouse Review 124, 130 (July–Aug. 2011).

[3]National Center for Medical-Legal Partnership, The Movement (2013), http://bit.ly/19lwpyO.

[4]Tames et al., *supra* note 2, at 130.

passage of the Patient Protection and Affordable Care Act, MLPs can be a key feature of the health care landscape of the future. Here we discuss the MLP model and how legal care not only is sustainable but also can thrive under the Affordable Care Act.

Medical-Legal Partnerships at the National and Local Level

An added component to a health care delivery model, an MLP aims to improve the health and well-being of low-income and other vulnerable populations by meeting legal needs and removing legal barriers to health. Professionals from the legal aid, law school, and private-sector pro bono communities are integrated into health care teams. The legal professionals partner with physicians, nurses, and case managers, among others, to provide direct legal assistance to patients; develop strategies to improve health care and legal institutions and practices; and change policies, thus ensuring that vulnerable people improve their health and sustain improvements. The MLP model is unique because it crosses sectors, integrates services, and influences changes at the individual, organizational, and system levels.[5]

National Center for Medical-Legal Partnership. Developed in 2005 and originally located in the Boston Medical Center, the National Center for Medical-Legal Partnership moved in 2012 to Washington, D.C., as a project of the Department of Health Policy of the George Washington University School of Public Health and Health Services.[6] The center works to improve the health and well-being of vulnerable people by leading research and policy activities to sustain and scale the MLP model of care. The center works in three key areas: promoting policy change at the institutional, local, regional, and national level; gathering data to demonstrate MLPs' efficiency; and growing and supporting the MLP network to achieve sustainability and quality.[7] In 2011 partnerships across the United States helped more than 54,000 people with legal needs and barriers that affect their health and health care.[8]

Medical-Legal Partnership of Southern Illinois. On May 16, 2001, a *New York Times* article about medical-legal partnerships caught the interest of Bill Sherwood, general counsel for Southern Illinois Healthcare (SIH), a nonprofit health care system.[9] Through three hospitals and two clinics in deep southern Illinois, SIH serves rural residents in an economically impoverished Delta region of 16 Illinois counties, 11 of which are classified as economically distressed.[10] Sherwood discussed the article with Southern Illinois Healthcare's director of community benefits. During a health policy institute at the Southern Illinois University School of Law, the director met a senior public benefits attorney from Land of Lincoln Legal Assistance Foundation, which is funded by the Legal Services Corporation (LSC), and discussed the medical-legal partnership idea. The Southern Regional office of Land of Lincoln Legal Assistance Foundation serves the same population that accesses health care through SIH. In the spring of 2002, with a modest $1,600 from SIH's community benefits resources for a 16-week pilot project, Medical-Legal Partnership of Southern Illinois was born.

In the 10 years since the partnership's inception,1,478 people have been referred and 1,237 legal issues have been resolved with positive outcomes (advice was received, disability or Medicaid benefits were obtained, a power of attorney was executed); almost $6 million in patient medical debt has been relieved; and SIH has been reimbursed over $1.3 million. More important, the partnership's le-

[5]National Center for Medical-Legal Partnership, The Model (2013), http://bit.ly/GzLr05.

[6]*Id.*, The Center, http://bit.ly/1boWmbj.

[7]*Id.*

[8]*Id.*, MLP Impact, http://bit.ly/1c4YXXB.

[9]Carey Goldbert, *Boston Medical Center Turns to Lawyers for a Cure,* New York Times, May 16, 2001, http://nyti.ms/1b7iPcR.

[10]Delta Regional Authority, Distressed Counties and Parishes (2013), http://bit.ly/16tS5uA.

gal interventions remove barriers so that patient-clients can focus on improving their health. The partnership's forward thinking has expanded the scope of services to include federally qualified health centers and senior citizen advocates to be a part of the partnership's network. This enables those upstream from inpatient or emergency department care to triage legal care needs in advance of health problems becoming critical. In addition to the benefits provided to clients and SIH, Land of Lincoln Legal Assistance Foundation has received SIH funding that has increased staff time dedicated to legal care. The partnership with Land of Lincoln Legal Assistance Foundation is a reflection of Southern Illinois Heathcare's mission-driven orientation to provide the best care within its facilities and in the community. Recently Medical-Legal Partnership of Southern Illinois's staff was a part of SIH's interview process to add staff to Southern Illinois's Community Benefits Department. Land of Lincoln Legal Assistance Foundation's relationship with the second largest employer in this geographic area allows the foundation to work with the community and make sure that employers, such as Southern Illinois Healthcare, understand the common needs that both organizations serve. In 2012 Medical-Legal Partnership of Southern Illinois was honored by the National Center for Medical-Legal Partnership as the Outstanding MLP of the Year.

The Affordable Care Act and Hospital Community Benefits

The Affordable Care Act aims to improve the quality of health care while reducing costs. The design of the Act is intended to (1) improve insurance coverage by offering insurance subsidies or tax credits, decreasing exclusionary criteria, and increasing marketplace competition in all states as well as expanding Medicaid in some states; (2) encourage payment models based on the quality of processes and outcomes as opposed to the quantity of services; (3) promote the role of primary and preventive medical care; (4) support innovation and coordination in the medical care system, especially for patients eligible for Medicaid or Medicare; (5) support the expansion of the health care workforce, especially with regard to primary care; (6) augment the health care safety net by supporting community health centers, community-based care, and community-health-needs assessments; (7) decrease out-of-pocket prescription drug costs for Medicare Part D enrollees; (8) provide for grant- and contract-funded projects in various areas, from medical malpractice to community-based physical activity; and (9) set minimum amounts of insurance premiums dedicated to clinical services (i.e., medical-loss ratios of insurers).[11]

As part of its support for community-based care, the Affordable Care Act changes nonprofit hospitals' reporting requirements. To maintain a nonprofit status, a hospital must annually complete Schedule H, an Internal Revenue Service (IRS) Form 990 attachment.[12] Schedule H reports the hospital's community benefit, which hospitals must provide to maintain 501(c)(3) nonprofit status and receive related tax benefits. Certain activities are eligible for inclusion on Schedule H while others are excluded. For example, hospitals may include charity care but not bad debt. Economic losses between costs and payments for Medicaid may be included, but the same losses for Medicare may not. Overall Schedule H is broad and allows for flexibility for specifying activities within categories.

The Affordable Care Act also requires nonprofit hospitals to complete a community-health-needs assessment and present a plan to meet those needs to comply with Section 501(c)(3). This new requirement adds a level of justification for activities in relation to needs that Schedule H did not

[11]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[12]Internal Revenue Service, U.S. Department of the Treasury Hospital Schedule H (Form 990): Hospitals (2013), http://1.usa.gov/1b7ptjw.

have.[13] Community benefits in general include programs and services designed to meet community health needs, increase access to health care, and respond to the needs of vulnerable populations. Community benefits activities fulfill a health system's commitment to provide care to those who are unable to pay and those who are members of traditionally vulnerable and underserved groups. Community benefits are mission driven, often supplying services or programs with a low or negative profit margin—programs that would likely be discontinued if the decision were solely financially driven. Community benefits include uncompensated (charity) care, free and reduced-cost services such as health screenings, community outreach and education, grants, sponsorships, meal programs, research, medical education, and other in-kind services. Community benefits do not include patient bad debt or the unpaid costs of providing care to those who have Medicare (reimbursement lower than actual cost of providing care.)

Although "charity care" has been part of the U.S. income tax structure for years, the adequacy of nonprofit hospitals' community benefits is increasingly the subject of congressional scrutiny.[14] Over time, due to the enactment of Medicaid and Medicare, nonprofit hospitals were providing less uncompensated care. As a result, in 1969 the IRS changed federal tax exemption reporting requirements from charity care alone to include community benefits.[15] Activities benefiting the community as a whole are tracked and reported to demonstrate the adequacy of a hospital's efforts to serve the health needs of the community. In 2008 the IRS revised reporting requirements for nonprofit hospitals to obtain increased transparency.[16] Changes included tracking the number of persons to whom charity care was provided and the proportion of the health care facility's operating expenses attributable to uncompensated care. The new community-benefit-reporting requirements separate activities into different cost categories that may qualify for community benefit expenses.[17] Despite increased interest in documenting community benefits, there is no federal guidance detailing the overall level of benefits necessary or the composition of activities needed to qualify or maintain a tax-exempt status.[18] State guidelines for evaluating whether hospitals are entitled to tax exemption vary with regard to defining community benefits, vulnerable populations to be served, and reporting requirements.[19] In March 2010 the Affordable Care Act further amended the Internal Revenue Code to include a community-health-needs assessment and implementation plan, financial assistance and emergency care policies, and limits on charges, billing, and collection activities devoted to uninsured individuals.[20]

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[13]See 26 U.S.C. § 501(r); Catholic Health Initiatives, Community Benefit (2013), http://bit.ly/1bc2aF0; Sara Rosenbaum et al., *Hospital Community Benefit Expenditures: Looking Behind the Numbers*, Health Affairs Blog (June 11, 2013), http://bit.ly/1eH2egs; Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 New England Journal of Medicine 1519–27 (2013).

[14]Donna Folkemer et al., Hilltop Institute at University of Maryland, Baltimore County, Hospital Community Benefits After the ACA: The Emerging Federal Framework (Jan. 2011), http://bit.ly/1aHloNA.

[15]*Id.*; IRS Revenue Ruling 69-545, 1969-2, C.B. 117 (1969), http://1.usa.gov/16dsZF0.

[16]U.S. Government Accountability Office, GAO-08-880, Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements (Sept. 2008), http://bit.ly/bhvqF2.

[17]Eileen Salinsky, National Health Policy Forum, Schedule H: New Community Benefit Reporting Requirements for Hospitals (April 21, 2009), http://bit.ly/1dU7haB.

[18]U.S. Congressional Budget Office, Nonprofit Hospitals and the Provision of Community Benefits 5 (Dec. 2006), http://1.usa.gov/1boKuX3 (hospitals' eligibility for tax exemptions are determined under state law; states develop and implement their own criteria and are not required to utilize standard for determining charitable status under federal law).

[19]Martha H. Somerville et al., Hilltop Institute at University of Maryland, Baltimore County, Hospital Community Benefits After the ACA: The State Law Landscape (March 2013), http://bit.ly/18oHKnJ.

[20]26 U.S.C. § 501(r).

Clients' Needs and Social Determinants of Health

The LSC estimates that 20 percent of Americans in 2012—over 60 million people—qualified for LSC-funded civil legal services. Those numbers represent an increase of 10 million people compared to 2007.[21] The gains in people qualifying for legal aid are projected to continue to rise through at least 2014.[22] Overall there is one legal aid attorney for every 6,415 people living in poverty.[23] The type of legal assistance needed has also changed due to the foreclosure crisis and the needs of returning veterans.[24]

Despite the documented need for legal assistance, the number of legal aid attorneys is at least one-fifteenth of attorneys available to the general population.[25] Legal aid in rural America is in even shorter supply; some estimate that there are 10,000 to 12,000 impoverished rural residents for every rural legal aid attorney.[26] Recent revenue reductions for legal services have exacerbated these problems; in 2011 alone LSC-funded organizations nationwide eliminated 661 full-time positions, including 241 attorneys.[27] An additional reduction of 333 attorneys in 2012 was expected.[28] This results in 50 percent to 80 percent of the civil legal needs of low-income people going unmet.[29] Since most people living in poverty have civil legal problems, and half of those seeking services do not receive services, the supply of legal assistance available to lower-income people is insufficient to meet the civil needs of rural Americans.[30] The LSC's October 2012 pro bono task force reports on this "perfect storm" of increased need in the face of cuts in LSC programs. The task force states that "one major theme of this report is collaboration."[31] MLPs, and the idea of bringing together attorneys and health care professionals where the clients already are, fit that theme perfectly.

Social determinants of health (i.e., education, employment, housing, and income) can negatively affect an individual's health and well-being, but the social problems that affect people's health often have legal solutions. Unenforced sanitary codes, which can lead to mold and, in turn, children becoming sick, are a legal problem. This is not a problem traditionally presented to a legal aid office because the client may not recognize the causal connection between mold and the client child's health problems. Legal problems such as these are front and center in health care centers or hospital emergency departments. The physician who works with the child during the health crisis learns that mold is a problem in the home through a thorough patient history. No matter how capable and compassionate the physician is, the child's health has a much greater chance of improving by the addition of a legal intervention that removes the root cause of the problem.[32]

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[21]Legal Services Corporation, Report of the Pro Bono Task Force 1 (Oct. 2012), http://1.usa.gov/1aHJjgT.

[22]*Id.*

[23]Legal Services Corporation, Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans 20 (Sept. 2009), http://1.usa.gov/150QDn1.

[24]Legal Services Corporation, *supra* note 21, Executive Summary.

[25]Legal Services Corporation, *supra* notes 21 and 23.

[26]Daniel T. Lichter & Domenico Parisi, Carsey Institute, Concentrated Rural Poverty and the Geography of Exclusion (Fall 2008), http://bit.ly/1714urh.

[27]Legal Services Corporation, *supra* note 21, at 2.

[28]*Id.*

[29]Legal Services Corporation, *supra* note 23, at 2–3; Laura K. Abel & David Pedulla, Brennan Center for Justice, Reform Federal Civil Justice Policy to Meet the High-Stakes Legal Needs of Low-Income People (Jan. 5, 2007), http://bit.ly/1boHsSq.

[30]Legal Services Corporation, *supra* note 21, at 1.

[31]*Id.* at 2.

[32]Joel Teitelbaum & Tom Koutsoumpas, *Health Reform Should Include Legal Care for Patients,* Health Care Blog (April 9, 2013), http://bit.ly/16ECvU1.

A health care system–funded MLP allows the legal aid partner to hire additional staff to take up previously unmet civil legal needs. A fully functioning MLP can also train the health care staff on legal issues, and thus the staff can resolve certain legal issues in the physician's office. For example, a doctor's office can be provided with advocacy tools to fight, on behalf of a patient, a utility company's disconnect notice when the patient's health is at risk. This means that a greater percentage of the low-income population can receive legal care without having to go to a legal aid organization.

A relationship with a health care provider through an MLP can also affect how the legal aid program establishes its priorities and case acceptance decisions overall. If only 20 percent to 50 percent of the legal needs in the community are met, legal aid programs' resources should be directed to where they will have the greatest impact. Legal aid attorneys should not only meet a legal need but also advocate on legal issues affecting their clients' health. The MLP culture can give greater depth to legal services being provided and a greater impact on the clients who are being served.

Through MLPs, clients can access legal care in a familiar and accessible setting: their physician's offices. Neighborhood legal aid offices are, more often than not, a thing of the past due to funding restrictions and other issues; the MLP model capitalizes on the patient-doctor relationship to bring legal care into patients' lives.[33] For example, Ms. P.'s treating physician repeatedly observed bruising on her and learned that she received the bruises from her abusive husband. This woman, who was trying to become a lawful permanent resident of the United States, was terrified because her husband was threatening to contact immigration services and have her deported. The only person she felt she could tell this story to was her physician. The physician brought her to the attention of a legal advocate at the Medical-Legal Partnership of Southern Illinois. Through the partnership, she obtained a divorce and an order of protection for her and her children. The partnership also referred her to a local immigration attorney, who assisted her pro bono. She is now a lawful permanent resident, works three jobs, is able to care for her children, and has a safe home environment.

Mr. V. was referred to Medical-Legal Partnership of Southern Illinois by a senior advocacy center. He was very ill and needed help in obtaining Medicaid and social security benefits. Because he had not visited a doctor in 20 years, he did not have any of the documentation necessary to obtain these much-needed benefits. Medical-Legal Partnership of Southern Illinois's legal advocate referred him to a physician at a partnering federally qualified health care facility. The physician contacted Southern Illinois Healthcare and got the medical tests he needed to make a proper diagnosis at no charge to the patient through Southern Illinois Healthcare's charity care program. The legal advocate sent the test results to the Illinois Department of Human Services and the Social Security Administration. Due to the severity of his condition, Mr. V. was approved for Medicaid and Supplemental Security Income benefits at the initial stage. Each of these linkages is a critical part of the partnership process and proved to be life changing for Mr. V, who now has access to medical care he needs, and resources for his basic necessities.

These are the clients receiving assistance through Medical-Legal Partnership of Southern Illinois. Domestic violence, lack of health insurance, and income problems are some of the social determinants of health directly affecting their lives. But for the partnership, such clients might not have found or had access to legal services. Their stories demonstrate the true partnership built through an MLP and how a community can work together to better the health of its citizens.

Legal Care as a Part of the Affordable Care Act

The Affordable Care Act aims to increase access to the medical care system. Access means, in part, that patients will be able

[33]Tames et al., *supra* note 2, at 133.

to receive professional medical services and that payment methods (i.e., insurance) will be available to resolve health issues. Although health care and medical care are often used interchangeably in the United States, the terms are not the same.[34] Health care is a broader term that subsumes subspecialties such as public health, medical care, and legal care. The Affordable Care Act is largely a medical care reform law. To meet accountability standards, decrease health disparities, and maintain global competitiveness, broader health care reform is necessary. Despite the impact of law on conditions and lifestyles that influence health, legal services are out of reach of many low- to moderate-income people. For lack of access to the legal tools and services to resolve health care issues adequately, vulnerable populations cannot navigate the legal system. In criminal cases Americans have the right to an attorney. In civil cases, the focus of MLPs, there is no such right. This means that, under the Affordable Care Act, an individual with asthma may have better access to a physician and be able to pay for medical care, but the individual may not have the tools to remediate the causes of the individual's poor health—tools such as that provided by an attorney who advocates improvements in the physical environment that triggers asthma.

In light of the Affordable Care Act's focus on financing care, there is interest in discussing innovative and integrated methods to change health systems to improve patient and population health. MLPs improve health care by better integrating medical and legal care. Integrating different types of care improves patient experiences and outcomes. Improving outcomes decreases preventable health care costs. The triple aims of health care are improvements in costs, processes, and outcomes.[35] The United States invests significantly more in medical care than any other country. However, the United States typically performs worse on almost all health indicators compared to similarly developed nations.[36] The United States has lagged behind other countries in recognizing the social determinants of health, even though social epidemiologists have long recognized the association of social determinants and health.[37] MLPs not only integrate types of care but also directly consider these social determinants.

Because of the large role of social and economic factors in shaping the health of communities, collaboration from all sectors is important.[38] Professionals in diverse fields working together to screen, diagnose, and treat nonmedical factors contributing to patients' health will be crucial as the health care system continues to integrate medical and legal care and evolve. Improving population health, enhancing the patient care experience, and reducing or controlling the costs of care are enhanced by multidisciplinary partnerships.

The Affordable Care Act promotes population health. Broader perspectives on care offer opportunities for adding MLPs into the health care system. The Act provides for lower absolute or relative payments for care for lower levels of patient experience or worse health outcomes. For example, hospitals will be penalized for hospital readmission within 30 days of discharge from an originating health event.[39] MLPs have potential to be part of a strategic plan to develop and implement processes to reduce avoidable emergency department visits and reduce avoidable

[34]Thomas O'Rourke, *Health Care Reform: Insights for Health Educators*, in Philosophical Foundations of Health Education 305–10 (Jill M. Black et al. eds., 2010).

[35]Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 Health Affairs 759–69 (2008).

[36]Commonwealth Fund, 2010 Annual Report (n.d.), http://bit.ly/1g0sr8V.

[37]Social Epidemiology (Lisa F. Berkman & Ichiro Kawachi eds., 2000).

[38]Paul W. Mattessich & Ela J. Rausch, Wilder Research & Federal Reserve Bank of Minneapolis, Collaboration to Build Healthier Communities: A Report for the Robert Wood Johnson Foundation Commission to Build a Healthier America 1 (June 2013), http://bit.ly/GzFQY0.

[39]Patient Protection and Affordable Care Act §§ 3025, 10309.

readmissions. MLPs can serve as an important part of care coordination. Many of the conditions leading to recidivism can be tended to by considering patients' needs broadly to include not only health indicators but also basic necessities such as income, safety, food, and shelter. Legal and health care delivery models can work together to prioritize patient care coordination and improve outcomes. Navigating the legal as well as the health care system can help individuals and their families avoid returning unnecessarily to a medical provider for a recurring condition.[40]

MLPs can inform hospitals about community needs during hospitals' community-health-needs assessments and can propose solutions as hospitals develop their plans to meet community needs. Legal care should be understood as a need and a solution in the medical care system and the broader health care system. Accountable care organizations aim to integrate care to control costs and improve processes and outcomes; MLPs align with the overarching aims of accountable care organizations.[41] Consumer assistance and health navigation programs within the Affordable Care Act promote objective communication, education, and advice on health insurance plans, medical complaints, and patient rights. MLPs can offer objective advocacy and pursue policy enforcement due to the professional training of legal advocates.

One economic justification for MLPs is health care recovery dollars to hospitals (i.e., back pay of Medicaid benefits for which a patient was entitled at the time of service). Are MLPs still helpful regarding health care recovery dollars post–Affordable Care Act? Since the Act aims to increase the number of people insured in the United States, will there be a need for health care recovery dollars? The answer to this is "yes." Even after implementation of the Act, millions of Americans will remain uninsured in 2014 and beyond. Because the Act expands Medicaid, more people will be eligible for Medicaid benefits, and some people will require legal advocacy to obtain them. People will drift in and out of insurance benefits from insured to uninsured, from one plan to another, and from one benefit eligibility status to another. Such fluidity is rife with legal issues and thus a need for advocacy. There is also a continuing need to equip medical professionals with the skills to recognize social determinants of health and potential unresolved legal needs and to understand the effect of poverty on health.[42]

Medical-Legal Partnership of Southern Illinois: Past, Present, and Future

Through shared goals of improving the health and well-being of vulnerable populations, and 10 years of trial, error, and success, Southern Illinois Healthcare and Land of Lincoln Legal Assistance Foundation have established a sustainable model for a rural MLP. Medical-Legal Partnership of Southern Illinois's processes and outcomes have made a difference in hundreds of patients' lives and resolved myriad legal problems. One element of the partnership that gained early recognition on a national scale is its return-on-investment data. Although these data are only a small part of the partnership, they have allowed the National Center for Medical Legal Partnership to make the case for MLPs to health care systems nationwide.

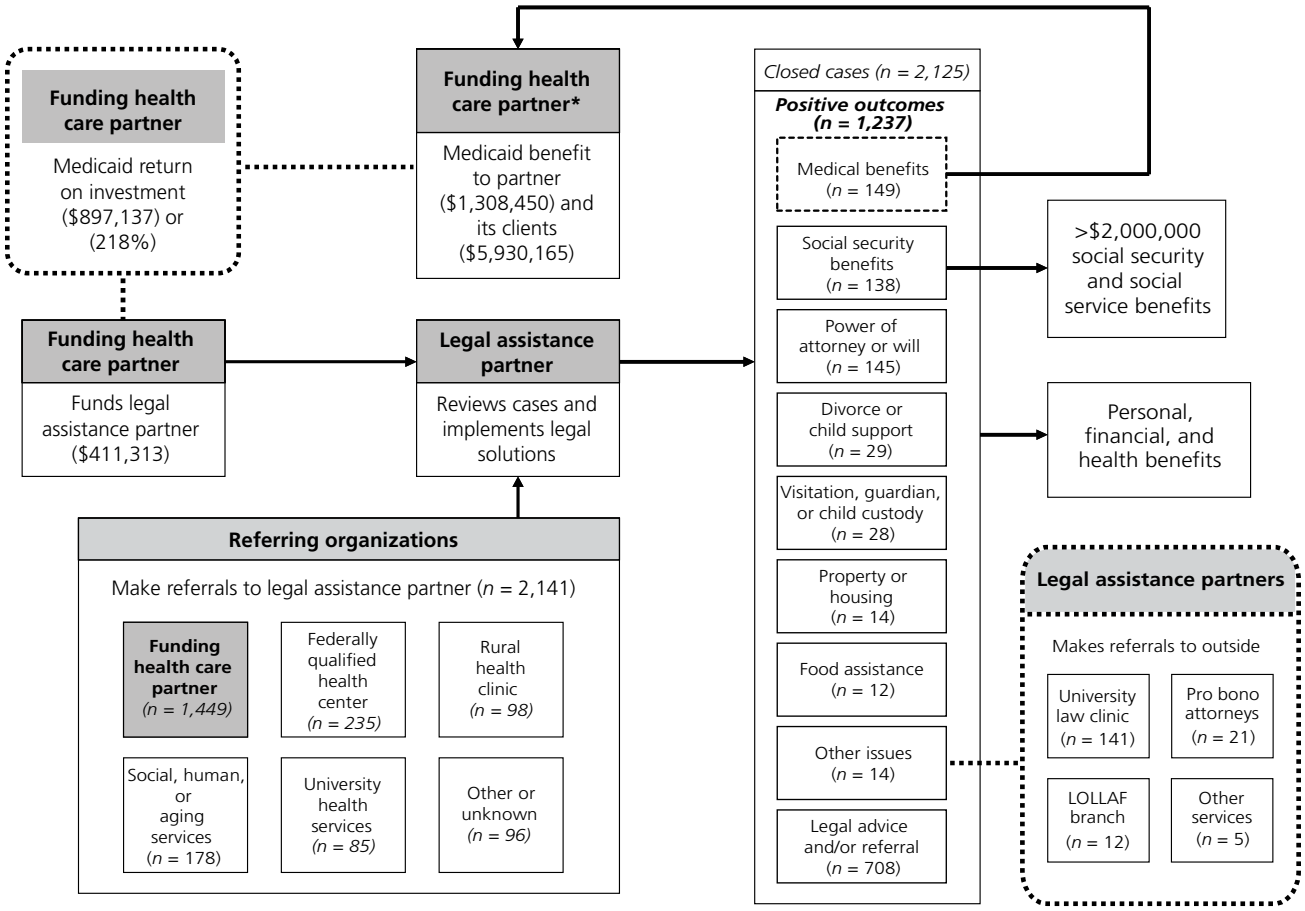
Medical-Legal Partnership of Southern Illinois has historically argued for return on investment based largely on health-care recovery dollars (i.e., the amount of health care dollars reimbursed to Southern Illinois Healthcare as a result of participation in the partnership). The investment, referral system, and outcomes are depicted in figure 1, which has been used as a model for MLP return on invest-

[40]Tames et al., *supra* note 2.

[41]Accountable care organizations are voluntary groups of physicians, hospitals, and other health care providers agreeing to operate together by using a care delivery model that ties together quality of care, payments, better care coordination, and shared total cost for a set population of patients (Centers for Medicare and Medicaid Services, Accountable Care Organizations (ACO) (March 22, 2013), http://go.cms.gov/GzK7u4).

[42]*Id.*

Figure 1. Summary of Medical-Legal Partnership of Southern Illinois investments, referrals, and outcomes.



Source: Evaluation study approved by Southern Illinois Healthcare institutional review board and on file with Land of Lincoln Legal Assistance Foundation.

ment. Between 2002 and 2012, Southern Illinois Healthcare invested $411,313 in Medical-Legal Partnership of Southern Illinois.[43] As a result of the partnership, patients had almost $6 million in medical debt relieved and Southern Illinois Healthcare received $1,308,450 in public insurance benefits. This is an estimated 218 percent return on investment. This amount is the lower-limit estimate of Southern Illinois Healthcare's recovery dollars since the amount includes only known reimbursements. Some patient reimbursement information was not disclosed, and a few Medicaid claim cases from 2011–2012 are still pending. The actual return on investment to Southern Illinois Healthcare from recovery dollars is estimated to exceed $1.5 million.

In the 2007–2009 Medical-Legal Partnership of Southern Illinois update study, the partnership moved toward a broader view of return on investment based on economic development and justice.[44] Economic development is integral to the maintenance, expansion, and recovery of economically disadvantaged

[43]All underlying data for figure 1 were collected through an evaluation study approved by Southern Illinois Healthcare's institutional review board (see James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-Up Study*, 23 Journal of Health Care for the Poor and Underserved 705 (2012), http://bit.ly/1eX4iRC (data on file with Land of Lincoln Legal Assistance Foundation)). The data supporting figure 2 were collected by us in 2013 and are on file with Land of Lincoln Legal Assistance Foundation.

[44]Teufel et al., *supra* note 43, at 705–14.

communities. The investment of internal community resources ($411,313 paid to Land of Lincoln Legal Assistance Foundation by Southern Illinois Healthcare) resulted in eight-and-one-half times as much external monetary resources being brought to the community (approximately $1.5 million in public health insurance funding and more than $2 million in social service benefits). Beyond health care debt relief, patients received social security back pay and ongoing monthly social security payments, Medicaid coverage, and food assistance payments. Patients had economic justice in the establishment and enforcement of child-support payments. Patients were relieved of debt burdens of over $6 million, including health care and consumer debt.

Three additional elements of return on investment are the relative value of services of legal assistance providers (i.e., free services that have an actual cost if offered on the free market); the integration of services and sectors; and the social return of easing life stressors related to legal issues. During 2012 Medical-Legal Partnership of Southern Illinois calculated the average value of legal services if purchased in the free market. The per-case average was estimated to be $887. Extrapolating that amount to all of the cases that the partnership worked on from 2002 to 2012 results in a legal services value of $1,899,067. Medical-Legal Partnership of Southern Illinois's addition of federally qualified health centers, mental health care organizations, and senior advocacy groups to the partnership's network has resulted in a diversification of referrals. This allows patients early (or earlier) access to legal care that may avert an emergency department visit or a hospital admission and indicates further integration of the partnership in and out of the health care system. The promotion of integration fits the MLP goal of broader health care system reform.

Medical-Legal Partnership of Southern Illinois continues to map the impact of its effort, broadening a traditional return on investment based on cost-benefit analysis to a social return on investment.[45] In the traditional return-on-investment calculation, funds spent and earned are compared. The partnership's return on investment was based on the dollars invested by Southern Illinois Healthcare and the dollars returned to Southern Illinois Healthcare, which received more than two dollars beyond every dollar invested. Through social returns on investment, value outcomes can be added. If the investment is held constant, a social return on investment will be equal to or greater than a traditional return on investment. For the partnership, the social return on investment significantly increases. The earned benefits include social security benefits, legal service provision, life-events stress eased, and health care recovery dollars.[46]

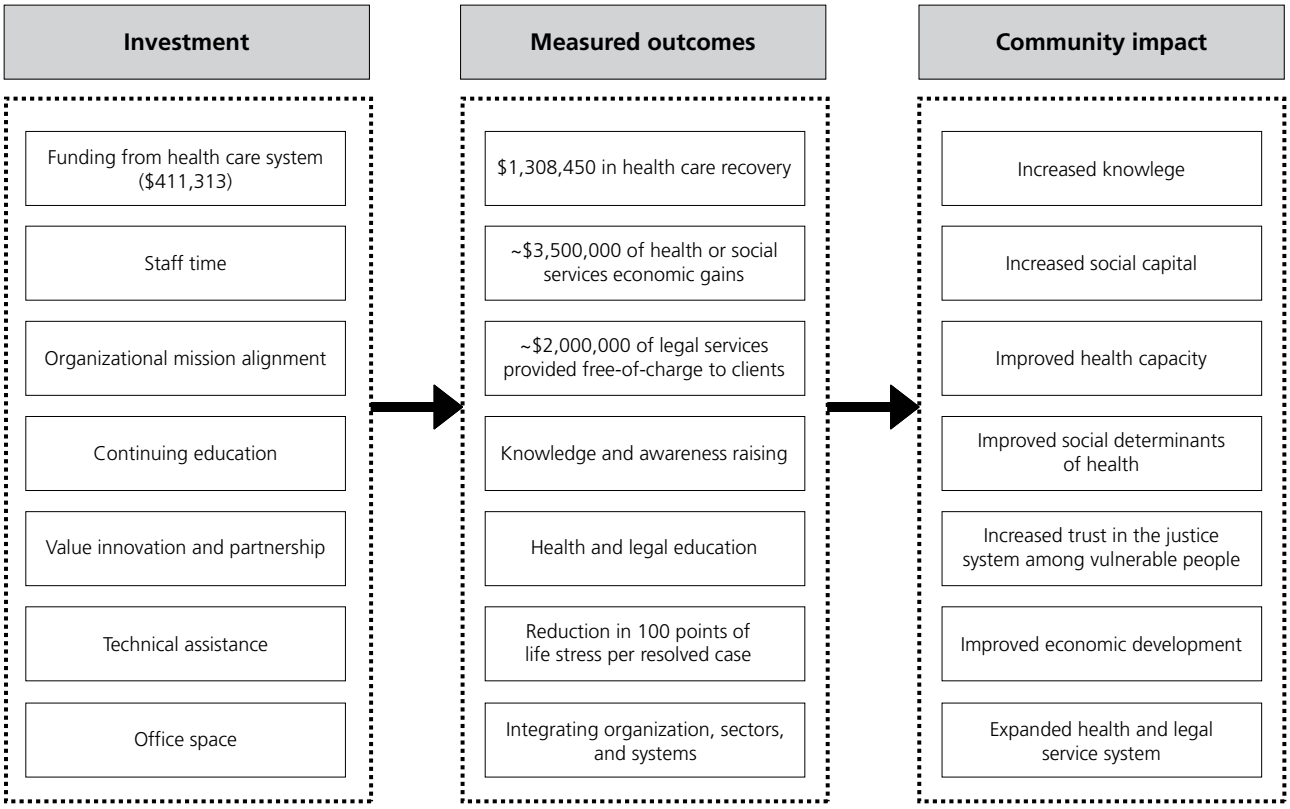
The social return on investment calculation supports a monetized return of more than 1,166 percent. The partnership's social return on investment is five times greater than the return on investment. The social return-on-investment calculation also used stress point value as a currently nonmonetized benefit. Other nonmonetized benefits include activities of Southern Illinois Healthcare's integration and participation, and perception of social capital such as increased trust in the justice and health systems. The broader social return on investment impact of the partnership is shown in figure 2.

Medical-Legal Partnership of Southern Illinois has expanded in a variety of ways and in recent years has shifted focus toward increasing depth rather than breadth of the partnership. The partnership's early years focused on market-

[45]Malin Arvidson et al., *The Ambitions and Challenges of SROI* (Third Sector Research Centre, Working Paper 49, 2011), http://bit.ly/16UdyNo; Jan Brouwers et al., Social Return on Investment: A Practical Guide for the Cooperation Development Sector (Oct. 2010) (on file with Diane M. Goffinet); Stephanie Robertson, SIMPACT StrategyGroup, Social Metrics, Outcomes Evaluation and Social Return on Investment (Feb. 29, 2012) (on file with Diane M. Goffinet).

[46]Life stress was estimated by linking life-stress points of the social readjustment rating scale, which links life events and stress levels and correlates levels of stress with health to legal issues considered by Medical-Legal Partnership of Southern Illinois (Thomas Holmes & Richard Rahe, *The Social Readjustment Rating Scale*, 11 Journal of Psychosomatic Research 213–18 (1967)). Social return on investment is equal to: (healthcare recovery dollars + social security dollars + legal service dollars + life stress value – dollar investment) / dollar investment. Dollar values are associated with all but life stressor points.

Figure 2. Social and economic return on investment of Medical-Legal Partnership of Southern Illinois.



Source: Data collected by Diane M. Goffinet, James A. Teufel, Diane Land, Andrew Weaver, and Woody Thorne and on file with Land of Lincoln Legal Assistance Foundation. © 2013 by James A. Teufel.

ing and reaching every site in the health system. The partnership now promotes legal care as the new standard of care, which demonstrates the partners' commitment to providing care to vulnerable populations. The partnership promotes itself as not just a referral program but "an integrated approach to health and legal services that facilitates critical, efficient, shared problem solving by health and legal teams who care for patients with complex health and legal needs."[47]

Under the Affordable Care Act, Medical-Legal Partnership of Southern Illinois seeks to demonstrate the efficacy of the care management team of nurses and social workers in reducing avoidable readmissions and emergency department visits by superutilizers. Some future initiatives are using standardized screening tools, integrating standardized letters and forms into primary care practice, and embedding prompts in the electronic health record to uncover potential unmet legal needs. These initiatives, along with social return on investment data, justify MLPs' future role.

■ ■ ■

In the era of the Affordable Care Act, cross-sector collaborations to manage population health are essential. MLPs enhance understanding of features of the social environment affecting individual health. These collaborations improve population health. Full responsibility for health is shared by coordinating efforts attending to a range of health influences. MLPs demonstrate how community stakeholders can find common ground through similar missions to protect and improve their communities. These efforts show how the MLP model can thrive during the era of the Affordable Care Act.

[47]Tames et al., *supra* note 2, at 131.

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