

Multiple Medicaid Missions: Targeting, Universalism, or Both?

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INTRODUCTION

Medicaid began as a poverty program for the poorest of the “worthy poor.” In the next five decades, it extended its reach to cover a broad population for some of its services, including, for example, about half of all childbirths in the United States,¹ and almost half of all long-term care services.² The Affordable Care Act (ACA)³ pushed Medicaid’s breadth further, although that extension was at least delayed in many states by the Supreme Court.⁴ Some scholars embrace Medicaid’s role as advancing toward universal coverage by filling the gap between Medicaid’s traditional poverty population and the population able to access employment-based coverage. Others, however, are concerned that asking Medicaid to cover broader population groups runs the risk of diminishing its essential mission of providing coverage for the poorest, who face unique health needs.

This disagreement suggests a need to choose between a Medicaid targeted to particular needs of the poor and one increasingly universal in scope. Yet, under the ACA, Medicaid can achieve both a universal and targeted mission by following Theda Skocpol’s “targeting within universalism” model.⁵ “Targeted” social policies address poverty issues through “highly concentrated . . . services devised especially for the poor,” while “universal” policies address poverty through broader programs that link the plight of the poor with those of the middle class.⁶ Skocpol argues for targeted programs “within certain universal policy

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1. See Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23 WOMEN’S HEALTH ISSUES e273, e275 (2013).

2. See *Medicaid’s Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings*, KAISER FAM. FOUND. 1 (2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7576-02.pdf>.

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

4. Nat’l. Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603-04 (2012) (Roberts, C.J., holding the ACA to be unconstitutionally coercive for requiring the states to expand Medicaid coverage).

5. See Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, in THE URBAN UNDERCLASS 411, 411-36 (Christopher Jencks & Paul E. Peterson, eds., 1991).

6. *Id.* at 412-13.

frameworks” to combine the benefits to the poor of targeted and universal policies.⁷ Medicaid, I argue, can become a broad—and broadly popular—health insurance while consciously targeting the very poor, whose health challenges are different in kind from those of the rest of society.

This Article will, in Part I, briefly outline the path of Medicaid’s development from 1964 to today, as its mission has broadened, with particular attention to the 2010-14 period of ACA implementation. Part II will describe the health status of America’s poor. Medicaid is undoubtedly successful in connecting its beneficiaries to health care services, but the poor continue to experience health outcomes far worse those of the rest of society. This apparent paradox is easily explained: health coverage permits the treatment of illnesses, but the poor carry an increased burden of illness due to social factors, including substandard housing, the unavailability of healthy food, and few recreational resources. Health insurance has not historically addressed those “upstream” factors that drive a significant portion of the poor’s excess burden of ill health. Part III outlines the dispute among advocates for the poor between advocacy for programs targeting the poor (providing resources where they are most needed, but risking the loss of political support) and advocacy for more universal programs (risking resource loss to higher-income, less needy persons, but likely gaining political viability). I argue that in the case of Medicaid, Skocpol’s “targeting within universalism” best serves the poor.

Part IV illustrates how a broadening Medicaid that sweeps in a growing class of the near poor can nevertheless provide special benefits for the very poor. This strategy entails the use of new models of health care finance and delivery, such as Accountable Care Organizations (ACOs). ACOs are designed to combat health care’s fragmentation, evidenced by poor communication and care coordination that can reduce the effectiveness of care and drive up costs. For non-poor recipients of care, financing innovations can improve the quality of care by fostering more integrated treatment. Similar medical treatment gains and cost savings are available when Medicaid adopts ACO methods. But an additional benefit is available for the poor. Community organizations forming Medicaid ACOs may receive supplemental reimbursement if they can improve the health status of populations of Medicaid recipients in a geographic area. This population orientation incents the organizations creating Medicaid ACOs to adopt a broader perspective toward health care, directly addressing some of the social factors beyond medical treatment that directly affect population health status. For the non-poor, ACOs can improve medical care. For the poor, ACOs can use the financial freedom created by population health rewards to incorporate social services not traditionally covered by Medicaid into their body of work. ACOs can be adapted to the needs of the poor by those in their community to help reduce the burden of disease and ill-health for those most in need. This functional targeting permits

7. *Id.* at 414 (emphasis in original).

expansion of Medicaid services not at the level of state regulatory design, but through the community-based choice of Medicaid ACOs' management.

I. SPECIFIC TO GENERAL: MEDICAID'S EVOLUTION

American Progressives sought a path to a general "sickness insurance" program for much of the twentieth century. As European democracies adopted various forms of social insurance and national health plans, America resisted for a range of social, political and economic reasons that are well-described elsewhere.⁸ While other wealthy nations experimented and finally settled on systems for the provision of health care as a public or social expense, Americans maintained a marketplace notion of health care, supplemented by a variety of public and private charity ventures for the most obviously disadvantaged.⁹

The adoption of Medicare and Medicaid in 1964 represented an expansion of the federal footprint in health finance. Medicare is a very popular social insurance program for a discrete population of beneficiaries. Some hope has persisted that it could be a vehicle for expansion to reach a broader demographic. Thus far, Medicare has been expanded only to the permanently and totally disabled (after a two-year waiting period) and to persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis.¹⁰ Medicaid's eligibility rules have evolved in a more complex fashion.

Medicaid was the successor to previous federal programs that provided grants in aid to states. These grants recognized the primacy of states in supporting the needy, and represented the furthest reach of the federal government into the patchwork of private and public charities directed to the plight of widows, orphans, and other particularly vulnerable—and "worthy"—poor.¹¹ Initially, eligibility was limited to very low-income single-parent families and the aged, blind, or disabled.¹² Even so, it was seen by some as a "sleeper" program, carrying with it the seeds of a more expansive public insurance program because of the breadth of its coverage structure. As Sara Rosenbaum has described, for some contemporary commentators "the program became the exemplar of a national health program of

8. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 237-89 (1982).

9. See Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 *HEALTH CARE FIN. REV.*, no.2, 2005-2006, at 11, 11-15.

10. *Id.* at 19-21.

11. See Nicole Huberfeld, *Federalizing Medicaid*, 14 *U. PA. J. CONST. L.* 431, 438-45 (2011); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 *U.C. DAVIS L. REV.* 413, 418-19 (2008); John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 *KY. L. J.* 357, 359 (2013-2014); Sara Rosenbaum, *Medicaid At Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 *J. HEALTH CARE L. & POL'Y* 5, 8-9 (2006).

12. See Jonathan Gruber, *Medicaid*, in *MEANS-TESTED TRANSFER PROGRAMS IN THE UNITED STATES* 15, 16 (Robert R. Moffitt ed., 2003).

the future, covering large population segments under a comprehensive scheme of government financing.”¹³

Medicaid expanded in the ensuing decades, although the expansions fell short of reaching its potential as an anchor for a universal coverage system. Eligibility rules evolved, extending Medicaid coverage to higher-income children, pregnant women, and two-parent poor families with children. A further cluster of expansions followed through the adoption of optional aspects of the program and through statutorily permitted waivers from general federal eligibility and coverage rules. These expansions included long-term care benefits for the elderly and disabled well above the income-eligibility limits for the program generally and the expansion of new ranges of home and community-based services for people who otherwise would have been eligible for care in nursing homes.¹⁴

By the time the ACA was adopted in 2010, Medicaid had grown far beyond its 1964 roots. It was a large program, covering over 68 million people by fiscal year 2011. About half the enrollees were children, about a quarter were adults without disabilities, about fifteen percent were people with disabilities, and about ten percent were elderly.¹⁵ Total federal and state program costs for fiscal year 2011 were approximately \$414 billion.¹⁶ A broad range of services—some beyond the norm for private insurance—were mandatory for all states, including:

- Hospital, physician, laboratory and imaging services;
- A broad range of services for children (enrollees under 21) under EPSDT;¹⁷
- Family planning services and supplies;
- Nurse midwife services;
- Transportation services;

13. Rosenbaum, *supra* note 11, at 10 (quotations and citations omitted).

14. See Gruber, *supra* note 12, at 19-25 (describing expansion of eligibility and covered services); Rosenbaum, *supra* note 11, at 11-15 (summarizing the range of Medicaid expansion in its first four decades); Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at 35*, 22 HEALTH CARE FIN. REV. 23 (2000); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 959-67 (2010) (describing expansion of nursing home and home care services).

15. ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 13-14 (2011).

16. *Medicaid: A Primer*, KAISER FAM. FOUND. 25 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

17. Early and periodic screening, diagnostic, and treatment (“EPSDT”) services comprise a broad range of scheduled diagnostic and treatment services for enrollees under 21 years of age. 42 U.S.C. § 1396d(r) (2012). Perhaps most significantly, after setting out a range of services that must be made available, the statute provides a final, catch-all category of required services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Id.

- Nursing facility services for those 21 years of age and above, and home health care services for those eligible for nursing home level of care; and
- Services provided by federally qualified health centers (“FQHCs”) and rural health clinics (“RHCs”).¹⁸

Most or all states also elected to cover a range of services beyond those required. These services include:

- Prescription drugs;
- Dental services;
- Eyeglasses and durable medical equipment;
- Case management;
- Personal care services and hospice services;
- Nursing facility and psychiatric facility services for those under age 21; and
- Home and community based services.¹⁹

By 2010, then, Medicaid was still a needs-based program, but one that had extended its eligibility rules to reach nearly one in seven Americans. It had also, in recognition of the broader needs of the poor, expanded its menu of covered services beyond core medical treatment to include health benefits other Americans are expected to purchase out of pocket. By the time the ACA was passed, it was a dominant payer of some services, covering about half of all births, and almost half of all nursing home services.²⁰ In addition, the eligibility criteria for Medicaid, which encompass poverty, disability, and old age, ensured that it disproportionately covers high-risk and high-cost persons.

The ACA significantly expanded Medicaid. In *National Federation of Independent Business v. Sebelius*, Justice Ginsburg and Chief Justice Roberts disagreed as to whether the expansions were part of a gradual evolution of the program, or representative of a dramatic shift in the nature of Medicaid. Justice Ginsburg described Medicaid as “a single program with a constant aim—to enable poor persons to receive basic health care when they need it.”²¹ In contrast, Chief Justice Roberts read the ACA as creating an entirely new program:

Here, the Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that

18. 42 U.S.C. § 1396d (2012). See HERZ, *supra* note 15, at 5-6; *Medicaid: A Primer*, *supra* note 16, at 13-14.

19. 42 U.S.C. § 1396d (2012). See HERZ, *supra* note 15, at 6; *Medicaid: A Primer*, *supra* note 16, at 14.

20. See Markus et al., *supra* note 1, at e275; *Medicaid’s Long-Term Care Users*, *supra* note 2, at 1.

21. See *Nat’l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part and dissenting in part).

Congress could change the terms of Medicaid when they signed on in the first place. . . . The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.²²

The Chief Justice's finding that the ACA's modification of Medicaid was one of "kind, not merely degree" allowed him to find that Congress's conditional spending powers do not extend to the enforcement of the ACA's Medicaid amendments on all states continuing to participate in Medicaid.²³ Whether the ACA's change was best characterized as evolutionary or revolutionary, it certainly added significantly to the scope of Medicaid's mission.

Under the ACA as written, then, states were required to sweep in all persons not previously eligible who have an income at or below 133 percent of the federal poverty level.²⁴ The extent to which each state's Medicaid enrollment would have been affected by this change hinged on the prior state-specific eligibility levels, but the estimates for total increases ranged as high as 21.3 million by 2022.²⁵ Those predictions had to be adjusted after the Supreme Court rendered the ACA's Medicaid expansion optional at the election of each state.²⁶ As of this writing, twenty-eight states have agreed to expand Medicaid to the income limits of the ACA, and two additional states are in discussions to do the same.²⁷ Whether and how the additional states will come into the fold is beyond the scope of this article.²⁸

22. *Id.* at 2605-06 (opinion of Roberts, C.J.).

23. *Id.* at 2606.

24. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012), *invalidated by* Nat'l Fed. of Indep. Bus., 132 S. Ct. 2566 (2012).

25. See *Medicaid's Long-Term Care Users*, *supra* note 2, at 11 (citing John Holohan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER FAM. FOUND. 4 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>).

26. *Nat'l Fed. of Indep. Bus.*, 132 S. Ct. at 2635.

27. *Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (2014), <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision>.

28. See, e.g., Maia Crawford & Shannon M. McMahon, *Alternative Medicaid Expansion Models: Exploring State Options*, CTR. FOR STATE HEALTH CARE STRATEGIES (2014) http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf (describing alternative state models for expanding Medicaid); Stan Dorn et al., *What Is the Result of States Not Expanding Medicaid?*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. (2014),

A central success of the ACA has been the decrease in America’s uninsurance rate. The uninsured percentage has dropped by about five percent as a result of increased private enrollment (through the federal and state exchanges or marketplaces and through off-exchange purchases of ACA compliant coverage) and through expanded Medicaid enrollment.²⁹ However, as Medicaid pushes into demographics beyond the very poor, care must be taken to preserve the aspects of “original” Medicaid that target the needs of the poorest and most vulnerable. The next Part addresses the particular vulnerability of that population.

II. BARRIERS TO HEALTH FOR THE POOR

As Medicaid’s role in American health finance expands, we must be cognizant of the fact that the poor have health needs that are different from those of the non-poor. This Part will acknowledge the health access gains the poor have experienced from Medicaid coverage, but will demonstrate that the health status of the poor continues to lag behind that of the non-poor. It will argue that special services are therefore in order, and point out that some of those special services are embedded in the ACA’s design.

Many studies have demonstrated that Medicaid coverage increases access to most types of health care. This research was recently summarized in the following terms:

Consistently, research indicates that people with Medicaid coverage fare much better than their uninsured counterparts on diverse measures of access to care, utilization, and unmet need. A large body of evidence shows that, compared to low-income uninsured children, children enrolled in Medicaid are significantly more likely to have a usual source of care . . . and to receive well-child care, and significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. . . . Nonelderly adults covered by

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946 (describing financial cost to federal and state governments of states’ Medicaid expansion decisions); Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf; Carter C. Price & Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And \$8.4 Billion Less In Federal Payments*, 32 HEALTH AFF. 1030 (2013).

29. See Sara R. Collins, et al., *Gaining Ground: Americans’ Health Insurance Coverage and Access to Care After the Affordable Care Act’s First Open Enrollment Period*, THE COMMONWEALTH FUND (July 2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf. See also *Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period*, ASSISTANT SECRETARY FOR PLAN. & EVALUATION (May 2014), http://aspe.hhs.gov/health/reports/2014/marketplacenrollment/apr2014/ib_2014apr_enrollment.pdf

Medicaid are more likely than uninsured adults to report health care visits overall and visits for specific types of services; they are also more likely to report timely care and less likely to delay or go without needed medical care because of costs.³⁰

The link between access and health outcomes is somewhat harder to quantify. A recent, widely-publicized study of Oregon's pre-ACA Medicaid expansion compared otherwise similar populations that differed on the basis of whether or not they had gained access to Medicaid. The Medicaid-insured cohort predictably had better access to health care services than the uninsured cohort.³¹ The measurable health outcomes were less clear-cut:

Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups—persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups)—showed similar results.³²

The study did find some health benefits, including a significant increase in the rate of diagnosis of depression and successful reduction over time in the manifestations of depression symptoms compared to the uninsured cohort.³³

Other studies have reported additional correlations between positive health outcomes and Medicaid membership. A team of researchers at the Harvard School of Public Health recently assessed the effects of pre-ACA Medicaid expansions and found improvements in the expansion states.³⁴ In particular, they found decreased mortality rates associated with the Medicaid expansions, determining that the mortality improvements were “greatest among non-whites and older adults.”³⁵ The effects of Medicaid will continue to be the subject of study, as the

30. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?*, KAISER FAM. FOUND. 6 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicoids-impact-on-access-to-care1.pdf>. See Marc L. Berk & Claudia L. Schur, *Access To Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169 (1998); Teresa A. Coughlin et al., *Assessing Access To Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073 (2005); Sharon Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39, 54 (2005).

31. Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1718 (2013).

32. *Id.* at 1716.

33. *Id.* at 1716-17. Another significant difference over time between the groups with Medicaid and without was a reduction in “financial strain” related to health expenditures, and in particular a reduction in the rate of catastrophic medical expenses. *Id.* at 1718.

34. See, e.g., Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012).

35. *Id.* at 1028.

expansion of Medicaid continues to be a sharply divisive political issue, and claims continue that Medicaid is “broken.”³⁶

Evaluating the effects of Medicaid is difficult in part because Medicaid historically has covered the most vulnerable of Americans. The non-elderly enrollment in Medicaid is over fifty-three percent Black or Hispanic, and the long history of race- and ethnicity-based health disparities in American health care strongly suggests that this overrepresentation of people of color will result in poorer health outcomes regardless of the faults or inefficacy of the Medicaid program itself.³⁷ In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.³⁸ People covered by Medicaid, then, are more medically fragile, have more complex health conditions, and are affected by determinants of poor health independent of their access to health coverage or care.

The inability of Medicaid to make healthy populations of the poor and vulnerable is not surprising. Health status is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of traditional health services.³⁹ One recent commentary observed that “[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them.”⁴⁰ These “determinants of health” that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.⁴¹ The research on social determinants of health suggest that advocates of health care for the poor should broaden their perspective on what constitutes health services. In particular, the research demonstrates that medical

36. See Jacobi, *supra* note 11, at 364-69 (describing the contours of the argument that Medicaid is “broken”).

37. See, e.g., BRIAN D. SMEDLEY ET AL., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE*, INST. OF MED. (2003); see also Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 857 (2012); David R. Williams & Pamela B. Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327-29 (2005).

38. See Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382-84 (2011); Williams & Jackson, *supra* note 37, at 327-28.

39. See Kelly M. Doran et al., *Housing as Health Care—New York’s Boundary-Crossing Experiment*, 369 NEW ENG. J. MED. 2374, 2374 (2013) (“experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest”).

40. David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012).

41. See Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 284 (2010); Nicole Lurie, *What The Federal Government Can Do About The Nonmedical Determinants*, 21 HEALTH AFF. 94 (2002).

care should no longer be viewed in isolation but should be part of a system that coordinates a variety of medical and social services.⁴² This systematizing of services can be achieved through the coordination of services provided by previously separate public agencies,⁴³ or through state Medicaid agencies' fostering of community organizations empowered and incented to integrate health and social services.⁴⁴ Both options would rethink the financing of health care for the poor to take into account the true barriers to good health.⁴⁵

III. TARGETED OR UNIVERSAL MEDICAID?

Medicaid was, is, and undoubtedly will be a program of health care for the poor and near-poor. But whether it will be dedicated to the interests of society's most vulnerable or serve as one of the launching pads for truly universal healthcare is a question of great moment. The previous Section described the particular health needs of the poor, and identified strategies to make Medicaid more effective in addressing those needs. Such a turn in Medicaid policy to a deeper commitment to the poorest and most vulnerable is in potential conflict with the trend, exemplified by the eligibility expansion in the ACA, to extend Medicaid to the less poor—a population potentially less affected by substandard housing, food deserts, and other plagues of the poor. A Medicaid program reconfigured to address the particular needs of the poor would be a *targeted* program; one that is more configured to extend traditional health coverage to a broader population would be a *universal* program. On one hand, a more targeted Medicaid program might better serve the needs of the poorest and most vulnerable by sweeping in coordinated access to non-medical social programs in their particular interest. On the other, a universal Medicaid program would serve the health care needs of broader class of Americans, helping to knit together a more universal health insurance system, and perhaps thereby place the Medicaid program on a firmer political footing.

The tug between a targeted or universal Medicaid system is not a new one. Colleen Grogan, a leading Medicaid scholar, has observed that mission uncertainty has been present since Medicaid's inception. In an influential 2003 article, Colleen Grogan and Eric Patashnik observed that mission uncertainty has been present since Medicaid's inception, and that it has since the beginning been "not one

42. See Lurie, *supra* note 41, at 105.

43. See *infra* text accompanying notes 63-68 (discussing Health in All Policies ("HiAP") initiatives).

44. See *infra* text accompanying notes 79-85 (discussing Medicaid Accountable Care Organizations).

45. Lurie, *supra* note 41, at 105 ("Donald Berwick's often-quoted adage, 'The system is perfectly designed to achieve exactly the results it gets. If you don't like the results, change the system,' applies not only to health systems, but also to the 'stovepiped' way in which policy and budget development often occurs." (citation omitted)).

program but many.”⁴⁶ Grogan and Patashnik outlined one perspective on the choice between focused coverage of the poorest and most vulnerable, and expansion to other tiers of the uninsured:

Two distinct paths for Medicaid’s future evolution are in view, and they lead in opposite directions. If policy makers decide to continue taking incremental steps toward coverage expansion . . . Medicaid could serve as a path to a more universal health care system for millions of Americans. Alternatively, if policy makers opt for the second path, Medicaid could revert back to “welfare medicine.”⁴⁷

Grogan and Patashnik argued that Medicaid’s role in American health finance is unsettled because of two ambiguities built into the program. First, the original statute failed to “provide precise definitions of the two concepts of medical indigence and comprehensive benefits.”⁴⁸ Second, it failed to “resolve Medicaid’s place in the overall U.S. welfare state and to determine whether or in what sense Medicaid benefits should be universal or targeted.”⁴⁹ Grogan and Patashnik clearly favored the more universal vision of Medicaid. They posited that policy makers will be driven to expand Medicaid because of the failures of the private insurance markets and the inadequacy of Medicare coverage for vitally important long term care services: “it will be increasingly difficult for policy makers not to grasp the vital importance of Medicaid to working-class and middle-class families.”⁵⁰ This prediction proved prescient; the ACA certainly responded to the logic of the argument for the expansion of both medical and long-term coverage to populations not previously within Medicaid’s mandate.

Grogan and Patashnik approve, at least implicitly, of Medicaid’s evolution as a “path to a more universal health care system for millions of Americans” and disapprove of a “reversion to ‘welfare medicine.’”⁵¹ There are, however, arguments for adhering to a narrower conception of Medicaid’s mission. As is described above, the poorest and most vulnerable are in need of a different range of health and social services than are the working poor or middle class. They have housing, environmental, community resource, and other deficits that affect their health status significantly. Community health advocates increasingly argue for a broader range of responses to the complex health needs of the poor, informed by analyses of the social health determinants that drive their health status deficits.

46. Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL’Y & L. 821, 824 (2003).

47. *Id.* at 822 (citing ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (1974)).

48. *Id.* at 852.

49. *Id.*

50. *Id.* at 854-55.

51. *Id.* at 822.

A proposal to reconfigure Medicaid to reach broadly into social services would fit imperfectly with universalist Medicaid vision. Such a proposal would likely split Medicaid into a program for the very poor on one hand and the working poor and middle class on the other hand.⁵² It would therefore drive Medicaid in a more targeted direction, as the additional social services would be significantly more appropriate for the traditional low-income Medicaid recipients, but less appropriate for working-class and middle-income recipients for whom Medicaid might otherwise be a path to ordinary health insurance coverage.⁵³

The distinction between a Medicaid program focused on the “neediest among us”⁵⁴ or one that is “an element of a comprehensive national plan to provide universal health insurance coverage”⁵⁵ is a real one. Targeted social welfare programs have the virtue of concentrating limited resources and programmatic design toward those most in need of social welfare benefits; however, targeted programs face uncertain political viability, as the majority of voters do not benefit from such programs. Universal programs, on the other hand, tend to enjoy broader electoral support, while allowing the poor to avoid stigma by participating in mainstream programs. However, universal programs tend to devote the majority of their funding and programmatic attention to the non-poor, diminishing opportunities for high-level change in their circumstances.⁵⁶ But is the choice between those two visions a real or false one? That is, can Medicaid serve both the function of providing the range of services peculiarly appropriate for the poorest and most vulnerable, while also serving as a piece of the puzzle for expanding health insurance to the working poor and middle class? The answer is yes.

Policy makers face a dilemma in choosing between targeted social welfare programs and universal programs. Theda Skocpol describes the contours of this dilemma,⁵⁷ while also providing a possible third way—targeting within universalism:

52. Medicaid is not a unitary program as it stands. The Deficit Reduction Act of 2006 allowed states to substitute weaker “benchmark” benefits patterned on employment-based coverage for the richer traditional Medicaid coverage, although the most vulnerable Medicaid beneficiaries are exempted from this change. 42 U.S.C. § 1396u–7(a) (2012) (exempting, e.g., blind, medically frail, and disabled recipients). The ACA similarly permits states to provide weaker “benchmark” benefits, and not the full traditional Medicaid benefits to the new eligible class, comprising mostly non-elderly adults not previously categorically eligible. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The proposal described in the text would clearly exacerbate this distinction.

53. The distinction, too, could be overstated. Clearly, some working-class consumers in some markets suffer from poor housing stock and other social barriers to good health status. But the very poor are clearly more exposed to these barriers to good health.

54. *Nat’l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (opinion of Roberts, C.J.).

55. *Id.*

56. See Skocpol, *supra* note 5, at 412–14.

57. *Id.* at 414.

[R]oom has been made *within* certain universal policy frameworks for extra benefits and services that disproportionately help less privileged people without stigmatizing them. What I shall call “targeting within universalism” has delivered extra benefits and special services to certain poor people throughout the history of modern American social provision, and new versions of it could be devised today to revitalize and redirect U.S. public social provision.⁵⁸

Skocpol recommends that policy makers structure necessary supports in a way that apply to universal needs, but that can be particularly beneficial to those most in need. While benefits can be general in nature, they could be provided more substantially to those in need. The earned income tax credit, for example, is operated through an income tax system in which all participate. The credit is available to all when and if their income drops to threshold levels, but the benefits accrue most powerfully to the neediest.⁵⁹

Targeting within universalism for Medicaid, then, would allow for expanded services for the poor *within* the increasingly universal framework of Medicaid as a broadly available health insurance program. There are two models to accomplish this task. In the next section, I describe a form of Medicaid ACO that permits Medicaid funding to be spent to provide broad services for the poor without changing the general medical coverage mission for the broader population.⁶⁰ In the remainder of this section, I describe an alternative whereby Medicaid funds are not spent on new social services, but rather Medicaid partners with other social programs and agencies to address the social needs of the poor.

The City of Richmond, California is a poor city. It has adopted a novel plan to integrate social and medical services to address broader barriers to health. About nineteen percent of Richmond’s residents are unemployed, and thirty-eight percent of its children live in poverty. Over half of its residents pay more than thirty percent of their income for housing.⁶¹ Residents face “environmental pollution, neighborhood violence, unemployment, [and] unsafe physical infrastructure,” and they lack access to affordable health care, nutritious food, and childcare.⁶² Richmond has adopted a Health in All Policies (“HiAP”) ordinance. HiAP calls for broad social policies across all public sectors that take into account determinants of health,⁶³ and further calls for cooperation among agencies

58. *Id.*

59. *Id.* at 428-31.

60. *See infra* Part IV.

61. Jason Corburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URBAN HEALTH 623, 625 (2014).

62. *Id.* at 627.

63. *Id.* at 624-25 (citing Ilona Kickbusch, *Health in All Policies: Setting the Scene*, 5 PUB. HEALTH BULL. S. AUST. 3 (2008)) (published by the South Australian Department of Health).

responsible for health, food, income, environmental, and housing policies.⁶⁴ Its governing philosophy has been described in the following terms:

The main principle behind the slogan ‘Health in All Policies’ is really very simple: Health is greatly influenced by lifestyles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly, decisions influencing people’s health do not concern only health services or ‘health policies’, but decisions in many different policy areas have their influence on these health determinants.⁶⁵

Richmond’s HiAP program advanced these principles through the convening of a process that produced a coordinating strategy and a HiAPP ordinance. The ordinance developed programmatic and policy strategies to incorporate a health orientation in six focus areas:

- Governance and Leadership: all city agencies must incorporate and further HiAP methods and goals;
- Economic development and education: city will invest in workforce development, particularly for people of color and women, child care, and community schools;
- Safe communities: city will promote reduction in environmental stress and improve services such as health food through rezoning and community investment;
- Residential and built environment: city will address substandard housing and lead paint abatement, develop homelessness programs, and improve recreational opportunities;
- Environmental health and justice: city will reroute truck routes, improve air quality through improved toxic waste monitoring, and remediate hazardous waste sites; and
- Health home and social services: city will assist in ACA-related health insurance enrollment and enrollment in other safety net programs.⁶⁶

The ordinance was only recently adopted,⁶⁷ and the city’s ability and willingness to follow through on the requirements are therefore unknown. In addition, there are few mature models of HiAP-driven integrated programs in the United States with which to compare the Richmond initiative, although such

64. Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population’s Well-Being*, 159 U. PA. L. REV. 1777, 1819-20 (2011).

65. Pekka Puska, *Health in All Policies*, 17 EUR. J. PUB. HEALTH 328, 328 (2007).

66. Corburn, *supra* note 61, at 629-30.

67. The ordinance was adopted in April 2014. Corburn, *supra* note 61, at 623-24.

programs are beginning to emerge, following on decades of development in other nations.⁶⁸

The adoption of HiAP policies in the United States holds promise as a mechanism to foster cooperate among agencies that, collectively, could integrate health and social services central to improving the health status of the poor.⁶⁹ Those attempting to create HiAP-governed cooperative efforts, however, do face difficulties:

HiAP implementation faces a number of challenges at the local, state, and national levels, including public health's limited connectivity to other sectors, organizational and technical barriers (eg, information systems, planning horizons, funding mechanisms), and intersectoral differences in values and cultures. Furthermore, intersectoral collaboration can be resource intensive, particularly in terms of staff time and expertise, which is a challenge in an era of decreasing public resources across government agencies.⁷⁰

If governmental leadership is present, and if agency staff cooperation is forthcoming, HiAP collaboratives dovetail nicely with the targeting within universalism model: Medicaid continues to exist as a general insurance program, and additional services particularly needed by very poor Medicaid recipients can be provided by other agencies. In the absence of a broad willingness and capacity for inter-agency cooperation, other methods of addressing the needs of the poor are necessary. The next section describes addresses another model.

IV. TACOS

Medicaid is a vital program for the poor, even as expands to become a source of health coverage for the near-poor and middle class. Advocates for the poor may favor a targeted approach to Medicaid development to concentrate attention and funding on the neediest. They may also favor a universalist approach to reduce the program's stigma and to gain political support from the expanded program's broader constituency. Targeting within a universal Medicaid will permit special services for the poor without diminishing the program's universal reach.⁷¹

The previous section described how HiAP policies can target within a universal Medicaid program. HiAP programs permit Medicaid to expand medical services to the non-poor while coordinating with other public agencies to provide supplemental services to the poor. Logistical and operational difficulties may limit

68. Lauren N. Gase et al., "Health in All Policies:" *Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. PUB. HEALTH MGMT. PRAC. 529, 530 (2013).

69. *Id.*

70. *Id.* at 537.

71. See Skocpol, *supra* note 5, at 413-14.

the proliferation of HiAP programs. This section describes Medicaid Accountable Care Organizations as alternative methods of targeting the poor within a general Medicaid program.

This section first describes the general problem of fragmentation in our health care delivery system, particularly for people with chronic illness. It then describes clinical innovations that integrate care for people with chronic illness, and explains how ACOs create organizational and financial support for such integration. Next, this section will demonstrate how the ACO model of integrating care for the chronically ill can be applied to Medicaid—a program that covers many people with chronic illness. Finally, it argues that the financing mechanism for Medicaid ACOs provides a promising means by which community-based organizations can be given the incentive and the Medicaid-provided financial capacity to provide poor and vulnerable Medicaid beneficiaries with the social services they need to thrive—without altering Medicaid’s general medical insurance mission for the expansion population.

The fragmentation of the American health care system is one of its major faults. The Institute of Medicine’s ground-breaking report *To Err is Human* described the nature and effects of that fragmentation:

The decentralized and fragmented nature of the health care delivery system . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence . . . At the same time, the provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information.⁷²

Fragmentation leads to bad decision-making due to a lack of coordination and communication among health care providers and institutions.⁷³ This fragmentation is further exacerbated by payment policies, which encourage fragmentation and increase costs.⁷⁴

Fragmented care creates particular health dangers for patients with chronic illnesses, who by the nature of their condition require frequent care. The danger arises through lost opportunities for appropriate care and conflicting treatments that can do more harm than good:

72. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 3 (Linda T. Kohn et al. eds., 2000).

73. See Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTHCARE: CAUSES AND SOLUTIONS* 1-2 (Einer Elhauge ed., 2010).

74. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 *HEALTH AFF.* 759, 764-65 (2008).

Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinical responsibility increases the chance that some services may not be provided at all. Among people with chronic conditions 71% report having no help coordinating their care. . . and 17% say they have received contradictory medical information from health care professionals.⁷⁵

Robert Kane, one of the leading clinical researchers into care for patients with chronic illness, has described the problem as a myopic focus on isolated symptoms rather than the whole person:

Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, (i.e., treat the disease in the patient rather than treat the patient with the disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.⁷⁶

The cure for the harm of fragmentation generally,⁷⁷ and for people with chronic illness in particular,⁷⁸ is the coordination of care across providers, disciplines, and institutions.

ACOs are one mechanism to remedy fragmentation. ACOs are organizations comprising a broad range of health care providers with the capacity to manage and be held accountable for improving health quality.⁷⁹ ACOs contain the raw material for reversing fragmentation, as they are provider-led organizations including primary care, specialty care, hospital care, and the range of other health services necessary to render coordinated care. Integrated delivery systems are not new; the innovation of ACOs is in the payment, by which the participating providers receive incentives for providing high-quality care in a cost-effective manner. The payment mechanisms can include gainsharing—the ability of the ACO to retain a portion of the cost-savings created by its efficient care management—or risk-based partial capitation, by which the ACO receives a set amount of compensation for each patient covered to spend as it judges best to provide some of the cost of care for

75. ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 50 (2005).

76. *Id.* at 50-51.

77. Berwick, *supra* note 74, at 765.

78. Kane, *supra* note 75 at 71-74.

79. See Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982-83 (2010); Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving The Cost and Quality Quandaries?*, URBAN INST. 1-2 (Oct. 2009), http://www.urban.org/uploadedpdf/411975_accountable_care_orgs.pdf.

the patients under its care.⁸⁰ At bottom, the payment is intended to provide incentives for ACOs to manage patient care well and efficiently, while devolving to the ACO substantial discretion on the means by which it can reduce costs while maintaining or improving quality.

The ACA created an ACO payment program in Medicare,⁸¹ but did not create a similar program in Medicaid. Experimental programs are growing in several states, however, built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.⁸² Much of the success of these ACOs is premised on their medical management, their ability to constrain health expenditures, and their ability to deliver coordinated care to improve the health status of Medicaid recipients.⁸³

Medicaid disproportionately covers the poor, disabled, and elderly, and therefore the chronically ill.⁸⁴ As with Medicare ACOs, Medicaid ACOs are structured to integrate care, and therefore have the capacity to improve care for people with chronic illnesses. The financing mechanisms for Medicaid ACOs reverse the incentive to avoid high-cost patients, and instead encourage them to seek out and care for the sickest, including those with chronic illness. The incentive derives from the population-based reimbursement for most models of Medicaid ACO. The range of payment methodologies can include pay-for-performance agreements, global payments, and gain-sharing payments with state Medicaid agencies, Medicaid managed care organizations, and other payers, as well as grant funding from foundations.⁸⁵ This population-based model attributes all Medicaid recipients in a designated to community to the ACO, and any gains, or risk-based reimbursement, is dependent on the ACO's ability to maintain or improve quality while driving down the aggregate cost of care in that community.⁸⁶

A community-based Medicaid ACO model, then, combines clinical integration with a financial incentive to reach out to the chronically ill in the ACO's geographic area to provide integrated chronic care. But the Medicaid ACO model

80. See Devers & Berenson, *supra* note 79, at 6-7.

81. 42 U.S.C. § 1395jjj (2012) (Medicare shared savings program, authorizing Medicare ACOs).

82. See Jacobi, *supra* note 11, at 374-76; Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care Organizations in New Jersey*, 16 POPULATION HEALTH MGMT. S-12, S-14-S-16 (2013); Tricia McGinnis & David M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES 5-8 (2012), http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf.

83. McGinnis & Small, *supra* note 82, at 2-3.

84. See John Billings & Tod Mijanovich, *Improving Care for High-Cost Medicaid Patients*, 26 HEALTH AFF. 1643, 1644-45 (2007).

85. See Valerie A. Lewis et al., *The Promise And Peril of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles*, 31 HEALTH AFF. 1777, 1781 (2012).

86. See N. J. REV. STAT. § 30:4D-8.5 (2013) (describing community-based gain-sharing program in New Jersey's Medicaid ACO program); Jacobi, *supra* note 11 at 375-76; McGinnis & Small, *supra* note 82, at 2.

can go beyond the provision of coordinated medical care. The financing structure that rewards Medicaid ACOs for reaching and treating people with chronic medical conditions can also reward it for reaching beyond medical care to the provision of social services to ameliorate the effects of the social determinants of health. By expanding the scope of their vision and their activities to include the social determinants of health, Medicaid ACOs can be transformative in their communities.

Poor and vulnerable populations can benefit much more from the broad integration of social and health services than they can from the integration of health services alone. Medicaid ACOs are designed to address the needs of both the clinically vulnerable and the socially vulnerable.⁸⁷ As is described above, the former group is a population that could be targeted by the medical care aspects of ACOs: those with chronic conditions or risk factors that can be addressed with sophisticated coordinated care.⁸⁸ The second group—the socially disadvantaged—require a stretching of the model.

Organizations that pursue this melding of social and medical coordination for the benefit of clinically and socially vulnerable patients have been christened “totally accountable care organizations,” or “TACOs.”⁸⁹ These organizations recognize that “much of what impacts health outcomes occurs outside of the health care system,” including in-jail diversion programs, improved substance use disorder services, and housing support services.⁹⁰ The flexibility created by population-based reimbursement systems allow TACOs to be responsive to the broad range of clinical and social barriers that affect their vulnerable target populations and that cause the population to absorb such a large portion of the cost of care.

Rewarding TACOs for reducing the overall burden of Medicaid costs gives them the flexibility to use their resources to address the particular cost-drivers of poor populations. They will have the funding, the capacity, and the incentive to target a broad range of social services:

[The reimbursement incentives available to Medicaid ACOs] may foster closer collaboration among health care providers and social service organizations, addressing a more holistic set of patient needs. For example, ACOs serving a sizeable homeless population may be able to use a portion of their shared savings

87. See Lewis et al., *supra* note 85, at 1778.

88. *Id.*

89. See Jennifer DeCubellis & Leon Evans, *Investing In The Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), <http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier>; Stephen Somers & Tricia McGinnis, *Broadening the ACA Story: A Totally Accountable Care Organization*, HEALTH AFF. BLOG (Jan. 23, 2014), <http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization>.

90. DeCubellis & Evans, *supra* note 89.

to work with local housing agencies to help patients get into stable housing and thereby reduce related, unnecessary medical spending—such as a longer-than-necessary hospital stay that occurs simply because a patient doesn't have a home to go to.⁹¹

TACOs, then, can achieve these improvements in the lives of the members of their communities through the melding of medical and social services. Further, they can do so without necessitating the creation of a separate, targeted, form of Medicaid. TACOs can coexist with other Medicaid provider organizations and share methods with them. All Medicaid providers—indeed, all health care providers—can explore the value of integrated care as a means to improve care for patients with chronic conditions, even though organizations serving higher-income beneficiaries are less likely to engage in housing or jail diversion efforts. Higher-income Medicaid ACOs may serve their populations well without the need to graduate to the status of TACOs.

TACOs are distinct from other Medicaid clinical providers not by virtue of their legal or regulatory mandate, but by virtue of the means they adopt to satisfy exactly the same mandate. That is, TACOs would not be required by Medicaid statutes or regulations to add social services to their activities. Instead, they would be empowered by state law to gain financially for improving care and reducing cost for a population of Medicaid-eligible residents of a community. They could use the gains they realize for achieving improvements to fund non-Medicaid services with their own funds, garnered through the gains they realize from care improvement and cost reduction.

Their special targeting of very vulnerable Medicaid recipients, then, satisfies the requirements described above⁹² to achieve targeting within Medicaid without impeding the goal of using Medicaid as a path to insurance expansion. TACOs serve Medicaid goals by correcting providers' perverse financial incentives and thereby reducing fragmentation of care. Once TACOs obtain a financial reward for reducing the cost of care to Medicaid, they can employ those rewards to use social services to counteract the effects of the social determinants of health. They could follow a virtuous cycle of employing gains from reducing costs of care for the poor to further reduce those costs by attacking the social impediments to health. By using a return on investment and not funds directed to social services by a state Medicaid agency, they can accomplish particular gains for the poor within the existing legal structure of the Medicaid program.

91. *Id.*

92. *See supra* Part IV.

CONCLUSION

The very poor often live with clinical and social vulnerabilities that require care that is different in kind from that required by the less poor and less vulnerable “expansion” populations added by the ACA. The ACA uses the Medicaid program to expand opportunities for access to health insurance to populations of higher-income working poor persons, and it may be so used in the future. The poor can benefit from this broadening, as a broader Medicaid is likely to be less stigmatizing to the poor and will gain political support through its wider reach into the American voting population. The broadening may, however, risk the reduction in Medicaid’s focus on the particular needs of the poor. Total Accountable Care Organizations—TACOs—in Medicaid can continue and enhance Medicaid’s services to the poorest and most vulnerable while allowing Medicaid to morph into a broader health insurance system, thereby achieving targeting within universalism. TACOs can employ general tools to coordinate care and expand access—tools that are available to all Medicaid providers under the ACA, and would also be available to Medicaid ACOs. In the case of TACOs serving very vulnerable populations, however, providers can choose to use their funds to address social concerns, such as substandard housing and food deserts that are less likely to affect higher-income Medicaid beneficiaries.

By allowing TACOs to serve social needs, Medicaid can create incentives and capacity for community organizations to provide specialized clinical and social services to our most vulnerable, while also providing general public health insurance to those shut out of private coverage. Organizations devoted to the care of the poor and vulnerable are moving toward the creation of functioning TACOs. Their actions should be supported and applauded without fear for the broader, equally important insurance-expansion mission of Medicaid.

