AMA Journal of Ethics®
August 2024, Volume 26, Number 8: E640-647

POLICY FORUM: PEER-REVIEWED ARTICLE

Why MLP Legal Care Should Be Financed as Health Care

William M. Sage, MD, JD and Keegan D. Warren, JD, LLM

Abstract
Medical-legal partnership (MLP) integrates the unique expertise of lawyers into collaborative clinical environments. MLP teams meet the needs of individual patients while also detecting structural problems at the root of health inequities and advancing solutions at the institutional, community, and system levels. Yet MLPs today operate in limited settings and survive on scant budgets. Expanding their impact requires secure funding. Financing MLPs as health care can do the following: (1) help address inequity at the point of care; (2) enable expert diagnosis and treatment of nonmedical drivers of health; (3) enhance team-based practice in health care organizations; (4) offer another way for clinicians to participate in advocacy; and (5) bolster a broader movement to increase access to justice.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ *available through the* AMA Ed Hub™. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

Medical-Legal Partnership Needs Funding

Medical-legal partnership (MLP) is an established, successful, yet underappreciated approach to care delivery that uses legal expertise to bridge the gap between America's enormous investment in medicine and the payoff of that investment in individual and population health. MLP addresses health-harming legal needs connected to nonmedical drivers of health (NMDOH). These are often summarized through the I-HELP™ acronym: income and insurance, housing and utilities, education and employment, legal status, and personal and family stability.[1] Beyond solving acute problems, MLP prioritizes moving from patients to policy by translating patterns of need into institutional, community, and system change.[2]

Because it does not command sufficient public attention or resources, MLP tends to operate in particular environments and generally survives on shoestring budgets.[3] Rather than offering general coverage of MLP through Medicaid or Medicare, federal policy targets specific clinical enterprises, including federally qualified health centers (FQHCs), nonprofit hospitals, and Department of Veterans Affairs facilities. Each setting has unique characteristics that demonstrate commitment to addressing NMDOH by incorporating legal interventions into the delivery of care.

Taken together, however, these federal programs convey what we consider a key insight for future MLP policy: that legal needs and social needs are inextricable from each other and from clinical interventions at the point of service. In our view, lawyers' expertise must be integrated into care delivery for the health care system to achieve consensus goals of increasing access to care, remediating avoidable health disparities, and improving the population's health. Achieving these goals requires consistent funding through public investment.

Although MLP financing could take various forms, coding and reimbursing health-promoting legal services based on clinical indications and impact embedded in electronic health records is most straightforward.[4] For example, substandard living conditions are classified as a habitability matter by housing attorneys, who document in structured, electronic fields the unhealthy home environment and the interventions employed to force a landlord to improve the situation. In combination with a clinical diagnosis, such as asthma, and a clinical outcome, such as reduced incidence of asthma attacks, the legal interventions enhance the value proposition of medical services and align with new screening and billing standards for NMDOH in primary care practices and emergency departments.[5,6]

Why MLPs Are Important

Recognizing the remediation of health-harming legal needs as part of clinical care would meet the moment in several important ways. First, it reinforces other efforts to achieve health equity by strengthening the connection between community and clinical settings for individuals and families as well as for populations. Second, by configuring legal assistance as clinical revenue generation through an adjustment of coding and claims rather than as a benefit expansion, it favors the integrated provision of MLP services over less measurably effective "referral out" models, in which legal needs are only loosely connected to patient well-being.[7]

Third, by bringing physicians, nurses, lawyers, social workers, and others together in pursuit of shared goals, funding MLP as clinical care helps accelerate interprofessional training and team-based practice, which adds a positive dimension to potentially concerning trends toward physician employment within large organizations. Fourth, MLP's incorporation of legal advocacy tools and training in clinical settings fosters a greater sense of agency and control in the postpandemic health care workforce, which struggles with burnout and moral injury.[8] Finally, funding MLP makes overall civil legal aid (ie, access to justice for those who cannot afford it) more financially secure by linking it conceptually and operationally to medical care that has broad-based public endorsement.[9]

Health Plans and Health Coverage

The Centers for Medicare and Medicaid Services (CMS) has acknowledged the value of legal expertise in expanding access to insurance, including through its Connecting Kids to Coverage outreach and enrollment initiative.[10,11] However, there is no statutory mandate for health plan coverage of legal services, whether through private insurance or under Medicare or Medicaid. Moreover, despite recent attention to NMDOH, CMS does not expressly identify health-harming legal needs or state that legal care to address them is part of health care. Nonetheless, some Medicaid managed care organizations have elected to finance legal care using administrative dollars, which are subject to competing priorities, or through state-based Section 1115 waivers if permitted.[12] To bolster arguments for sustained Medicaid support, researchers have

recommended that MLP activities be framed by health plans as "case management," "care management and coordination," or "value-added services."[13]

Expanding health plan coverage—the most straightforward way to fund MLPs—requires consistency in coding and measuring legal care. Fortunately, MLP legal professionals already gather an extensive social history from patients to assess their health-harming legal needs. This process yields information important to medical decision-making that otherwise may be hard for a clinician to obtain and share as structured data. In many cases, the associated complexity and risk also will justify higher-level Current Procedural Terminology codes for the clinician's services. Similarly, MLP legal care data enables more accurate recording of the Z codes that already exist in the *International Statistical Classification of Diseases and Related Health Problems* structure for documenting health-related social needs.[14] Anyone can "diagnose" using these codes, and many are similar to the problem codes that MLP legal teams routinely employ in legal recordkeeping. In addition to inputting Z59.1 (inadequate housing) for asthma,[14] the MLP legal team would document the type of housing, which is critical for both choosing the correct acute intervention and advocating for better population-level policies. Having lawyers and physicians work together on Z code strategy would also help align the MLP model of care with established claims verification and payment processes.

Delivery System Funding of MLPs

In contrast to the embryonic state of MLP in laws governing health coverage, committed support for legal services is evident in the regulation of FQHCs, nonprofit hospitals, and Department of Veterans Affairs facilities.

Health centers. The Public Health Service (PHS) Act defines a "health center" as an entity that provides primary health services to medically underserved areas or populations.[15] Comprehensive primary care, specialty care and behavioral health care, education of patients and the community, and—discussed in more detail below—case management services and enabling services comprise the "primary health services" that are required for designation as an FQHC. Additional health services, including to alleviate unhealthy conditions in the living, built, and natural environments, may be provided directly or by contract.

Enabling services expressly include patient-facing legal services.[16] Although the recognition of legal services as enabling services by the Health Resources and Services Administration (HRSA) was not explicit until 2014, the agency takes the position that MLP "was always part of enabling services."[17] For example, lawyers enable care when they appeal a reduction in home health hours, empower a domestic violence survivor to receive services, or alleviate financial stressors that inhibit a person's ability to obtain treatment.

Case management also explicitly encompasses legal services.[16] The PHS Act includes within case management services "establishing eligibility for and gaining access to federal, state, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services."[15] For example, legal services may be necessary to assert due process rights when a person is wrongfully denied Medicaid, loses their Section 8 housing voucher, or seeks accommodations at school for a medical condition.

Because the work of MLP is expressly within the HRSA's definition of required primary health services, FQHCs may use their federal funding to develop and maintain MLPs, counting incidents of contracted legal care in their HRSA-approved scope on Form 5A.[16] HRSA has made awards specifically for MLP as a primary health service since at least 2015, including a September 2023 initiative targeting disparities in perinatal health.[18] HRSA regulation of FQHCs aligns with MLP's core premise: that meeting legal needs is integral to the delivery of quality care.

Nonprofit hospitals. To maintain federal tax exemption as a charitable organization under Internal Revenue Code §501(c)(3), nonprofit hospitals must provide "community benefit," and the Patient Protection and Affordable Care Act of 2010 (ACA) requires them to conduct a periodic community health needs assessment (CHNA) and to adopt an implementation strategy for meeting identified needs.[19] Community health needs include "the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."[20] Beyond CHNAs, MLP helps hospitals meet requirements related to NMDOH and health equity in their own licensure and accreditation standards and in standards governing the health plans that pay them.

Without MLP legal expertise, hospitals may miss critical drivers of community health.[21,22] The American Hospital Association (AHA) comprehensively surveys its members annually and includes questions about hospital collaboration with legal services organizations.[23] A research study based on the 2020 survey found that the roughly 55% of hospitals reporting a relationship with a legal services organization were more likely to have lower health care costs and utilization.[24] The AHA recommends "engaging or consulting legal organizations to take part in developing a community health needs assessment, to help identify interconnections or linkages between health outcomes and legal assistance and potential community-level interventions."[25]

Veterans Affairs' outpatient clinics and medical centers. The Veterans Health Administration (VHA) provides for the care and treatment of military veterans and is the nation's largest integrated health care system.[26] Studies have shown positive correlations between MLP and veteran physical and mental health.[27,28] Several VHA system-wide directives emphasize the importance of civil legal services to the health of veterans, such as Directive 1510, which permits in-kind space donation to MLPs or similar organizations for training VA medical staff and providing legal care to patients.[29]

Interdisciplinary and Community Engagement

Pursuing a more visible, financially sustainable role for MLP has ethical as well as clinical significance, as health care professionals, policy makers, and the public confront new challenges involving equity, opportunity, and trust in health care. When MLP began decades ago, the expectation was that physicians' clinical knowledge and authority would help lawyers do their jobs better. Recent MLP experience suggests that, particularly in integrated delivery models associated with academic health centers and law schools, lawyers training physicians to operate the levers of social change through analysis and advocacy is an equally meaningful interprofessional transfer of knowledge.[30]

Few major infrastructure changes are necessary for most health care entities to integrate MLP lawyers into the delivery of care. Mirroring clinical practice, legal service

delivery includes well-developed systems to track and share social diagnoses, interventions, and outcomes, thereby forming an information base for collaboration, evaluation, and payment. No expensive referral platform is needed, and best practices exist for prioritizing patients' needs and pursuing both individual and population health strategies to meet them.[31,32]

We do not argue for medicalizing legal drivers of health or transferring responsibility for addressing them to hospitals and health professionals.[33] Control over legal interventions that supplement clinicians' biomedical perspective should remain with MLPs and other community-based legal services entities that have demonstrated their expertise, experience, and trustworthiness.[34] Health care organizations should be an active, creative, but generally deferential partner.

At scale, MLP can also help the nation's legal aid lawyers improve their overall effectiveness at achieving justice. In 2020, the American Academy of Arts and Sciences endorsed MLP and similar collaborations between legal and health professionals as the most important step in closing the "justice gap" in American society that contributes to health inequity.[35]

Finally, unlike most other forms of social support, legal services follow a model of professional control and client centeredness that is sufficiently similar to medical services as to be intuitive to the health professions. As members of the health care workforce contend with feelings of powerlessness to serve patients and society in accordance with their ethical beliefs, engagement with lawyering skills through MLP can help chart a productive interdisciplinary path forward. Many steps can help move MLP in this direction, but in our view the most important is for policy makers to accept MLP services as a form of clinical care and fund them accordingly.

References

1. Marple K. Framing legal care as health care. National Center for Medical-Legal Partnership; 2015. Accessed February 6, 2024. https://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf
2. Tobin Tyler E. Medical-legal partnership in primary care: moving upstream in the clinic. *Am J Lifestyle Med.* 2017;13(3):282-291.
3. Baños J, Trott J, Regenstein M. Environmental scan of medical-legal partnerships in health centers. National Center for Medical-Legal Partnership; 2023. Accessed January 22, 2024. https://medical-legalpartnership.org/wp-content/uploads/2023/08/Environmental-Scan_Final.pdf
4. Sage W, Warren K. Swimming together upstream: how to align MLP services with US healthcare delivery. *J Law Med Ethics*. 2023;51(4):786-797.
5. CPT® evaluation and management (E/M) code and guideline changes. American Medical Association; 2022. Accessed September 23, 2023. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
6. Beck AF, Henize AW, Qiu T, et al. Reductions in hospitalizations among children referred to a primary care-based medical-legal partnership. *Health Aff (Millwood).* 2022;41(3):341-349.
7. National Center for Medical-Legal Partnership. The Medical-Legal Partnership Toolkit—phase I: laying the groundwork. National Center for Medical-Legal Partnership; 2015. Accessed February 6, 2024. https://www.medical-

legalpartnership.org/wp-content/uploads/2014/03/MLP-Toolkit-Phase-I-FINAL-FILLABLE.pdf
8. Sage WM, Tiase VL. Risk, responsibility, resilience, respect: COVID-19 and the protection of health care workers. In: Cohen IG, Gluck AR, Kraschel KL, Shachar C, eds. *COVID-19 and the Law: Disruption, Impact, and Legacy*. Cambridge University Press; 2023:42-57.
9. Cannon Y. Medical-legal partnership as a model for access to justice. *Stanford Law Rev*. 2023;75(1):73-88.
10. Tobin Tyler E. Improving outreach and enrollment efforts in health centers through medical-legal partnership. National Association of Community Health Centers; 2017. Accessed April 22, 2024. https://medical-legalpartnership.org/wp-content/uploads/2017/08/O-E-MLP-Feb-2017-Issue-Brief-FINAL.docx.pdf
11. Outreach and enrollment grants. InsureKidsNow.gov. Accessed October 4, 2023. https://www.insurekidsnow.gov/campaign-information/outreach-enrollment-grants/index.html
12. Trott J, Peterson A, Regenstein M. Financing medical-legal partnerships: view from the field. National Center for Medical Legal Partnership; 2019. Medical-Legal Partnership Fundamentals Issue Brief 2. Accessed February 6, 2024. https://medical-legalpartnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf
13. Mann C. Tapping into Medicaid financing streams strategies for medical-legal partnerships. National Center for Medical-Legal Partnership webinar. June 10, 2019. Accessed September 23, 2023. https://www.youtube.com/watch?v=bOdgNuIdTQk
14. ICD-10-CM codes lookup. American Association of Colleges of Pharmacy. Accessed March 28, 2024. https://www.aapc.com/codes/icd-10-codes-range/
15. Health Centers, 42 USC §254b (2024).
16. HRSA Health Center Program. Service descriptors for Form 5A: services provided. Bureau of Primary Health Care. Accessed September 23, 2023. https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-service-descriptors.pdf
17. Legal aid is now an enabling service for health centers [2015 MLP summit]. National Center for Medical-Legal Partnership. May 18, 2015. Accessed September 23, 2023. https://youtu.be/_ijltVJvyw0
18. Healthy Start Initiative: Eliminating Disparities in Perinatal Health. Health Resources and Services Administration. September 22, 2023. Accessed February 6, 2024. https://www.hrsa.gov/grants/find-funding/HRSA-24-033
19. Rosenbaum S, Byrnes M, Hurt N. Community benefit and the ACA: a brief history and update. George Washington University Milken Institute School of Public Health. Accessed September 26, 2023. https://nchh.org/resource-library/HCF_CBACA%20overview.pdf
20. Internal Revenue Service. Additional requirements for charitable hospitals; community health needs assessments for charitable hospitals; requirement of a section 4959 excise tax return and time for filing the return; final regulations. *Fed Regist*. 2014;79(250):78954-79016.
21. Theiss J, Regenstein M. Facing the need: screening practices for the social determinants of health. *J Law Med Ethics*. 2017;45(3):431-441.
22. Crossley M, Tobin Tyler E, Herbst JL. Tax-exempt hospitals and community health under the Affordable Care Act: identifying and addressing unmet legal needs as social determinants of health. *Public Health Rep*. 2016;131(1):195-199.

23. AHA data resources. AHA Data and Insights. Accessed September 23, 2023. https://www.ahadata.com/aha-data-resources
24. Hamadi HY, Zhao M, Park S, et al. Improving health and addressing social determinants of health through hospital partnerships. *Popul Health Manag*. 2023;26(2):121-127.
25. American Hospital Association. Improving health equity through medical-legal partnerships. American Hospital Association; 2020. Accessed September 23, 2023. https://www.aha.org/system/files/media/file/2020/11/aha-medical-legal-partnerships-1120-final.pdf
26. Veterans Health Administration. US Department of Veterans Affairs. Updated April 2, 2024. Accessed March 28, 2024. https://www.va.gov/health/
27. Trott J, Lattimore K. Medical-legal partnerships for veterans: assisting veterans and service members with legal needs during VA transitions. National Center for Medical-Legal Partnership; 2020. Accessed March 26, 2024. https://medical-legalpartnership.org/wp-content/uploads/2020/10/BWF-VA-Transitions-Issue-Brief-FINAL.pdf
28. Tsai J, Middleton M, Villegas J, et al. Medical-legal partnerships at Veterans Affairs medical centers improved housing and psychosocial outcomes for vets. *Health Aff (Millwood)*. 2017;36(12):2195-2203.
29. Veterans Health Administration. VHA directive 1510: veterans legal referral process. US Department of Veterans Affairs; 2021. Accessed February 6, 2024. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9450
30. Marple K, Curran M, Lawton E, Rahajason D. Types of training that help meet patients' needs and strengthen the health care and legal workforces. National Center for Medical-Legal Partnership; 2020. Accessed January 22, 2024. https://medical-legalpartnership.org/download/tool-types-of-trainings/
31. Theiss J, Sandel M, Teitelbaum J, Marple K. Applying the medical-legal partnership approach to population health, pain points and payment reform. National Center for Medical-Legal Partnership; 2016. Accessed February 6, 2024. https://medical-legalpartnership.org/wp-content/uploads/2016/10/Applying-the-MLP-Approach-to-Population-Health-October-2016.pdf
32. Marple K, Curran M, Lawton E, Rahajason D. Bringing lawyers onto the health center care team to promote patient and community health. National Center for Medical-Legal Partnership; 2020. Accessed February 6, 2024. https://medical-legalpartnership.org/wp-content/uploads/2020/10/Health-Center-MLP-Toolkit-FINAL.pdf
33. Sage WM, Laurin JE. If you would not criminalize poverty, do not medicalize it. *J Law Med Ethics*. 2018;46(3):573-581.
34. Glied S, D'Aunno T. Health systems and social services—a bridge too far? *JAMA Health Forum*. 2023;4(8):e233445.
35. Frazier KC, Levi JG, Minow ML, et al. *Civil Justice for All: A Report and Recommendations From the Making Justice Accessible Initiative*. American Academy of Arts and Sciences; 2020. Accessed October 3, 2023. https://www.amacad.org/sites/default/files/publication/downloads/2020-Civil-Justice-for-All_0.pdf

William M. Sage, MD, JD is a professor at the Texas A&M University School of Medicine and Texas A&M University School of Law. He is also a professor (by courtesy) of government and public service at Texas A&M's Bush School of Government and Public Service as well as the founding faculty director of the university's Institute for Healthcare

Access. He holds an undergraduate degree from Harvard College and medical and law degrees from Stanford University.

Keegan D. Warren, JD, LLM is the executive director of the Institute for Healthcare Access at Texas A&M University in Fort Worth. She has over a decade of experience in the integration of medical and social services through medical-legal partnerships. Warren earned an LLM degree in health law and policy from Southern Illinois University, a JD degree from the University of Texas, and a BA degree in Spanish, international relations, and Latin American studies from the University of Arkansas.

Citation
AMA J Ethics. 2024;26(8):E640-647.

DOI
10.1001/amajethics.2024.640.

Conflict of Interest Disclosure
Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

Copyright 2024 American Medical Association. All rights reserved.
ISSN 2376-6980