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The Medical Legal Partnership for Children: Policy Strategies for Expanding a Gateway Program

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THE MEDICAL LEGAL PARTNERSHIP FOR CHILDREN: POLICY STRATEGIES FOR EXPANDING A GATEWAY PROGRAM

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Abstract: The authors featured in Ending Poverty in America propose progressive strategies for combating poverty, including the creation of gateway programs through which the poor can obtain comprehensive services. One of these programs, the Medical Legal Partnership for Children, has effectively implemented a new kind of preventative medical care by placing lawyers alongside pediatricians to address health issues with a related legal dimension. This book review analyzes MLPC and suggests that revising the Medicaid statute and earmarking a portion of the State Children’s Health Insurance Program block grant will help ensure the long-term viability of this important program.

Introduction

A staggering thirty-six million people in the United States live in poverty.1 Almost thirteen million of these individuals are children under the age of eighteen.2 These numbers find their origin in a daunting confluence of economic and social forces.3 They are a reflection of the moral failure of government and society, a failure that is often the result of complexity rather than inaction.4 Despite obstacles to implementation, however, there are strong progressive proposals and existing programs that can address the complex societal problems that result in the culture of poverty in America today.5

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2 See id.

3 See generally Ending Poverty in America, How to Restore the American Dream (John Edwards et al. eds., 2007) (discussing the causes and impacts, as well as possible solutions, to poverty in America).

4 See generally id.

5 See generally id.
Many of the most promising strategies are sketched out in *Ending Poverty in America: How to Restore the American Dream.*\(^6\) Published in conjunction with the Center on Poverty, Work and Opportunity, the essays provide an interdisciplinary approach to issues facing the working poor.\(^7\) The policies described in the book are tied together by the common ideals of hard work, equal opportunity, thrift, and strong families.\(^8\) A belief in the existence of the “American Dream” serves as the foundation for these essays, and underscores former Senator John Edwards’ challenge to his readers and to his country not to be satisfied with modest improvement, but to set the goal of ending poverty in the United States in the next thirty years.\(^9\)

The essays’ authors advocate for diverse programs offering creative ideas and practical solutions to the problem of poverty in America.\(^10\) These programs cannot be expected to alleviate poverty in any meaningful way, however, if they are not integrated into comprehensive federal or state efforts.\(^11\) Any viable solution must be designed to address the reality that the problems burdening impoverished Americans are complex and never mutually exclusive.\(^12\) In his essay “Connecting the Dots,” Pulitzer Prize-winning author David K. Shipler illustrates how poverty results from a combination of structural and cultural forces.\(^13\) Shipler, in recognizing the need for systemic solutions, suggests broadening schools, medical clinics, and other institutions frequently used by the poor into gateways through which they can obtain multiple services that address all of their needs.\(^14\)

An example of a gateway model is the Medical Legal Partnership for Children (MLPC).\(^15\) Originally established as the Family Advocacy Program in 1993 and housed at the Boston Medical Center in Boston, Massachusetts, it was the brainchild of the hospital’s Chief of Pediatrics, Dr. Barry Zuckerman.\(^16\) Dr. Zuckerman recognized the effects that liv-

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\(^6\) See generally id.

\(^7\) See id. at ix.

\(^8\) See John Edwards, Conclusion to *Ending Poverty in America*, supra note 3, at 256, 259.

\(^9\) See Edwards, supra note 8, at 257.

\(^10\) See generally *Ending Poverty in America*, supra note 3.

\(^11\) See *Ending Poverty in America*, supra note 3.

\(^12\) See David K. Shipler, *Connecting the Dots*, in *Ending Poverty in America*, supra note 3, at 13, 20–21.

\(^13\) See id. at 13.

\(^14\) See id. at 20.

\(^15\) See id. at 16.

ing in poverty had on the health of his patients and their families.\textsuperscript{17} He realized that successful medical interventions addressed environmental risk factors—such as stress, inadequate social support, and maternal depression—and created appropriate protective mechanisms.\textsuperscript{18}

Dr. Zuckerman’s experience led him to believe that legal assistance could be an effective tool for ameliorating the effects that living in poverty has on pediatric health.\textsuperscript{19} As a result, MLPC introduced preventative law into the clinical setting by offering on-site civil legal services for children and their families.\textsuperscript{20} Because pediatricians are in a position to develop long-term relationships with the families they serve, they are uniquely situated to identify potential legal issues and refer families for attorney counseling.\textsuperscript{21} Attorneys and other staff members can assist families in obtaining government benefits, securing safe and affordable housing, and resolving family disputes to ensure that children’s basic needs are met.\textsuperscript{22} The success of the model has led to its replication in over fifty clinical sites.\textsuperscript{23}

MLPC provides integrated, preventative services that reflect the importance of treating the whole patient.\textsuperscript{24} This holistic approach, blending medical treatment with the treatment of poverty, is supported by the essays in \textit{Ending Poverty in America}, which argue that the cost of health care and resultant medical debt has reached the level of national crisis.\textsuperscript{25} In order to begin addressing the connections between poverty

\textsuperscript{17} See Steven Parker et al., \textit{Double Jeopardy: The Impact of Poverty on Early Child Development}, 35 Pediatric Clinics of N. Am. 1227, 1227–36 (1988); MLPC Mission & History, supra note 16.

\textsuperscript{18} Parker et al., supra note 17, at 1235–36.

\textsuperscript{19} See MLPC Mission & History, supra note 16.

\textsuperscript{20} Id.


\textsuperscript{22} See MLPC Mission & History, supra note 16.

\textsuperscript{23} See Lawton, supra note 21, at 38.

\textsuperscript{24} See id. at 37–39.

\textsuperscript{25} See, e.g., Elizabeth Warren, \textit{The Vanishing Middle Class, in Ending Poverty in America}, supra note 3, at 38, 43–44, 45, 47 (discussing how increases in fixed costs such as health care and housing have made it nearly impossible for the typical two-income family to afford basic expenses); ABC News/Kaiser Family Found./USA TODAY, Health Care In America 2006 Survey 3 (2006), available at http://www.kff.org/kaiserpolls/upload/7572.pdf (finding that of those Americans having trouble paying medical bills, over two-thirds had health insurance); Michelle M. Doty et al., Commonwealth Fund, Seeing Red: Americans Driven into Debt by Medical Bills 2 (2005), available at http://www.
and incomplete, inadequate health care, Congress must increase funding for public benefits programs and implement reasonable and workable guidelines to encourage MLPC and similar gateway programs.26

This book review argues for the continued implementation of the MLPC model in the pediatrics departments of hospitals and health centers across the country. Part I looks at the mission of MLPC and how the program addresses legal problems that would otherwise undermine the health of pediatrics patients. Part II discusses how Medicaid and the State Children’s Health Insurance Program (SCHIP) provide health care for children most benefited by the MLPC model. Part III considers how revising the guidelines for Medicaid and earmarking block grants can encourage health care providers to implement the MLPC model in their facilities. Providing adequate reimbursement for MLPC services will ensure that pediatric health care providers can implement this type of collaborative effort to bring preventative health-related legal services to children.

I. The Medical Legal Partnership for Children

Each year approximately half of all low- and middle-income households are confronted with circumstances that raise a civil legal issue.27 Among these issues, those least likely to be brought to the civil justice system are health-related matters, including children’s health problems that are exacerbated by poverty.28 Traditionally, indigent families had access through community programs to social and legal services that could provide assistance with health-related legal issues, but federal budget cuts have reduced access to these resources.29 While there are

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26 See Edwards, supra note 8, at 257–58.
27 See Consortium on Legal Servs. and the Public, American Bar Association, Legal Needs and Civil Justice, A Survey of Americans, Major Findings of the Comprehensive Legal Needs Study 23 (1994). “Legal issues” refers both to situations that were brought to the attention of the civil justice system and events or difficulties that low- and moderate-income households attempted to handle on their own. See id. at 2. The study found that the most common legal needs mentioned by participants were personal finance, consumer issues, and housing related matters. See id. at 5–6, 24.
28 Id. at 24.
numerous government programs specifically designed to address the health-related legal issues facing the children of low-income families, inconsistent implementation, bureaucratic inefficiency, incompetence, and mere disregard or misinterpretation of existing regulations often result in illegal or improper denials of benefits and services to these children.\textsuperscript{30} Hospitals and clinics provide natural access points to address these legal issues.\textsuperscript{31} MLPC is exactly the kind of gateway program that fills this void by helping indigent families access appropriate public support and combat the legal dimensions of poverty that undermine their health.\textsuperscript{32}

A. The Mission

The doctors and staff attorneys at MLPC are trained to recognize social stresses and barriers affecting the health of their child patients that have possible legal solutions.\textsuperscript{33} Seen as the legal equivalent of preventative care, the program, according to Dr. Laura A. Smith, a pediatrician and medical director of MLPC, uses “the skills of lawyers to address the non-biological factors that contribute to and exacerbate health problems.”\textsuperscript{34} The MLPC model involves three core principles: (1) providing direct legal services and ongoing advocacy to low-income children and their families to prevent some health problems and to ensure long-term improvements; (2) training for healthcare professionals to identify social and economic origins of their patient’s ill health and the appropriate legal resources to help them; and (3) systemic advocacy to bring about change in local, state, and national policy and programs that can help improve child health.\textsuperscript{35}

\textsuperscript{30} See Barry Zuckerman et al., Why Pediatricians Need Lawyers to Keep Children Healthy 114 PEDIATRICS 224, 224 (2004). Many eligible individuals do not receive benefits due to language barriers or the complexity of the application process. Katherine S. Newman, Up and Out: When the Working Poor are Poor No More, in ENDING POVERTY IN AMERICA, supra note 3, at 101, 111. Programs like MLPC and SeedCo, a nonprofit based in New York, recognize that for policies to be successful, their benefits must be accessible to targeted families. See id. at 111–12. SeedCo has implemented a web-based tool that allows case managers to determine their clients’ eligibility for multiple kinds of benefits and to complete applications for those benefits online, without having to navigate each bureaucratic structure individually. See id.

\textsuperscript{31} See Lawton, supra note 29, at 12.

\textsuperscript{32} See id. at 12–13.

\textsuperscript{33} See id. at 13.

\textsuperscript{34} Id.

At the Boston MLPC site, six in-house attorneys work with physicians and patients’ families to identify legal needs that may undermine the children’s health. The pediatricians at the hospital are trained to view patients as part of a family unit shaped by complex social and economic factors. As families establish long-term relationships with their pediatricians, they begin to view them as trustworthy and concerned professionals to whom families can safely reveal private information without fear of judgment. Providing a continuity of care over a long period of time gives pediatricians the ability to gauge the effectiveness of interventions and modify them accordingly.

For these reasons, the clinicians who started MLPC recognized that pediatricians are in a unique position to spot legal health risks before they become full-blown crises. The clinicians noted, however, that treating physicians are frequently reluctant to ask broad questions about legal issues affecting a family’s well-being. This is either because the physicians find the law intimidating or they do not have the background or resources to engage in legal advocacy for their patients. The partnership with attorneys recognizes that pediatricians are prepared to identify, but not necessarily address, the social origins of child health, and that lawyers are often in the best position to interpret agency guidelines and to counsel parents on their rights and legal remedies.

Armed with the knowledge that they are supported by attorneys, doctors are comfortable asking questions that can lead to disclosure of information related to an issue that might be addressed by MLPC attorneys. In the clinical setting, where there are significant time and informational constraints, these attorneys are available whenever a doc-

38 See Lawton, supra note 29, at 12. Lawton also references focus group findings that families considered their pediatrician the most trustworthy source of information about their eligibility for government benefits and services. See id.
39 See Tames et al., supra note 37, at 506.
40 See Lawton, supra note 29, at 13.
41 See id.
42 See id. Lawton states “that the reasons physicians do not assess a patient’s unmet needs include: 1) insufficient knowledge of how to screen for the problems; 2) lack of confidence; 3) a deficiency in knowledge of available resources; 4) difficulty in setting the referral process in motion; and 5) lack of time.” Id. at 15.
43 See Press Release, Boston Univ., supra note 35.
44 See Zuckerman et al., supra note 30, at 224–25.
tor needs them to provide immediate consultations. While social workers and case managers remain integral to the success of the program, lawyers are better trained in the art of advocacy and can better determine and pursue the appropriate legal recourse for issues affecting patients’ health.

B. Success Stories

Dr. Zuckermann described an example of the partnership in action in an opinion piece he wrote for the Boston Globe in 2002. The story he tells exemplifies a theme in Ending Poverty in America; small barriers imposed by poverty, such as lack of bargaining power with a landlord, combine to exacerbate health and social problems. A mother of a six-year-old boy with severe asthma risked losing her job as a result of his many absences from school. A nurse was sent to the family’s home in an effort to locate possible environmental triggers for his asthma. She found that mold due to a leaky pipe and dust mites in wall-to-wall carpeting were exacerbating the boy’s asthma. After several unsuccessful requests by the mother that the landlord fix the problems, the mother was referred to an attorney at MLPC, who researched the local and state health and housing code regulations. Finding that the landlord was legally responsible for fixing the pipe and removing the carpeting because they severely impacted the boy’s health, the attorney called the landlord. Faced with the threat of court action, the landlord fixed the problems and the boy’s health improved, allowing him to return to

45 See Lawton, supra note 29, at 13–14. To be effective in a clinical setting, lawyers must understand how doctors are trained and provide digestible advocacy information that can easily be incorporated into a patient’s overall treatment plan. See id.
46 Id. at 13; Zuckerman et al., supra note 30, at 225.
48 See, e.g., Shipler, supra note 12, at 16–17 (recounting how a single mother with medical insurance was plunged into debt after her son’s asthma attack); William Julius Wilson, New Agenda for America’s Working Poor, in ENDING POVERTY IN AMERICA, supra note 3, at 88, 92–94 (discussing how urban sprawl and economic stagnation have resulted in high unemployment and deteriorating neighborhoods in America’s inner-cities); Carol Mendez Cassell, A Hopeful Future: The Pathway to Helping Teens Avoid Pregnancy and Too-Soon Parenthood, in ENDING POVERTY IN AMERICA, supra note 3, at 205, 208–211 (highlighting how teen pregnancy is linked to a lack of social and economic opportunities).
49 Zuckerman & Lawton, supra note 47.
50 Id.
51 Id.
52 Id.
53 Id.
and regularly attend school. In this case, a small amount of help from medical and legal professionals yielded many benefits.

Another goal of MLPC, “systemic advocacy,” is illustrated by an attorney who in 1999 saw that multiple families that should have been eligible for welfare-to-work exemptions because of chronically ill children were repeatedly being denied. Research by the attorney revealed that the Massachusetts Department of Transitional Assistance had made it more difficult for families to meet the standards to qualify for these work exemptions. MLPC partnered with local legal services organizations to bring a class action suit that resulted in an injunction against the application of the higher standard. Additional systemic advocacy activities include organizing a Child Health Impact Assessment working group to evaluate the impact of policy, regulations, and legislation on children’s overall health; so far, the group has looked at the Massachusetts Rental Voucher Program and high energy costs.

Overall, since 1993, MLPC has assisted over 5000 families and its interdisciplinary effort has been met with praise from the medical and legal communities. In 2006, MLPC announced that it had secured $2.7

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54 Zuckerman & Lawton, supra note 47.
55 See Zuckerman et al., supra note 30, at 226.
56 See id. By applying stricter standards not intended for this use, the Massachusetts Department of Transitional Assistance effectively raised the bar for eligibility. Id.
57 See id.
59 See Press Release, Boston Univ., supra note 35. Initially, there was some worry that the American Bar Association (ABA) would voice concern over this multidisciplinary model. See Tames et al., supra note 37, at 508; MLPC Mission & History, supra note 16. In 1998, the president of the ABA convened a Commission on Multidisciplinary Practice to determine if the model professional rules should be modified to accommodate these organizations. John Gibeaut, It’s a Done Deal: House of Delegates Vote Crushes Chances for MDP, 86 A.B.A. J. 92, 93 (Sept. 2000). One year later, the Commission issued its findings and suggested that the model rules be amended to allow for lawyers and other professions to join in certain commercial partnerships. See id. at 92. Before the recommendations could be voted on, they were rejected by a 3-to-1 margin by the House of Delegates. See id. Despite this record indicating its disapproval for a multidisciplinary approach to legal problems, in August 2007, the ABA passed a resolution encouraging its members to engage in medical-
million over five years in foundation grants to provide technical training, resources, and seed money for similar programs nationwide.\textsuperscript{60} While much of the funding came from large foundations, including the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation, law firms committed to pro bono work have also committed significant financial resources and manpower to the effort.\textsuperscript{61} For the attorneys involved, the collaboration is an effective and efficient means of providing pro bono legal services because the medical team essentially prescreens clients and refers them based on legal and economic qualifications.\textsuperscript{62}

These grants for implementation of the model and necessary training, however, will run out before these programs have a chance to fully establish themselves in hospitals and clinics.\textsuperscript{63} Given the dire financial condition of most hospitals today, it is unlikely that they will be able to fund and maintain MLPC programs without external support.\textsuperscript{64} For these reasons, the long-term viability of MLPC and similar programs will depend largely on securing adequate public funding through reimbursement and block grants that favor preventative interdisciplinary approaches to children’s health.\textsuperscript{65}

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\textsuperscript{60} See Sacha Pfeiffer, \textit{BMC to Go National with Legal Aid Program, Boston Globe}, Apr. 10, 2006, at A1; Press Release, Boston Univ., \textit{supra} note 35.

\textsuperscript{61} See Press Release, Boston Univ., \textit{supra} note 35.

\textsuperscript{62} See Matthew Hersh, \textit{Legal Prescription, Lawyer Treats Kids for Legal Maladies, Recorder} (San Francisco), July 26, 2006, at 1.

\textsuperscript{63} See Press Release, Boston Univ., \textit{supra} note 35.


II. Medicaid and SCHIP: Complementary Goals, Different Designs

For every ten uninsured children who qualify for Medicaid or SCHIP nationwide, six are not enrolled.66 Both programs provide necessary medical care for children living in poverty.67 Increased funding for Medicaid and SCHIP will create more access to public benefits for eligible children and families, thus raising revenues for already strapped local clinics and hospitals.68 In addition, increased funding for these programs will ensure the long-term viability of the MLPC model by providing reimbursement for legal services.69

A. Medicaid

Medicaid and SCHIP are the two crucial sources of coverage for low-income families who would otherwise be unable to purchase health insurance.70 Together, Medicaid and SCHIP cover more than thirty million low-income children, approximately one in four children in the United States.71 It is estimated that there were almost nine million uninsured children in 2006.72 Of these, two-thirds were eligible for Medicaid or SCHIP but were not enrolled, evidence that many parents of eligible children are either not aware of the funding available to them or are discouraged by the administrative hurdles they face in signing up for the programs.73


67 See Dorn, supra note 66, at 1.


69 See New England Regional Medical-Legal Network, supra note 65, at 6–11; Lawton, supra note 21, at 41. Medicaid and SCHIP reimbursement for MLPC legal aid services is warranted because these programs reimburse for similar case management services. See New England Regional Medical-Legal Network, supra note 65, at 6–11; Lawton, supra note 21, at 41.


71 See id.

72 Id.

Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program that represents the largest single source of health insurance for Americans.\(^74\) The program provides federal funding to the states, which in turn provide medical assistance programs to low-income individuals who meet certain statutory requirements.\(^75\) Medicaid is the primary source of federal financing assistance to the states, with the federal government setting broad guidelines and the states having substantial flexibility to structure eligibility and benefits and administer their own programs.\(^76\) While participation is voluntary, a state’s agreement to participate in the program has the force and effect of federal law and the consenting state must comply with the controlling federal regulations and statutes.\(^77\)

Medicaid’s policy priorities are reflected in the categories of low-income individuals—children, the elderly, the disabled, and pregnant women—for whom the federal government will provide states with matching funds.\(^78\) There are some categories that states must cover if they participate in the Medicaid programs, and other categories for which federal matching funds are available should a state choose to extend eligibility.\(^79\) If federal matching funds are not available for a population that a state wants to make eligible, the state has to fund

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\(^{74}\) See Grants to States for Medical Assistance Programs, 42 U.S.C. §§ 1396a–1396v (2000); Sara Rosenbaum et al., Public Health Insurance Design for Children: the Evolution from Medicaid to SCHIP, 1 J. HEALTH & BIOMEDICAL L. 1, 7 (2004).

\(^{75}\) See §§ 1396–1396v; Rosenbaum et al., supra note 74, at 7.


\(^{77}\) See Westside Mothers v. Haveman, 289 F.3d 852, 858–59 (6th Cir. 2002).

\(^{78}\) See David Rousseau et al., Kaiser Comm’n on Medicaid & the Uninsured, Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefit Categories 1–2 (2002); Schneider et al., supra note 76, at 4, 5. Children eligible for Medicaid on a mandatory basis include those six and under who live in families with family incomes at 133% of the federal poverty level. See Schneider et al., supra note 76, at 11. For children ages six through eighteen, eligibility is at 100% of the federal poverty level. Id. Childless, nondisabled adults under age sixty-five are not generally covered unless through a state waiver. See id., at 10–11. There are five requirements relating to eligibility, two of which are financial, that vary on a state by state basis: categorical, income, resource, immigration status, and residency. See id. at 6.

\(^{79}\) See Schneider et al., supra note 76, at 5.
services to that population itself, making it less likely that states will take the initiative and expand coverage on their own. 80

Medicaid provides more expansive coverage than most private insurance. 81 The Social Security Act does not define health care services that are “medically necessary.” 82 Rather, the federal government requires that services provided by Medicaid be consistent with the goals of the program and that they be just. 83 In keeping with this intent, judicial rulings and agency interpretations have reinforced the preventative goals of the program and generally do not allow for limits on coverage that could interfere with the need for treatment. 84 This standard ensures coverage for far more treatments than private insurance, which traditionally relies on a model that seeks to limit coverage to treatment that will restore functioning and does not take prospective measures or a long-term perspective on health care. 85

Medicaid is more generous in its provision of benefits and services to children than to adults, as children are eligible for more benefits and states are mandated to provide more preventative programs to them. 86 One of these programs is the Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. 87 Enacted in 1967, the pro-

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80 See id.
81 See Sara Rosenbaum et al., Commonwealth Fund, Room to Grow: Promoting Child Development Through Medicaid and SCHIP 17 (2001).
83 See Dickson, 391 F.3d at 589–593; 42 C.F.R. § 441.50–.56; Rosenbaum et al., supra note 74, at 13.
84 See Dickson, 391 F.3d at 589–593, 597; Rosenbaum et al., supra note 74, at 13.
85 See Rosenbaum et al., supra note 81, at 17. EPSDT standards result in a form of “third party financing,” which is not matched by any private insurer, especially when considered alongside “[m]edicaid’s general prohibition against discrimination in the provision of mandatory treatments and services based on an individual’s diagnosis or condition.” Rosenbaum et al., supra note 74, at 14.
86 See Rosenbaum et al., supra note 74, at 11–13; see also § 1396(d) (r). Children under eighteen cannot be charged co-payments for covered benefits and services. Rosenbaum et al., supra note 74, at 13. As a result of a provision added in 1988, Medicaid’s financial eligibility options for children allows states to extend Medicaid through the use of more lenient income and asset “disregards” used to calculate financial eligibility for Medicaid. Id. at 10. Medicaid is also retroactive in nature, eligibility can begin up to three months prior to the date of application if the individual would have previously satisfied program eligibility. Id.
87 See 42 U.S.C. § 1396(d) (r) (2000). EPSDT include screening services—such as physical exams, immunizations, vision and dental check-ups—either at regular intervals or at those which are medically necessary “to determine the existence of certain physical or mental illnesses or conditions.” See id. EPSDT must also provide “[s]uch other necessary health care, diagnostic services, treatment, and other measures 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.” See § 1396(d) (r) (5).
gram sets a treatment baseline that mandates that any medically necessary health care service be provided to treat a child’s mental or physical illness when first diagnosed. The mandated services include scheduled “as needed” health exams, age-appropriate immunizations, and screening for vision, dental, and hearing care.

In 1989, amendments to EPSDT expanded the diagnosis and treatment authorization mandate to include all forms of medical assistance for children, including preventative and prospective care. This means that as soon as a clinical need for medical treatment is identified, treatment for the long-term effects of the illness can be covered under the program. In this way, this standard gives great deference to the opinions of treating physicians. Due to its inclusive and progressive nature, the EPSDT program has been politically unpopular and states have asked for its mandate to be narrowed in scope. Yet it is clear that the comprehensive nature of the program has been successful in improving the health care of children living in poverty. The objective of EPSDT—to provide preventative treatment—suggests that EPSDT benefits could be appropriately extended to fund legal services that address the health-related legal problems facing poor children and their families.

B. SCHIP

In contrast to Medicaid, SCHIP is a relatively new program authorized by Congress for a ten-year term as part of the Balanced

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88 See Rosenbaum et al., supra note 74, at 14. The Centers for Medicare and Medicaid Services (CMS) overview of the program highlights the standard of preventative care and the program’s goal of diagnosing and treating health problems early on, before they become more complex and treatment more costly. See Ctrs. for Medicare & Medicaid Servs., EPSDT Overview, http://www.cms.hhs.gov/MedicaidEarlyPeriodicSrn/ (last visited Mar. 25, 2008). According to CMS, “[t]he EPSDT program consist[sic] of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources.” Id. The two components enable state agencies to manage a comprehensive program of prevention and treatment, determine those children that might be eligible for the program, and to inform their families of the health services and assistance available and how they can use these most efficiently. Id.

89 See § 1396(d)(r).

90 Rosenbaum et al., supra note 74, at 13–14.

91 See id. at 14.

92 See id. at 13–14.

93 See id. at 15.

94 See HEALTH COVERAGE OF CHILDREN, supra note 68, at 1–2.

Budget Act of 1997. SCHIP is a federally-funded block grant program that allows states flexibility in determining how they want to extend coverage to families with income levels above those eligible for Medicaid. For example, in 2007, fifty percent of states covered families with incomes at or below two hundred percent of the federal poverty level. All SCHIP funding is capped so that states can only receive matching federal grants up to their annual allotment.

The decision to enact SCHIP was a result of a confluence of factors: a healthy economy, a revenue surplus, and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. However, SCHIP represents a policy compromise in that it is not an expansion of the Medicaid program, but rather allows states to choose SCHIP as an alternative to Medicaid. Under this statutory structure, states can either provide coverage to uninsured children through existing Medicaid programs, through a state’s own SCHIP program, or by some combination of the two. SCHIP subsidizes the enrollment of participants into

96 See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251 (1997); Robert F. Rich et al., The State Children’s Health Insurance: An Administrative Experiment in Federalism, U. ILL. L. R. 107, 107 (2004). The purpose of the Act is to “provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.” 42 U.S.C. § 1397aa(a).


98 CHIPRA, supra note 73, at 1. The report found that nine states cover children at less than 200% of the federal poverty level (FPL), twenty-three states at 200% FPL, eight states at 201–250% FPL, and eleven states, and the District of Columbia, at 250% FPL. Id. The federal poverty guidelines are updated each year by the U.S. Department of Health and Human Services and are used to set eligibility criteria for a number of administrative programs. U.S. Dep’t of Health & Human Servs., Frequently Asked Questions Related to the Poverty Guidelines and Poverty, http://aspe.hhs.gov/poverty/faq.shtml#differences (last visited Apr. 2, 2008). The federal poverty guidelines “are a series of income levels, with different values for family units of different sizes, below which the family units are considered poor for statistical or administrative purposes.” Gordon M. Fisher, Poverty Guidelines for 1992, 55 Soc. Security Bull. 43, 43 (1992).

99 CHIPRA, supra note 73, at 2.


101 See Rosenbaum et al., supra note 74, at 17.

102 See Grogan & Patashnik, supra note 100, at 848. As of 2002, nineteen states had combination programs, sixteen used their SCHIP funds for separate programs, and sixteen used their federal matching funds to expand their currently existing Medicaid programs. CINDY MANN ET AL., KAISER FAMILY FOUND., REACHING UNINSURED CHILDREN THROUGH MEDICAID: IF YOU BUILD IT RIGHT, THEY WILL COME 4 (2002). States generally chose to create their own programs for two reasons: it allows them to cut costs by offering reduced benefits and, in the wake of welfare reform, it was thought that that working families would refuse to
approved state health plans. There are no statutory standards for determining the acceptability of available plans and the program’s definition of medical assistance only discusses what services and benefits the states may finance, not those that are required. States have enormous discretion in the kinds of basic and additional services that they choose to cover; there are no federal standards of reasonableness, medical necessity, or non-discrimination.

Medicaid and EPSDT reflect a congressional intent to provide a prospective entitlement to children. SCHIP, on the other hand, can be seen as a more conservative program that affords the states considerably more flexibility in determining their scope of coverage. Because of this heightened discretion, standards are not uniform across states and generally do not reflect the preventative mentality that underpins the EPSDT guidelines. Although there are shortcomings, SCHIP is credited with the huge decrease over the last decade in the rate of low-income uninsured children by providing free or affordable coverage options for children whose families earned too much to be eligible under Medicaid but could not afford the high costs associated with private insurance plans.

Despite the benefits of health care programs for children, and the well-established effects of poverty on children’s health, a debate over the funding of programs like SCHIP remains. In the fall of 2007, a debate between President George W. Bush and Congress over the reauthorization and expansion of SCHIP highlighted a larger ideological battle over health care. In October 2007, the President vetoed the

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103 See Rosenbaum et al., supra note 74, at 18.
104 Id.
105 Id. at 20.
106 See id. at 13–14.
109 See Health Coverage of Children, supra note 68, at 2. The combination of SCHIP and Medicaid are credited with expanding the rate of uninsured children by one-third since 1997. Id.
110 See Parker et al., supra note 17, at 1235–36.
111 See Editorial, Misleading Spin on Children’s Health, N.Y. Times, Oct. 5, 2007, at A24 (highlighting that President Bush repeatedly made misleading statements about the program prior to the House and Senate votes on the bipartisan Children’s Health Insurance Program Reauthorization Act of 2007, despite the fact that since it is not an entitlement
bipartisan Children’s Health Insurance Program Reauthorization Act of 2007 (CHIPRA) that proposed providing an additional $35 billion to fund SCHIP over five years.\textsuperscript{112} The bill would have provided coverage to the more than 6.6 million children already enrolled in SCHIP, plus expanded coverage to an additional 4 million children.\textsuperscript{113} President Bush likened the expansion of the program to a move by Congress towards universal health care, and stated that he favored moving children with no health insurance onto private insurance plans.\textsuperscript{114} The Bush Administration’s plan would increase SCHIP expenditures by less than twenty percent, relying instead on changes in the federal tax code to provide for additional families.\textsuperscript{115} This lack of adequate funding indicates a re-

\begin{itemize}
\item CHIPRA, supra note 73, at 4. CHIPRA’s benefits would have been funded by a sixty percent increase in the tobacco excise tax. See H.R. 976, 110th Cong. (2007); SCHIP Bill Seen Better than Bush Plan for Reducing Number of Uninsured Children, BNA HEALTH CARE DAILY REP., Oct. 15, 2007.
\item Office of Mgmt. & Budget, EXECUTIVE OFFICE OF THE PRESIDENT, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2008, at 68 (2007). The President’s proposal would increase funding for the program by a modest $5 billion over five years. See id. Each family would be able to deduct the first $15,000 from their income towards their health care spending ($7500 for an individual). See LINDA J. BLUMBERG, URBAN INST., CAN THE PRESIDENT’S HEALTH CARE TAX PROPOSAL SERVE AS AN EFFECTIVE SUBSTITUTE FOR SCHIP EXPANSION? 1 (2007), available at http://www.urban.org/UploadedPDF/411557_schip_expansion.pdf. According to a recent study by the Urban Institute, however, the financial burden of obtaining health insurance for families between 150% and 300% of the federal poverty level would be much higher under the President’s proposal and the potential to decrease the number of uninsured children in the country would be reduced. Id. A problem with President Bush’s proposal is that because it was not specifically designed to subsidize the purchase of insurance for children, but was part of a broader plan to subsidize the purchase of health insurance, it requires that adults also purchase insurance, thereby decreasing the likelihood of enrollment for poorer families. See id. The study found that while a two-parent family with two children earning $32,000 a year could obtain child health care through SCHIP at no cost, under the President’s plan, despite receiving
jection of the policy goal, inherent in Medicaid and SCHIP, of providing comprehensive, preventative care for children in order to ensure their long-term well-being.\textsuperscript{116}

III. **Writing Better Standards for Preventative Care**

**A. Medicaid**

In a country that has largely turned to the private sector to provide health care services, the persistence of an entitlement program as large as Medicaid, with its progressive EPSDT benefits, seems counterintuitive.\textsuperscript{117} Although there is concern that Medicaid faces an uphill battle at the state and federal levels due to tax cuts and balanced budget requirements, cutting an entitlement program like Medicaid is politically difficult, especially given the vocal support that the EPSDT program has received from child health advocates over the years.\textsuperscript{118} Reimbursement for procedures made possible by EPSDT provides hospitals and clinics with the revenue necessary to provide basic pediatric services to patients.\textsuperscript{119} Continued funding of Medicaid at its current level or higher is

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\textsuperscript{116} See Parker et al., supra note 17, at 1235–36.

\textsuperscript{117} See Timothy S. Jost, *Disentitlement?: The Threats Facing Our Public Health Care System* 65 (2003). One reason why Medicare and Social Security Disability Insurance have maintained their legitimacy is the perception that it is a quid pro quo arrangement in which individuals contribute to the social insurance trust funds that they are eventually paid out of. Id. at 64–65. Although Medicaid is a means-tested program and lacks this quid pro quo element, courts have recognized a property right in this social entitlement which has helped to entrench this means-tested program. See id. at 64–66. Means-tested entitlement programs that lack the contractual relationship of a program like Medicare, however, are much more politically tenuous. See id. at 65–66.


\textsuperscript{119} See John K. Inglehart, *The Dilemma of Medicaid*, 348 New Eng. J. Med. 2140, 2141 (2003); Newman, supra note 30, at 109. Many doctors have refused to see Medicaid pa-
also essential to a program like MLPC because it provides financial support for the fundamental resources, including staffing and office space, which make the services offered by MLPC possible.\textsuperscript{120} Additionally, MLPC is an important program that helps fill in the gaps between treating immediate health concerns and ensuring long-term improvement for complications that are often the result of systemic poverty.\textsuperscript{121}

Since the EPSDT guidelines were first enacted in 1967, they have been amended, administered, and judicially interpreted in a progressive manner that extends additional protections to children.\textsuperscript{122} This notion of applying a comprehensive and prospective approach to treating children in poverty correlates with the theory underpinning the MLPC approach and is representative of the progressive proposals for policy reform that are described throughout \textit{Ending Poverty in America}.\textsuperscript{123} The most direct way to promote the MLPC model would be to revise the EPSDT guidelines to establish that social services, such as the legal services provided by the MLPC model, are within the statute’s notion of preventative care.\textsuperscript{124} EPSDT guidelines could be expanded to define “other necessary health care, diagnostic services, and treatment” that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services” as including legal intervention that can help improve the overall physical

tients due to what they deem to be economically unfeasible reimbursement rates. See Pasquele, \textit{supra} note 118, at 46. It is estimated that twenty-five percent of American doctors do not treat patients on Medicaid and that two-thirds of those who do, limit the number of Medicaid insured patients they will treat due to inadequate reimbursement rates. See Sidney D. Watson, \textit{Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest}, 21 Am. J. of L. & Med. 191, 193 (2005); see also Ceci Connolly, \textit{Proportion of Doctors Giving Charity Care Declines}, Wash. Post, Mar. 23, 2006, at A9 (discussing how busy schedules, reduced reimbursement rates, and medical-school debt have caused many physicians to reduce the charity care they provide to needy patients).

\textsuperscript{120} See Inglehart, \textit{supra} note 119, at 2141; \textit{New England Regional Medical-Legal Network}, \textit{supra} note 65, at 6–11.

\textsuperscript{121} See Lawton, \textit{supra} note 29, at 13.

\textsuperscript{122} See Rosenbaum et al., \textit{supra} note 74, at 13–14.

\textsuperscript{123} See Parker et al., \textit{supra} note 17, at 1235–36. \textit{See generally} \textit{Ending Poverty in America}, \textit{supra} note 3 (advocating for policy reform that provides opportunities and expanded protections to at-risk individuals).

\textsuperscript{124} See 42 U.S.C. § 1396(d)(r) (2000); Eleanor D. Kinney, \textit{Rule and Policymaking for the Medicaid Program: A Challenge to Federalism}, 51 Ohio St. L. J. 855, 875–881 (1990). Kinney’s article discusses at length the congressionally mandated changes that were made to the Medicaid program during the 1980s. \textit{See id.} Although Kinney argues that use of limited statutory amendments has led to a complex program that is difficult to administer, this does not negate the fact that guidelines are frequently revised and that with proper guidance from the Centers for Medicare and Medicaid Services, the agency that administers Medicaid, changes to EPSDT are a feasible option. \textit{See id.} at 865–66.
and mental well-being of the child. Under this model, the diagnosis of, and action to correct, potential legal problems that either directly or indirectly affect a child’s health would be reimbursable.

Linking the need for social services to the mandate for preventative medical care reflects the understanding that legal and medical issues are rarely mutually exclusive for children living in poverty. MLPC has proven that legal services are in many ways medically necessary to achieve prevention and treatment. Take, for example, how the non-biological factors of the six-year-old boy’s asthma had to be addressed and corrected by a lawyer before he could be healthy enough to return to school. For children, legal problems and poor health that intersect in the context of poverty can be most effectively solved in tandem through gateway programs like MLPC.

Another solution, one currently being explored by MLPC, is making medical-legal collaborative services reimbursable through the case management provisions of the Medicaid statute. The statute defines case management services as those “which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services,” and includes identifying needs, referral services, and follow-up care. As case management is currently defined,
the services offered by the MLPC model could be construed as fitting within the specifications of the statute.\textsuperscript{133} Congress must choose to further define what it means by case management and include language that highlights legal services as those for which a state may seek reimbursement.\textsuperscript{134}

\section*{B. SCHIP}

If revising the EPSDT and case management standards proves too politically difficult, the federal government must instead change the SCHIP grant structure to create incentives to incorporate the MLPC model.\textsuperscript{135} The Bush Administration’s opposition to an expansion of SCHIP in the fall of 2007 indicates that providing any additional coverage will be challenging.\textsuperscript{136} Nevertheless, Congress should set aside a portion of the block grant given to states specifically for MLPC services to be used only for preventative screening and treatment.\textsuperscript{137} This will ensure that a certain amount of the grant is designated for financing legal and other social services that serve the purpose of improving children’s overall well-being.\textsuperscript{138} Congress should also define “child health assis-
tance” in the SCHIP grant as including the services provided by MLPC, thereby alerting states to this option and encouraging spending for holistic programs like MLPC that offer comprehensive treatment for the whole child.\textsuperscript{139} The mere presence of the option to receive additional funding will make preventative programs like MLPC an economically attractive option for states and will force states to at least consider these programs.\textsuperscript{140} States should be encouraged to implement MLPC programs, especially if future research proves that the model is a cost-effective means of both improving children’s overall health and increasing enrollment in public benefits, including Medicaid.\textsuperscript{141}

Rewriting legislation so that additional services are reimbursable and grant money is set aside will undoubtedly increase government spending at a time when the economy is in serious trouble and President Bush has outlined major cuts to social services in his budget.\textsuperscript{142} However, as concerns over the economy and the deficit heighten, it is essential to recognize that any economic downturn will likely result in an increase in the number of families without private health insurance.\textsuperscript{143} Even more children will become eligible for Medicaid and SCHIP and will need to rely heavily on the kinds of services provided by MLPC.\textsuperscript{144}

**Conclusion**

Gateway programs like MLPC recognize that poverty in the United States results from a confluence of factors and that a solution must be comprehensive. The potential for the MLPC approach to combat the

\textsuperscript{139} See 42 U.S.C. § 1397jj(a) (2000). The statute already defines children’s health insurance to include case management services and any other preventative service that is recognized by state law and furnished by a physician. See § 1397jj(a) (20), (24).

\textsuperscript{140} See 42 U.S.C.A. § 1396n(g)(2)(A)(ii) (Supp. 2007); Zuckerman et al., supra note 30, at 224–25, 226.

\textsuperscript{141} See Lawton, supra note 21, at 41; Press Release, LegalHealth, Legal Care Good for Patients, Good for Hospitals’ Bottom Line (Feb. 26, 2007), available at http://legalhealth.org/docs/pr_goodhosp.pdf (finding that over a two–year study period, the services of a program similar to MLPC resulted in $345,222 in collections and $1.3 million in billings for two hospitals); cf. Eckholm, supra note 64 (discussing how preventative care can reduce costs for hospitals).


\textsuperscript{143} See Lame Duck Budget, supra note 142 (criticizing President Bush’s budget cuts as “exactly the wrong direction to go in tough economic times, when low-income workers who lose their jobs need Medicaid coverage and states have fewer funds to supply it”).

\textsuperscript{144} See Lawton, supra note 21, at 37–38; Lame Duck Budget, supra note 142.
cyclical nature of poverty should not be underestimated. Although it is a young program, MLPC is gaining broad support in the legal and medical communities as a way to treat medical issues and improve public health by simultaneously remedying corresponding legal concerns. The federal government must support the program in an effort to provide tangible benefits for the poorest of our nation’s children and address the structural nature of poverty in the United States. Congress should do this either by revising the Medicaid statute to make MLPC services reimbursable or through the use of a block grant. Both alternatives match congressional intent, track the history of the programs, and are a concrete step towards promoting preventative health care services.

If these measures prove successful, Congress should experiment with ways of creating incentives for hospitals to extend the MLPC model into other departments, such as emergency rooms, in order to realize the full potential of this interdisciplinary model. Medicaid and SCHIP were intended to do more than merely provide limited health care treatment options, and by changing these programs to better encourage MLPC services, comprehensive preventative health care can be used as a tool to help break the cycle of poverty. As the authors in *Ending Poverty in America* argue, any solution to the intertwined health care and poverty crises in America today must be prospective, preventative, and holistic.