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Contents

Rules and Regulations of Health Care Transformation

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ABSTRACT

Governments and regulators influence the performance of health care organizations and practitioners primarily through positive and negative financial incentives, regulatory constraints on their licenses to practice, and support of performance-improvement activities through education, research, and measurement programs. The financial approaches aim to motivate change in the way organizations and practitioners configure their systems and deliver care, under the assumption that once they're motivated to seek surplus or avoid sanction, they'll be willing and able to make local operational changes to reduce cost and improve safety, patient experience, and outcomes. Unfortunately, experience shows that although a changed market may be a helpful precondition to local performance improvement, it hardly guarantees effective operational change. Some organizations have successfully transformed themselves, however, substantially improving efficiency and quality. How have they done so? One popular approach is top-management–led structural and governance change — moving boxes on organizational charts of an individual entity or regional system.

Keywords: Care Coordination, Health Care System

INTRODUCTION

Services are merged or broken up, new roles defined, and new responsibilities assigned. This approach appeals to boards, CEOs, and consultants because big changes can be made rapidly. But such rearrangements may disappoint.1 Examination of organizations that have achieved and sustained substantial performance improvements reveals that lasting transformation requires the relentless hard work of local operational redesign. Organizations' delivery of care is ultimately governed by structures and processes at the ward, clinic, or practice level. These elements have usually accreted over time, often in response to regulations or technology and without subsequent performance review or deliberate updating. In contrast, successful “transformers,” from Seattle's Virginia Mason Medical Center to the Salford Royal National Health Service Foundation Trust in England, constantly make small-scale changes to their structures and processes over long periods.2 Everything from communicating with patients to cleaning gastro scopes to ordering tests and choosing therapies has been subject to redesign. Major change emerges from aggregation of marginal gains.

Health Care Transformation: the Affordable Care Act

Health care costs have been rising, quality of care issues must be addressed, and equity of healthcare access needs to be improved. For these reasons, though there is disagreement about some aspects of reform, most Americans agree that healthcare delivery systems in the United States require significant restructuring and improvement. ANA has long been a strong advocate of health care reform, and many of the provisions of the Affordable Care Act (ACA) align with ANA's Health System Reform Agenda.

This chart offers information about recent and proposed health system changes with implications for nurses and nursing. Currently, most of the changes presented here reflect provisions of the Patient Protection and Affordable Care Act (Public Law 111-148) (ACA). ANA invites you to continue to follow updates to this chart that reflect nursing's progress in influencing regulations and other activity to implement health reform and specific provisions of the ACA in the wake of the Supreme Court decision upholding most of the law. This chart also spotlights opportunities for RNs and APRNs to take advantage of new programs and pilot for healthcare innovations, and funding and grants for education and nursing workforce development.

On June 28, 2012, the U.S. Supreme Court upheld almost all provisions of the ACA, including the "shared responsibility" to purchase health insurance (so- called "individual mandate"). By upholding this cornerstone of the law, a multitude of other provisions survived challenge, including scores of important advances for the nursing profession and individual nurses, detailed in this chart. The Court struck down a single part of the ACA that would have required states by 2014 to expand Medicaid eligibility to everyone earning below 133% of the federal poverty level, or lose all federal Medicaid matching funds.

The law offers states a 100% subsidy to cover this additional population, decreasing slowly to a 90% subsidy by FY2020. Based on the Court's decision, states instead have an opportunity to opt-out of the Medicaid expansion and this extra funding without endangering their current funding levels.

As the largest single group of clinical health care professionals within the health system, registered nurses are educated and practice within a holistic framework that views the individual, family and community as an interconnected system that can keep us well and help us heal. Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current "sick care" system into a true "health care" system. The ANA is actively engaging with federal policymakers and regulators to advocate for system transformation that includes the valuable contributions of nursing and nurses.

Health care payers, including the Centers for Medicare and Medicaid Services (CMS), are shifting away from fee-for-service payments that reward volume toward paying for value, including improved population health outcomes. HHS Secretary Burwell recently announced that by 2018, 50 percent of Medicare payments will be tied to value through alternative payment and care delivery models, such as Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). As payment models shift, health care providers—including hospitals, clinics, physicians' offices, and long-term care settings—are redesigning how they deliver care and how they redeploy the workforce in new roles and settings. Health systems and payers are increasingly focused on "upstream" preventive and primary care and the health workforce is shifting from acute to outpatient settings.

In redesigned health care systems, nurses are assuming expanded roles for a broad range of patients in ambulatory settings and community-based care. New job titles and roles are emerging, particularly in population health management, patient coaching, informatics design and analysis, geriatric care, and managing patient care transitions. Nurses are increasingly employed as "boundary spanners," connecting patients with services in health and community settings. As the Institute on Medicine noted, nurses are increasingly called upon to collaborate as members of inter professional teams. These emerging and expanding roles for RNs will require the application of nursing skills in new ways, as well as the development of new skills. However, current educational programs vary considerably in their ability to prepare nurses for the evolving health care system, a system that will emphasize accountability for the health of populations and place nurses in roles that address the increasingly complex needs of patients with multiple chronic conditions. In this new system, nurses will need to consistently apply skills associated with a continuous learning health system, including care coordination and transitional care; optimize care through use of data and evidence, often gleaned from electronic medical records; collaborate inter professionally, and actively engage in performance improvement. Below we summarize key dimensions of each of these opportunities and their relevance to the preparation of the emerging nursing workforce.

Population Health

Public health nurses have long played a role in developing, implementing, and monitoring programs to advance the health of populations through health promotion and disease prevention. Today, there is growing recognition that many individual health problems have antecedents in the community, and can

be prevented through improved population health programs. In serving their patients and communities, nurses and other health care providers must understand and navigate the social, political, and economic factors that influence individual and population health. For nurses to be effective in care management and coordination roles, as well as in primary care in general, they will need to address how the community affects each patient, and how interventions at a broader level—either for a patient panel or community—can improve individual outcomes. This perspective demands greater knowledge of epidemiology, sociology, and social determinants of health.

More recently, the term "population health" has emerged within the U.S. health care system to refer to accountability for the longitudinal care and outcomes of an identified group of patients whose health care needs are typically addressed across multiple sectors (e.g., primary care, hospitals, post-acute settings, home, and hospice).Newer models of health care delivery, such as ACOs or PCMHs, have incentive structures that tie "value" to health indicators in these patient groups, identified by their clinical conditions and/or non-clinical characteristics such as socioeconomic status.

Complex Older Adults and Their Family Caregivers

The rapidly-growing population of older Americans will demand more health care services in general, as well as more long-term care. A growing share of long-term care is being provided in home- and community-based settings, through home health, adult day care, and other support services. Through the Medicaid program, CMS has provided incentives to states to encourage greater use of community services. Consequently, a number of innovative state-led reforms in the provision of long-term services and supports are being tested. In addition to providing valuable clinical care to older adults, the nursing workforce will be central to meeting this growing need in the following ways:

- By assessing the long-term needs of individuals with physical and cognitive impairments, developing customized care plans, coordinating care across providers and settings, and overseeing the adequacy of services. Established and emerging programs for older adult and long-term care populations are leveraging nurses to improve care transitions, preventing physical and cognitive decline while ensuring that older adults can live in the community.
- By engaging family caregivers, broadly defined to include relatives, neighbors, and friends in the implementation of older adults' plans of care. Addressing the unique needs of this "invisible workforce" will be a major challenge in the transformed health care system.

Care Coordination and Transitional Care

Care coordination involves working with patients to help organize the services they receive, ensure that their preferences and needs are met, share information across health care providers, and facilitate the appropriate delivery of health care services. New financial incentives have emerged; for example, as of January 2015, Medicare is paying $42.60 per month for care management of patients with two or more chronic conditions, like heart disease and diabetes.

Many types of interventions fall under the umbrella of care coordination, including care transitions, guided care, and collaborative care models. Numerous programs have demonstrated the value of care coordination, as well as the capacity of nurses to design, implement, and participate in care coordination projects and practices. While transitional care has traditionally focused on providing continuity between health care settings and providers, care coordination is more broadly defined to encompass both health care and social services, including the physical, behavioral, social, and economic dimensions of care. The use of evidence-based models to guide system transformation is growing. A recently completed national scan funded by the Robert Wood Johnson Foundation revealed that 59 percent of clinicians or clinical leaders from nearly 600 distinct health care sites (e.g., hospitals, home care agencies) reported use of the Transitional Care Model, a proven nurse-led team based approach, as a foundation for system change.

The American Academy of Ambulatory Care Nursing recently developed RN competencies for care coordination and transition management, and an online course to impart these competencies, including:

- Support for self-management
- Education and engagement of patients and families
- Cross-setting communications and care transitions
- Coaching and counseling of patients and families
- Nursing process: proxy for monitoring and evaluation
- Teamwork and collaboration
- Patient-centered care planning
- Population health management
- Advocacy

The roles and optimal mix of clinical and non-clinical professionals in coordinating care is not clear. A recent survey of 48 PCMHs in New York found that RNs and other employees (including clinicians such as social workers and support staff such as medical assistants and peers) were responsible for care

coordination in roles such as care managers, care coordinators and patient navigators. Their functions varied considerably. Some also were employed as health coaches, helping patients understand and manage their conditions, including patient education activities, motivational interviewing techniques, providing referrals to community-based services, and visiting patients in their homes. Nearly three-quarters of responding organizations used peer staff rather than licensed health professionals in some of these roles. The use of lay community health workers to improve population health is increasing, but a 2013 systematic review by the Agency of Healthcare Research and Quality revealed limited evidence of improved patient knowledge, behavior change, health outcomes, and cost effectiveness.

Some programs use nurses to improve organizations' capacity to coordinate care. For example, Minnesota's Health Care Homes program established the job category of Nurse Planners, who are responsible for supporting integrated care across multiple Health Care Homes. Their specific responsibilities include developing resources such as care coordination and patient and family engagement toolkits, and offering technical assistance to help Health Care Homes improve their capacity to function in an integrated way. Nurse Planners also lead the certification and re-certification of clinics as Health Care Homes, and recruit primary care clinics to join the program. The developers of the Health Care Homes program initially anticipated that nonclinical professionals could manage this work, but quickly determined that the clinical background of nurses was ideally suited to this organizational coordination role.

Use of Data, Evidence, and Other Performance Improvement Skills

Increasingly, nurses are using data from electronic health records (EHRs) and patient registries to identify unmet health needs and to target population health interventions. Health information technology allows health care providers to access patient and community information rapidly, as well as supports efficient communication between providers. When designed well, these systems improve care coordination, increase quality of care, and lower costs. Telehealth systems allow health care providers to remotely monitor and communicate with patients, allowing for timely identification of emerging issues and consultations that are convenient to patients. Effective use of health information and telehealth systems are considered essential for successful care coordination.

Nurses will increasingly use health information technologies to advance evidence-based practice. Data embedded in EHRs can be used to rapidly assess the effectiveness of interventions for specific patients, as well as to assess broader relationships between care processes and patient outcomes. Nurses can leverage these systems both to better meet immediate care needs and to guide organization policies toward care improvement.

Interprofessional Collaboration

A hallmark of the transformed health system is a new level of collaboration across the health professions, including physicians, nurses, social workers, physician assistants, pharmacists, and medical assistants. Nurses' clinical knowledge and presence across all care settings will likely make them primarily responsible for navigating interactions between patients and providers along the continuum of care. They can play a key role in developing systems to ensure that primary care patients receive appropriate specialist consultations, physical therapy, nutrition counseling and education, medication reconciliation with pharmacists, and assistance with socioeconomic issues that affect patients' abilities to care for themselves. The Inter professional Education Collaborative has developed the following core competencies for inter professional collaborative practice:

- Values/Ethics for Inter professional Practice (work with individuals of other professions to maintain a climate of mutual respect and shared values)
- Roles/Responsibilities (use the knowledge of one's own role and those of other professions to appropriately assess and address health care needs)
- Inter professional Communication (communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach)
- Teams and Teamwork (apply relationship-building values and the principles of team dynamics to perform effectively in different team roles)

Despite recent advances in the identification of these competencies, few health professionals participate in inter professional educational activities. It is essential that nurses and other health professionals avoid the “turf wars” that inhibit effective collaboration, and leverage the skills of all health professionals at the highest level. In many states, licensure and scope of practice acts reflect the intense competition that exists among providers, rather than being structured to enable all health professionals to maximize their contributions to a transformed health system.

Redesigning Education, Regulation, and Policy to Support New Roles

In their systematic review of transitional care programs that help patients with complex chronic conditions, Naylor et al. (2011) noted that health care licensure, certification, and accreditation requirements need to better reflect emerging roles and accountabilities. Ricketts and Fraher (2013) have called for better connections between education and practice so that the transformative changes

underway in front-line care delivery systems are incorporated into the curriculum and clinical placement requirements for nurses, physicians and other health professionals. Dower et al. (2013) have noted the importance of restructuring the regulatory system to accommodate the more flexible deployment of the workforce that will be needed to staff new models of care.

As new roles diffuse through the health care system, nurse educators and employed nurses need to focus on building the skills to meet patient needs in a rapidly changing and increasing value-focused care environment. To accomplish this, nurses will need to identify and advocate for the education and regulatory changes to support the nursing workforce as they shift employment settings and take on new roles.

Regulation and Policy

Regulatory and policy changes are needed to support nurses practicing in new roles to the full extent of their education. The IOM strongly recommended that regulatory barriers be removed if they prevent RNs and other nurses from utilizing their skills to the maximum benefit of patients. A growing body of research supports this IOM recommendation, concluding that restrictive state regulations regarding scope of practice hinder access to care, lower the supply of providers, and increase costs. Employers and health care providers often have internal rules that are more restrictive than state laws. Hospitals, clinics, and medical groups need to ensure they are using RNs at the top of their ability and at the top of the legal authority. Goldberg et al. (2013) have described a “top of the license model” in which physicians and nurses jointly care for a panel of patients with nurses taking on many of the tasks formerly done by physicians, including collecting and entering information into EHRs about a patient's history of the present illness, reviewing past problems and treatments, discussing medication lists, assessing a patient's social history, and updating preventive care needs. Adoption of this care model depends on scope of practice laws that allow such task shifting to occur. An updated, interactive view of state scope of practice laws can be found here.

Insurance reimbursement rules also can hinder nurses from delivering optimal services. Each state determines its own Medicaid payment rate for advanced practice nurses, and private insurance companies establish their own rules. In the Medicare program, NPs must seek physician approval for home health services for their patients. Although federal regulations prohibit NPs from ordering home health services for Medicare recipients, a number of states have authorized this activity through statute or regulation to improve access for patients who are covered by other payers, including Medicaid. The ACA added an additional requirement that physicians certify beneficiaries' eligibility for these services and for durable medical equipment. These inefficiencies can reduce the amount of time NPs spend with

their patients and result in care delays, especially in remote settings. The movement of health care reimbursement away from fee-for-service payment and toward paying for improved outcomes will likely support efforts to maximize nursing contributions to care. In addition, new provisions for Medicare coverage of wellness and behavioral tele health visits and care coordination for patients with multiple chronic conditions will bring more attention to the role of nurses in these areas.

State nurse licensing boards regulate the content of nursing education, and may need to modify rules governing entry-level nursing programs to ensure that graduates have the new skills and competencies needed. They also should consider adjusting requirements regarding clinical experiences of pre-licensure students, to include more ambulatory experiences. This will likely require new regulations regarding faculty-to student ratios in ambulatory settings and the qualifications of preceptors. Non-nurses might prove to be able preceptors for some curricular components, such as population health management and informatics.

The National Council of State Boards of Nursing provides a national licensing exam for RNs, called the NCLEX. The NCLEX is revised periodically to ensure that the content is current and relevant. Pre-licensure education programs design their curricula to ensure that their graduates can pass this exam. Thus, important changes in education are not likely to occur unless the NCLEX changes. It is essential that the NCLEX reflects new roles, including the shift of nurses from acute to ambulatory settings and the expanding role of nurses in care management and coordination, informatics, long-term care, and population health.

Finally, federal and state funding agencies have a key role in tracking changes to the health care system, identifying the new skills needed to optimize care, and supporting innovative education programs to meet future care needs. The U.S. Bureau of Health Workforce operates several grant programs related to nursing education. The Nurse Education, Practice, Quality, and Retention program provides grant support for academic, service and continuing education projects. The most recent set of grants focused on expanded enrollment in baccalaureate nursing programs, as well as internship and residency programs; education in new technologies; nursing practice in non-institutional settings; care for underserved populations and other high-risk groups; managed care, quality improvement, and other skills; and retention, including career ladder programs. In addition, the ACA authorized $200 million over four years for the Graduate Nursing Education Demonstration to increase the number of advanced practice RNs prepared to provide primary care to Medicare beneficiaries. Five teaching hospitals have received funds to partner with nursing schools and community-based clinics to offer education in care transitions and chronic disease management, along with other areas.

Conclusion

The United States health care system is undergoing transformative change. Nurses are the single largest licensed health professional group and they practice in nearly every setting of the health care system, including hospitals, long-term care, home health, ambulatory care, diagnostic and treatment facilities, and clinics. In these settings, nurses will assume important new roles to improve care, advance health, and increase value.

New roles will require that nurses be adept at recognizing the impact of community characteristics on patients and populations; understand the complex needs of older patients; design and implement care coordination programs; leverage data and technology to enhance patient care; and collaborate effectively with diverse teams of health professionals. Nursing education needs to incorporate the competencies required for nurses to be successful in new roles, through entry-level and continuing education programs. Educators need to pay particular attention to designing programs that enable nurses to seamlessly gain new skills and competencies; preparing faculty and preceptors to teach in ambulatory and community settings; and leveraging emerging educational modes such as flipped classrooms and online education. Policymakers need to modernize regulations to allow nurses to practice at the highest level of their knowledge. Now is the time to mobilize educators, nurse leaders, policymakers, and employers to advance nursing's capacity in a transformed health care system.

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Law of Hospitalists Decline of Comprehensive Care

Puneet Meena

A B S T R A C T

The hospitalist model has provided such putative benefits as reductions in length of stay, cost of hospitalization, and readmission rates — but these metrics are all defined by the boundaries of the hospital. What we don't yet know sufficiently well is the impact of the rise of hospital medicine on overall health status, total costs, and the well-being of patients and physicians. The increasing number of hospitalists cannot, in and of itself, be taken as conclusive evidence of benefit. Such increases can be driven by a variety of perverse incentives, such as low payment rates for primary care that place a premium on maximizing the number of patients a physician sees in a day and therefore militate against taking the extra time required to see inpatients.

Keywords: Affordable Care Act, Primary Care

Introduction

The hospitalist model also carries risks and costs for physicians. As community physicians, for their part, participate less frequently in the care of hospitalized patients, their knowledge and skills in hospital care may decline, and they may play a shrinking role in hospital-based education, as both teachers and learners. Over time, it's likely to become increasingly difficult for community physicians to really mean it when they promise patients to always be there for them — a limitation that may, in turn, erode the physician's professional fulfillment.

Meanwhile, hospitalists face a parallel narrowing of their comfort range. As members of a young field, many hospitalists have relatively little experience with outpatient medicine, a deficit that's exacerbated by hospital-only practice. Physicians who never see outpatients are at a disadvantage in understanding patients' lives outside the hospital. Over time, hospitalists may become progressively less accountable to nonhospitalized patients and their communities, ultimately becoming less effective advocates for comprehensive medical care.

More broadly, the profession of medicine stands to suffer. As patient care becomes increasingly fragmented, many physicians find it more and more difficult to provide truly integrated care. Physicians whose practices rest on a clear separation between inpatient and outpatient care or manifest a shift-work mentality are more likely to respond to requests from patients and colleagues with, “Sorry, but that's not in my job description.” Such practice models may make physicians' lives easier, but they may also reduce professional fulfillment and promote burnout.

At the same time, the physician's lounge, once an important site of knowledge sharing and professional collegiality, may become depopulated. Exclusively inpatient and outpatient physicians see each other less frequently, and medical students and residents have fewer role models who provide comprehensive care. In effect, the mounting walls of the hospital constitute an increasingly impermeable barrier between the members of the profession.

The very term “hospitalist” seems problematic. If we call some physicians hospitalists, should we call others “clinicists” or “officists”?3 Similarly, the move toward shift work may open the door to “matinists” and “nocturnists.” Using a misnomer such as “hospitalist” to mean acute care medicine may seem harmless, but calling things by the wrong names is often the first step toward becoming confused about them — a particularly hazardous state of affairs for a profession facing an era of great flux.

A high percentage of hospitalists are employed by hospitals or work at only a single hospital, which can shift loyalty away from patients and the profession and toward the hospital. Some physicians may be captured by the hospital, whose incentives to increase market share and profits are not always well aligned with the best interests of patients and communities. For example, hospital marketing may encourage patients to suppose that their relationship with the hospital is more important than their relationship with any particular physician.

And yet even hospitals suffer in some ways from the hospitalist model. As community physicians relinquish their hospital privileges, the number of physicians on hospital medical staffs tends to decline. Fewer and fewer physicians in the community ever set foot in the hospital, let alone participate in its decision making. As a result, hospital leaders can become less informed and engaged with the needs of their community. In settings where community physicians have functioned as effective advocates, the loss of their voice can widen the gap between hospital policies and community needs.

The reality is that medicine can be practiced without hospitals, but hospitals cannot function without physicians. In war-torn parts of the world today, for example, physicians are caring for seriously ill and

injured patients and even performing complex surgeries in outpatient settings.4 Although this state of affairs is undesirable, it's also a powerful reminder of the real sine qua non of medical care. A good hospital is a great boon to patient care, but the hospital itself is ultimately a tool — to be sure, a large, complex, expensive tool — without which patients can still be given care.

To position the hospital at medicine's center is to create an unbalanced system, one that will continually jar both patients and the health professionals who care for them. The true core of good medicine is not an institution but a relationship — a relationship between two human beings. And the better those two human beings know one another, the greater the potential that their relationship will prove effective and fulfilling for both. Models of medicine that ensconce physicians more deeply in spatial and temporal silos only make the prospects for such relationships even dimmer.

Effects of Use of Hospitalists

The typical and historical hospitalization for patients was one in which the patient's own physician admitted them to the hospital and followed them throughout the hospitalization as the attending physician. With the emerging use of hospitalists nationwide, patients and physicians may have concerns about the quality and advantages to patient care in handing patients over to hospital physicians.

Virtually all of the various studies on the results of the use of hospitalists have revealed decreased lengths of stay for those patients being treated by hospitalists. Additionally, hospital costs are cut, saving hospitals billions of dollars each year. Additional studies have indicated decreased mortality rates and hospital readmissions. Hospitalists are generally more familiar with the hospital system and functions than the outpatient physician and are more familiar with the hospital staff, resulting in better working relationships that can only serve to benefit the care of the patient. Hospitalists are always available on-site to handle situations as they arise without a delay in attention to the patient. These physicians are repeatedly exposed to diseases and complex illnesses that improve their level of skill in the management of the illnesses with each presentation. Medication mistakes have shown to decrease. Still others have shown decreases in length of stay, use of resources, costs per case, and complication rates and increases in patient satisfaction and comfort levels.

The use of the hospitalist can be seen as a threat to some physicians. However, they actually serve to allow the outpatient physician more time to spend with his/her office patients, rather than rushing back and forth to the hospital for patient coverage. It is a matter of convenience. Physicians are guaranteed that expert medical care is always available for their hospitalized patients, even when they cannot be

present. Once patients are discharged, they are once again treated by their outpatient physicians. Thus, there is no concern about the hospitalist "stealing" their patients.

Hospitalists typically work in a block schedule of five to seven consecutive days, for 10- 12 hours each day, and then are off five to seven consecutive days. This type of block scheduling allows the hospitalist quite a bit of time off. Additionally, during their time off, hospitalists do not have to take calls and do not have to worry about patients, as those patients are covered by the hospitalist on duty. Unlike their outpatient physician counterparts, they do not have to worry about managing their own practice and the issues that go with a practice, such as staffing, billing, marketing and advertising. They work as part of a team rather than autonomously. The average salary for a hospitalist is from about $175,000 per year to upwards of $250,000, with the median salary at $179,352.

Meeting over a period of two days, the Advisory Panel delineated some general themes and projections, concluding:

1) Health reform is comprised of two elements: "Informal reform," (i.e., societal and economic trends exerting pressure on the current healthcare system independent of the Patient Protection and Affordable Care Act), and "formal reform," (i.e., the provisions contained in the Act itself).
2) The current iteration of health reform, both formal and informal, will have a transformative effect on the healthcare system. This time, reform will not be a "false dawn" analogous to the health reform movement of the 1990s, but will usher in substantive and lasting changes.
3) The independent, private physician practice model will be largely, though not uniformly, replaced.
4) Most physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals and health systems for capital, administrative and technical resources.
5) Emerging practice models will vary by region—one size will not fit all. Large, Accountable Care Organizations (ACOs), private practice medical homes, large independent groups, large aligned groups, community health centers (CHCs), concierge practices, and small aligned groups will proliferate.
6) Reform will drastically increase physician legal compliance obligations and potential liability under federal fraud and abuse statutes. Enhanced funding for enforcement, additional latitude for "whistleblowers" and the suspension of the government's need to prove "intent" will create a compliance environment many physicians will find problematic.

7) Reform will exacerbate physician shortages, creating access issues for many patients. Primary care shortages and physician mal distribution will not be resolved. Physicians will need to redefine their roles and rethink delivery models in order to meet rising demand.

8) The imperative to care for more patients, to provide higher perceived quality, at less cost, with increased reporting and tracking demands, in an environment of high potential liability and problematic reimbursement, will put additional stress on physicians, particularly those in private practice. Some physicians will respond by opting out of private practice or by abandoning medicine altogether, contributing to the physician shortage.

9) The omission in reform of a "fix" to the Sustainable Growth Rate (SGR) formula and of liability reform will further disengage doctors from medicine and limit patient access. SGR is unlikely to be resolved by Congress and probably will be folded into new payment mechanisms sometime within the next five years.

10) Health reform was necessary and inevitable. The impetus of informal reform would likely have spurred many of the changes above, independent of formal reform. Net gains in coverage, quality and costs are to be hoped for, but the transition will be challenging to all physicians and onerous to many.

Affordable Care Act Provisions That Impact Primary Care

- Medicare 10% increase in primary care reimbursement rates, 2011–2016 ($3.5 billion)
- Medicaid reimbursement for primary care increased to at least Medicare levels, 2013–2014 ($8.3 billion)
- 32 million more people insured, with preventive and primary care coverage, leading to less uncompensated care
- Medicare and Medicaid patient-centered medical home pilots
- Grants/contracts to support medical homes through:
  - ♦ Community Health Teams increasing access to coordinated care
  - ♦ Community-based collaborative care networks for low-income populations
  - ♦ Primary Care Extension Center program providing technical assistance to primary care providers
- Scholarships, loan repayment, and training demonstration programs to invest in primary care physicians, midlevel providers, and community providers

Medical specialization dates back at least to the time of Galen. For most of medicine's history, however, the boundaries of medical fields have been based on factors such as patient age (pediatrics and geriatrics), anatomical and physiological systems (ophthalmology and gastroenterology), and the physician's toolset (radiology and surgery). Hospital medicine, by contrast, is defined by the location in which care is delivered. Whether such delineation is a good or bad sign for physicians, patients, hospitals, and society hinges on how we understand the interests and aspirations of each of these groups. The hospitalist model has provided such putative benefits as reductions in length of stay, cost of hospitalization, and readmission rates — but these metrics are all defined by the boundaries of the hospital. What we don't yet know sufficiently well is the impact of the rise of hospital medicine on overall health status, total costs, and the well-being of patients and physicians. The increasing number of hospitalists cannot, in and of itself, be taken as conclusive evidence of benefit. Such increases can be driven by a variety of perverse incentives, such as low payment rates for primary care that place a premium on maximizing the number of patients a physician sees in a day and therefore militate against taking the extra time required to see inpatients.

In fact, increasing reliance on hospitalists entails a number of risks and costs for everyone involved in the health care system — most critically, for the patients that system is meant to serve. As the number of physicians caring for a patient increases, the depth of the relationship between patient and physician tends to diminish — a phenomenon of particular concern to those who regard the patient–physician relationship as the core of good medical care.

Practically speaking, increasing the number of physicians involved in a patient's care creates opportunities for miscommunication and discoordination, particularly at admission and discharge. Gaps between community physicians and hospitalists may result in failures to follow up on test results and treatment recommendations.1 Moreover, the acute care focus of hospital medicine may not match the need of many patients for effective disease prevention and health promotion. Studies are under way to see whether these pitfalls can be mitigated, but I suspect the inherent tensions will remain fundamentally irresolvable.

From the patient's point of view, it can be highly disconcerting to discover that the physician who knows you best will not even see you at your moment of greatest need — when you are in the hospital, facing serious illness or injury.2 Who is better equipped to abide by an incapacitated patient's preferences or offer counseling on end-of-life care: a physician with whom the patient is well acquainted or one the patient has only just met? The patient–physician relationship is built largely on trust, and levels of trust are usually lower among strangers.

Conclusion

Although the future of the hospitalist movement is uncertain, it seems to have been successful so far. If the trend continues, it can be expected to expand from the general internal medicine arenas to more specialized areas such as pediatrics, surgical specialties, neurology, and obstetrics. Much of the success of expansion depends on the acceptance and promotion of the hospitalist in those areas by the outpatient physician. Studies will be necessary to evaluate and substantiate the same advantages to those practice areas as has been demonstrated in earlier studies.

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Raisin Regulations Raise Reconsiderations Of The Benefit Offset Problem

Suraj Yadav

A B S T R A C T

Surprisingly, the complexity and ambiguity of the United States Supreme Court's current partial takings doctrine is most recently demonstrated in a case stemming from depression-era regulations, not about climate change or coasts, but about California raisins. The Great Depression and its aftermath presented some of "the most difficult and chaotic" economic conditions in United States history. The banking system shut down and defaults were widespread among "every class of borrower except the Federal government." This wave of disorder did not spare the agriculture industry, which was already suffering from a substantial price collapse in the 1920s. In response, the Federal government enacted new agriculture-related laws between 1933 and 1939, almost twice as many as in the previous fifty years. Congress enacted 60% of these new laws for price support and supply management. One such law was the Agricultural Marketing Agreement Act of 1937, which authorized raisin regulations.

INTRODUCTION

The Agricultural Marketing Act authorizes a "marketing order," 221 requiring raisin growers to provide a portion of their crop (the "reserve" portion) to a government Raisin Committee in order to control the supply and therefore the market price of raisins. 222 The Committee takes ownership of the raisins and then donates them, sells them outside of the primary raisin market (to federal agencies, foreign governments, or exporters, for example), or otherwise gets rid of the product.

Raisin growers Marvin and Laura Home took issue with the Raisin Committee's reserve requirement. The Homes refused to reserve any of their own raisins or the raisins that they handled from other growers. The Homes argued that because the government acquired their property-the raisins-and did not pay for it, the marketing order amounted to a taking without just compensation.

That challenge rose to the Supreme Court of the United States and on June 22, 2015 the Court delivered an opinion in Home v. Department of Agriculture. The primary question in Home was whether a

physical appropriation of personal rather than real property-for example, the government taking possession of the Home's raisins as opposed to their land-is a constitutional taking that requires just compensation. Although the Court had not previously addressed this question, an 8-1 majority found that "nothing in the text or history of the Takings Clause, or our precedents, suggests that the rule is any different" between real and personal property. In short, "The Government has a categorical duty to pay just compensation when it takes your car, just as when it takes your home."

Having determined that the government seizure of the Homes' property was a taking that required just compensation, the benefit offset problem was the next hurdle, which split the justices more narrowly. The Homes probably received a monetary benefit from the long-term operation of the supply management program: by limiting the supply of raisins, the program raised the price and increased the Hornes' profit on their crop. Should courts consider a regulatory benefit of this nature when calculating just compensation? Despite a robust dissent from Justice Breyer, Chief Justice Roberts, writing for the Home majority, said no-the regulatory benefits should not reduce the total compensation but the Chief Justice did not adequately explain his reasoning or announce any new framework for settling future compensation disputes.

Although it was not well expressed in their opinions, the dispute among the justices seemed to center on whether the benefits the Hornes may have received were too general and whether those benefits were certain or speculative. On the one hand, the Government had earlier imposed a fine on the Homes that was equal to the market value of the raisins that the Homes failed to deliver to the Raisin Committee. Chief Justice Roberts and his majority relied on the rule that market value is a fair measure of compensation, but said little more about the generality or certainty of the benefit. On the other hand, the Government, and three justices led by Breyer in the dissent, raised the benefit offset problem. They argued that the Supreme Court should send the case back to the lower courts in order to calculate compensation, adjusting the calculation to account for benefits that the price support system delivered. The dissent, therefore, suggested that market value alone may not be the right measure of compensation. The Government argued, and Justice Breyer in his dissent agreed, that under the Takings Clause "a property owner is entitled to be put in as good a position pecuniarily as if his property had not been taken, which is to say that he must be made whole but is not entitled to more." The Court cannot ignore, therefore, that the reserve requirement exists to reduce raisin supply and increase raisin prices. Of course, the purpose of the reserve requirement is to benefit an entire class of people, raisin growers, not any single raisin grower and, in fact, any benefit that accrues does apply across the industry. The broad application of the benefits leads to the question of special versus general benefits. This point came up briefly at oral argument, but Professor Michael McConnell, representing the Hornes, brushed off the

issue, warning the Court: "I don't think we want to get into whether this would be a special benefit." Given the difficulty of the question, it is understandable that they would want to avoid it, but the Court should have addressed this issue directly in order to better justify its decision and clarify its jurisprudence on the subject.

Despite the warning, Justice Breyer did assess the special versus general distinction in the Court's precedent. As discussed in Section IV, supra, that precedent analytically relies on market value, which is calculated based only on certain benefits that are certain and quantifiable at the time of the taking, but the precedent also repeatedly refers to general and specific benefits. Justice Breyer read that precedent to speak primarily about the breadth of a benefit, whether the benefit is unique to the property owner or applies more widely. Overlooking the issue of whether the benefit was certain and calculable and reflected in the market value of the property, Justice Breyer reached the conclusion that the "Constitution does not distinguish between 'special' benefits, which specifically affect the property taken, and 'general' benefits, which have a broader impact." 24' He concludes, therefore, that the lower court should measure the benefit that arises from the regulatory program (in the form of increased prices for the raisins that the Hornes sell on the open market) against the value of the raisins that the government took from the Hornes. If the benefit exceeds, or exactly matches, the value of the taken property, then the government need not provide additional compensation. Justice Breyer, however, was wrong in his disposition because he read the precedent only for its rules on the special-general distinction and not on the market value analysis. Had he focused on the market value test that really underlies the Court's previous decisions, he would have had to consider whether the benefits of the raisin regulations were certain and calculable and could therefore be objectively extracted from the market value for the purposes of offsetting compensation.

In his majority, Chief Justice Roberts quickly dismissed Breyer's reasoning. Roberts characterized the Government's argument and Justice Breyer's more detailed analysis as the "notion that general regulatory activity . . . can constitute just compensation for a specific physical taking." But rather than consider that rule, he called upon the "clear and administrable rule" that 'just compensation normally is to be measured by 'the market value of property at the time of the taking.'" Justice Breyer's dissent cited Bauman, McCoy, and Olson, among other cases, for the proposition that there is no prohibition against considering widespread benefits. The Chief Justice, in laying out an apparently simple market value rule, opaquely distinguished these cases, noting that they "raise complicated questions ... but they do not create a generally applicable exception to the usual compensation rule." However, by distinguishing those cases, Chief Justice Roberts failed to recognize their endorsement of the market value rule on which he explicitly relied, and the certainty and calculability test that he implicitly applied. The benefits

were too uncertain to be disaggregated from the market value of the remainder raisins and to offset against the value of the raisins taken. Put differently, the Chief Justice looked only at the market value of the taken portion and not the market value of the remainder.

But by endorsing a market value rule for setting compensation, the Chief Justice did seek to ignore hypothetical or speculative benefits. In particular, Roberts emphasized that if the Hornes did benefit from the government program, it was from a far-reaching and long running regulatory program as opposed to a public works project, such as a dune. While his intentions with this distinction are not clear, it seems likely that the impacts of a regulatory program, particularly one that has been running for generations, are harder to determine than those of a public works project. That is, the impacts of a regulatory program are generally more speculative and more difficult to calculate. Ultimately, Chief Justice Roberts' conclusion does flow from the Court's precedent and if read to mimic that precedent they would present a more appropriate rule for addressing the benefit-offset problem. Unfortunately, in haste, Roberts distinguished precedent that does more to support his position, and he certainly failed to articulate his thinking in a compelling way.

Home presented the opportunity to resolve a lingering issue in takings jurisprudence: how to deal with the benefit-offset problem. The question was barely briefed,25' not forcefully presented at oral argument, and though Justice Breyer chose to make it the centerpiece of his three justice dissent, Chief Justice Roberts gave it only superficial treatment. With the increasing impacts of climate change and the growing efforts to adapt to them, this failure makes it more difficult for local governments and lower courts to effectively design resilience projects that involve partial takings of private property.

ARTICULATING A FAIR-MARKET VALUE FRAMEWORK FOR THE BENEFIT-OFFSET PROBLEM

When the United States Supreme Court next has the opportunity to consider the benefit-offset problem, it should avoid its errors in Home and adopt an explicit and just rule. This does not require a reinvention of their doctrine. The Court has applied consistent reasoning when dealing with the benefit-offset problem, but has not articulated a rule in a sufficiently transparent and powerful way. In New Jersey, however, Karan very clearly announced a fair market value rule: when there is a partial taking, the courts will consider both unique and widespread benefits to the remaining property as long as those benefits are certain and calculable enough to have an impact on the price a willing buyer would pay a willing seller for the remaining property. 253 Though it would not be a departure from its current jurisprudence, the United States Supreme Court has failed to explicitly adopt this same rule, and Chief Justice Roberts

declined the opportunity in Home. The Court's ongoing failure to clearly outline a fair-market based benefit-offset rule may have led to the Chief Justice's correct conclusions but insufficient analysis in Home. When properly articulated, the rule aligns with Roberts' conclusion while also paralleling the New Jersey Supreme Court's reasoning and conclusion in Karan, despite the fact that the cases reach opposite conclusions with respect to "offsetting" the respective benefits. Understanding the lessons of Karan provides the bulk of the analysis needed for a new articulation of the fair market value rule in the Supreme Court. This Section highlights those lessons, fleshes out a fuller analysis, and rectifies the divergent conclusions of Karan.

Lessons from Karan

The rule and rationale in Karan are, for all practical purposes, perfect reflections of the Supreme Court's jurisprudence, and since the Supreme Court has yet to clearly articulate the current lessons of its cases, Karan is an excellent guide.

The Karan court provided a good assessment of the rationale for disposing of the special-general distinction in New Jersey and relying instead on fair market value, which is central to the Supreme Court's precedent. In fact, the Karan court had to deal with equally confusing and more explicitly contradictory New Jersey case law than the Supreme Court will have to address in its own precedent, should it take an opportunity to clearly announce a cohesive rule for the benefit-offset problem.

In disposing of the special-general distinction, Karan reasoned: "the terms special and general benefits do more to obscure than illuminate the basic principles governing the computation of just compensation in eminent domain cases." The court continued, "the problem with the term 'general benefits' is that it may mean different things to different courts. To some courts the term 'general benefits' is a surrogate for speculative or conjectural benefits." Indeed, Karan explained fully that courts must avoid speculative and conjectural benefits, but that is distinct from broadly applicable or widespread benefits, which courts may consider but are also sometimes subsumed by the definition of "general benefits."

To avoid speculation and conjecture, and to move away from the special-general distinction, Karan announced the controlling rule as follows: "The fair-market considerations that inform computing just compensation in partial-takings cases should be no different than in total-takings cases. They are the considerations that a willing buyer and a willing seller would weigh in coming to an agreement on the property's value at the time of the taking." Further:

just compensation should be based on non-conjectural and quantifiable benefits that are capable of reasonable calculation at the time of the taking. Speculative benefits projected into the indefinite future should not be considered. Benefits that both a willing buyer and willing seller would agree enhance the value of the property should be considered in determining just compensation, whether those benefits are categorized as special or general.

To highlight the need for non-conjectural benefits, Karan focused on several clearly speculative arguments. For example, the rapid growth of railroads in the nineteenth century led to many partial takings in which railroad companies utilized portions of private property for track and sought to minimize their payments for damages to the remainder. Railroads minimized their obligation to compensate for the initial taking by insisting that the presence of tracks would increase population and commerce, making the remaining property more valuable. Courts responded to this rampant injustice by developing the idea of general benefits, initially curbing the railroads' free pass based on the idea that the population and commercial benefits to which the railroads pointed were widespread, applying to the entire community. But in hindsight, a more accurate interpretation of the relevant cases is that the impacts of new population and new commerce were speculative and there was no way to calculate the present value of a non-quantifiable increase in population or commercial activity. As the Karan court explained, earlier courts "expected that benefits emanating from a public project that enhanced the value of the remainder property in a partial-takings case-benefits that were non-speculative and reasonably calculable at the time of the taking-would be weighed in fixing an award of just compensation."

Karan added more clarity to the early concerns about uncertain benefits by explaining that a benefit is conjectural if it might arise "in the indefinite future." A benefit is unquantifiable if it is "so uncertain in character as to be incapable of present estimation." In contrast, what the court must look for is benefits that are "capable of present estimation" (i.e., reasonably certain), "capable of ... reasonable computation" (i.e., calculable), and "actual benefit" (i.e., non-speculative), and an "enhancement in market value" (i.e., real and measureable). The Supreme Court's decisions already represent a nearly identical framework, though it has not yet attempted to lay out that framework in one systemized analysis. Below is an effort to do SO.

A Fair-Market-Value-Based Approach to the Benefit-Offset Problem

This Article argues for the following approach to the benefitoffset problem: when a government regulatory program or public works project partially takes private property and creates a benefit to the remaining property, the owner is entitled to compensation that reflects certain and calculable increases

in the market value of the remainder. 27 3 A court need not try to distinguish between special and general benefits insofar as those terms relate to the scope of the benefits. Across the board, courts should jettison these terms, which have never been well articulated and are frequently confused and misused, treated as controlling the outcome when they are merely descriptors, and inconsistent descriptors at that. Rather than leaning on an antiquated and unreliable distinction around the scope of benefits, the court need only determine if the benefits are reasonably certain and capable of present calculation, and therefore influence the market value of the remainder. If the benefits are reasonably certain and capable of present calculation; if they do not require speculation, qualitative judgments, or waiting for some prospective benefit to actually arise so that it can be calculated; and if they increase the fair market value of the remaining property; then the court can subtract that from the compensation for the part taken.

This rule is easily applicable in practice when the benefits are certain and quantifiable. If a government takes a sliver of land to create a park, which will reduce the size of a property but will also give it access to a new park, assessors will determine the fair market value of the property based on, for example, its acreage and its proximity to the park. The assessors will look to recent sales of similar property in the area. The shrinking lot size, when considered alone, will certainly decrease the property value, while the new park will likely increase the value. Based on their calculations, the assessors will be able to determine if the final fair market value of the property is higher or lower based on the government project. The benefit of the park is not speculative: there is no question that the park now exists and that the public, including the property owner, can access and use it. The benefit of this park is calculable if assessors can rely on sales of other homes in similar situations. This is not a rare situation. It is not a vague benefit but is instead easily identifiable when searching for comparable properties. If the park has increased the fair market value of the remainder, if a willing buyer would now pay a willing seller more than she would have before the park existed, then the government has not damaged the remaining property and the court can identify the margin of increase to offset the compensation. If the value of the remainder has decreased from its value prior to the park's creation, the court must order compensation equal to the decrease in fair market value, in addition to compensation for the part taken.

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Raisins And Resilience: Elaborating Horne's Compensation Analysis

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A B S T R A C T

The increased need for government-driven coastal resilience projects will lead to a growing number of claims for "partial takings" of coastal property. Much attention has been paid to what actions constitute a partial taking, but there is less clarity about how to calculate just compensation for such takings, and when compensation should be offset by the value of benefits conferred to the property owner. While the U.S. Supreme Court has an analytically consistent line of cases on compensation for partial takings, it has repeatedly failed to articulate a clear rule. The authors argue the government should compensate property owners based on the free market value of their remaining property, the calculation of which should include all non speculative, calculable benefits of the taking. The governments began, for instance, a major dune restoration project in 2005 in order to protect the New Jersey coast from massive storm surges that could destroy homes and businesses. To carry out the effort, the local governments sought to purchase, the right to build along the seaward portion of property owners' land, and would then construct roughly twenty-foot-high, thirty-foot-wide dunes.3 If the government and the landowner could not agree on a price or the landowner refused to sell, the government would acquire the necessary strip of property using eminent domain: the right of government to take private property for public use as long as it offers just compensation.4 This Article is about the proper way to calculate just compensation when government partially takes private property for a use that provides a degree of benefit to the remaining property.

Key words: *Psychological Performance, Resilience, Environmental Protection*

INTRODUCTION

Most of the studies that examine the effects of sleep deprivation (SD) on behavior and psychological performance have concentrated on measures deemed sensitive to "sleepiness," favoring more basic skills, such as vigilance, reaction time, and aspects of memory (cf. the recent review by Pilcher & Huffcutt, 1996). These tests are usually combined with monotony and lack of environmental stimulation, which, taken together, produce optimum conditions for maximizing the adverse effects of SD. Such monotony is further facilitated by the need to ensure that participants are well trained in the test procedures beforehand to minimize practice effects.

The extent to which these more conventional laboratory-based tests relate to real-world tasks is a matter for debate. A good illustration, and an example attracting much attention, concerns junior hospital doctors (interns) who experience SD with long working hours on a routine basis. Much of the SD research, as of this writing, has focused on cognitive processes that have little to do with the true nature of the job or normal working duties (e.g., serial reaction time, vigilance). Sometimes, the overall picture can be confusing, with findings showing no impairments for certain clinical skills and concurrent deterioration in psychological performance tasks of unknown relevance to these and other medical skills. For example, Beatty, Adhern, and Katz (1977) noted that after a night of being on call, anesthesiologists had no difficulty in monitoring vital signs during a surgical simulation, although they were impaired on Baddeley's (1968) Grammatical Reasoning Test. Little consistency in these findings is further highlighted in a comprehensive review of this area by Leung and Becker (1992), who concluded that lack of control data, bad methodology, and poorly defined SD criteria provide no clear conclusions, despite the large number of studies. For example, SD findings are usually compared with off-duty days, when the clinician is still recovering from the effects of long work hours, and performance is still impaired. Hence, it is likely that the effects of SD are underestimated and give little insight into performance during a medical emergency. Probably, the only consistent finding has been the effect of SD on the clinician's mood, but the relationship between this and performance remains speculative.

The Importance of Climate Change Resilience and the Option of Eminent Domain

Coastal climate change adaptation strategies like those in New Jersey, which assess and then respond to all types of climate vulnerabilities, are critical. The United States coasts are home to more than 164 million people, more than 50% of the country's population. 5 These areas support "66 million jobs and $3.4 trillion in wages.'" 6 In the aggregate, coastal communities "generate 58% of the national gross domestic product" 7 and contribute $6.7 trillion to the United States economy.8 But this concentration of people, jobs, wealth, and economic energy is threatened by climate change.

The risk is particularly acute given historical development patterns. Shoreline developments have "frequently occurred without adequate regard for coastal hazards." 9 Sea levels rose at an average of 1.7 millimeters per year through the 20th century, and this rate seems to be accelerating. 10 Other studies estimate "global sea levels rose approximately eight inches [203 millimeters], despite stable levels over the previous two millennia."'" Some research estimates that global sea levels could rise by a meter or more over the next hundred years.' 2 And sea level rise is likely to continue for many centuries.

This threat has not escaped public notice. Sea level rise has resulted in a "national conversation about what coastal developments should be permitted and how they should be built. There have been various attempts to chronicle local, regional, and national adaptation activities. "Hard" protections, such as sea walls, can exacerbate erosion and coast loss, resulting in "negative effects on coastal ecosystems, undermining the attractiveness of beach tourism."' Alternatively, "soft" coastal adaptation strategies, such as dune renourishment, are less expensive but still effective, which helps explain why they are the most common method of coastline protection in the United States.'7 "Soft" adaptation "is commonly employed along ocean shores-generally at public expense."18 In some cases dunes and other soft projects might not intrude on private property. In most cases, however, coastal adaptation projects will require government possession of strips of private property on the seaward edge of coastal lots, which may require the use of eminent domain.

Despite the clear and present threat of climate change-or, at the very least, intense and destructive coastal storms-there is perhaps a feeling among some coastal residents that it is not climate change, but government-driven coastal resilience projects, that are the real threat to their property.

Naturally, government adaptation programs have spawned litigation, from Washington to Texas to Florida to New Jersey. The litigation addresses coastal sewage systems, integration of adaptation into utility development plans, nutrient concerns in changing water conditions, and insurance considerations, to name a few. 20 In New Jersey alone, the Department of Environmental Protection estimates needing 4,200 easements for public projects along the coast, and, though it has acquired all but 366, 239 owners refuse to sell the needed portion of their property. However, constitutional protection of private property is not absolute. The government may take private property, through eminent domain, to serve the public good as long as the government also offers the property owner just compensation. 22 Accordingly, one must ask: what is 'just" in the case of a partial taking, where the government takes part of a property, but leaves a "remainder" in private hands? How much should the government compensate for the taken portion? How does the government account for damages to the remaining portion? What do they do when the remaining portion benefits from the taking? What is just when a coastal resilience project takes a small portion of property to construct a dune, and the dune blocks a beautiful ocean view but also saves a beachfront home from complete destruction at the hands of an enormous storm? This was the issue the New Jersey Supreme Court faced in Borough of Harvey Cedars v. Karan. The New Jersey court issued a sound and comprehensive answer, focusing on market value of the remainder, which is a model for other courts.

The United States Supreme Court, on the other hand, lacks a clear rule for this benefit-offset problem. 24 The Court's 2015 case Home v. Department of Agriculture revolved around raisin farmers who, by federal regulation, were required to turn a portion of their crop over to the federal government in order to lower supply and raise raisin prices nationwide. 25 When debating the correct method for setting compensation, justices were misdirected by their complex precedent and poorly defined standards. Home demonstrates that the Court has been bogged down in jargon related to the scope of benefits, including whether they are "general" or "special" 26 and how to account for those benefits that accrue to the general public, the whole neighborhood, or just to a single landowner, for example. 27 This is not the correct framework for dealing with the benefit-offset problem, and it can lead courts to set unjust compensation that ignores real benefits that impact a property's market value.

Because adaptation projects protect private property, they often lead to landowner benefits. Therefore, coastal governments need articulate guidance from the Court in order to implement appropriate adaptation measures. This Article argues that the United States Supreme Court should move beyond the impenetrable nomenclature that it has used for more than a century to assess compensation in cases of so-called "partial takings," and should instead adopt a simple rule, setting compensation that accounts for the market value of the remainder, and reducing compensation by any calculable and certain increase in that value.

As governments more frequently acquire private property in coastal resilience efforts, often through eminent domain, courts will need to confront this partial-takings issue head on. Therefore, this Article seeks to coalesce a doctrine that can address the benefit-offset problem. While fair market value is the standard measure of just compensation, in an effort to solve the problem, some courts have created a dichotomy of "special" and "general" benefits-those that are unique to a single property versus those that apply to all properties in the area. But this dichotomy is unhelpful and courts have misapplied their own distinction or simply treated it as a post hoc justification rather than analytical tool. 28 As this Article explains, the distinction is subjective, has no basis in the Constitution, and, ultimately, is not a good solution to the benefit-offset problem.

A Proposed Solution

This Article also seeks to rectify apparent discrepancies among leading cases that address the benefit-offset problem. In over a century of case law, courts have sometimes used benefits to offset

compensation and other times have refused. This Article argues that the consistent analytical rule applied in all these cases is not the special-general distinction, that is, the breadth of the benefit, but rather whether the benefit has a certain and presently calculable impact on the market value of the property. If the impact is certain and calculable, then courts must offset the increase against compensation.

The following Section offers a primer on takings law. Section III goes on to discuss the scope of the benefit-offset problem by focusing on the antiquated and unhelpful distinction between "special" and "general" benefits. Section IV reviews Supreme Court doctrine around benefit calculations and concludes that the Court has implicitly used a fair market value analysis even when it claims to use a special-general benefit rule. Section V analyzes the New Jersey Supreme Court's decision in Harvey Cedars v. Karan and offers it as a sound and eloquent statement of the rule that the United States Supreme Court should adopt to set compensation for partial takings. Section VI revisits Home and describes how the Chief Justice's misinterpretation of the Court's precedent nevertheless resulted in the correct disposition. Section VII seeks to articulate a constitutionally sound and practically administrable doctrine that rectifies Home with the existing precedent.

A VERY BRIEF PRIMER ON TAKINGS LAW

It is important briefly to cover the concept of takings before exploring the benefit-offset problem and the nuances of just compensation.

The government can take private property, whether directly through the power of eminent domain, or whether inadvertently, through a regulatory program. The Fifth Amendment to the United States Constitution, however, places certain limitations on that allowance. First, the Takings Clauses of the Fifth Amendment explicitly requires that the government can only take property for "public use." Generally speaking, any purpose that promotes the public health, safety, welfare, or morals is a valid public use. Thus, while a government "may not take the property of A for the sole purpose of transferring it to another private party B state may transfer property from one private party to another if future use by the public is the purpose of the taking" or if the purpose of the transfer is broad economic development.
The second limitation on the government's power to take private property is that the government must give the property owner (or prior property owner, as the case may be) "just compensation."Determining what amount of compensation is just is the responsibility of the judicial branch. The remainder of this Article addresses one aspect of judicial calculation of just compensation. But, in broad terms, the constitutional guarantee of just compensation assures that the government will put the property owner

"in the same position monetarily as he would have occupied if his property had not been taken." At the same time, the courts must assure that compensation is not only just to the individual whose property was taken, but also to the public at large. 38 After all, it is the public, through their tax dollars, that foots the compensation bill. To best balance these two competing components of just compensation, the Supreme Court has frequently held that the market value of property at the time of the taking is the best measure for compensation.

GENERAL VERSUS SPECIAL BENEFITS

Because the government can only take property for the purposes of public use, it is natural that whenever the government takes property, there will be some resulting benefit to the owner or former owner. The quantity and quality of that benefit, however, can vary dramatically. The distinction between "general" and "special" benefits arises from this inevitable reality.

Unfortunately, the exact definitions of "general" and "special" are quite unclear, 4' and reliance on this distinction can lead to unjust calculations of compensation. Although this Article argues that courts should dispose of the general-special dichotomy, it is necessary to have a working explanation of the terms in order to understand the problems that they cause.

When the government effects a partial taking, a general benefit is a benefit to the remaining property that is similar to the benefits that other properties in the area will receive from the project or regulatory scheme. By some definitions, a benefit that is uncertain, speculative, or unquantifiable is also a general benefit. Conversely, a special benefit is a benefit that is unique to the targeted property, does not apply to other properties, and in some applications, is reasonably certain to occur and reasonably calculable.

The same example can be used to illustrate a special benefit. Suppose that to construct the highway DOT will drain an inundated portion of the farmer's land. When it drains the wetlands, the farmer will have more arable land and can grow more crops. This benefit is unique to the farmer's property. While the entire community benefits from the highway generally, only the farmer will have new cropland available and this benefit would therefore fall under the standard definition of "special benefit." With respect to the speculation-oriented definition, there is no speculation needed to recognize the individualized advantage here: when DOT drains the land, it will be available for planting without respect to contingencies such as highway usage or the effect of highway usage on the local economy. Moreover, while it may not be easy to calculate the value of the new cropland, it is certainly quantifiable in a way that benefits from new traffic are not.

How HAS THE SUPREME COURT DEALT WITH THE BENEFIT-OFFSET PROBLEM?

The Supreme Court precedent regarding the benefit-offset problem begins with the rule that when property is taken, the former "owner is to be put in the same position monetarily as he would have occupied if his property had not been taken." 53 Early on, the Court settled on fair market value as the mechanism to give effect to this command. 54 In the case of a partial taking, the Court has had a more difficult time articulating a simple rule because of its adherence to the special-general benefit terminology and because a partial taking creates opportunity for benefits to accrue to a remainder.

The following Section demonstrates that despite the inconsistent vocabulary and the confusion it causes with decision makers and lower courts, the Supreme Court's practice is, in fact, centered on a market value approach, even in the case of partial takings.5 6 This Section uses the existing case law to justify the following rule: if a government project or regulation produces a benefit that is reflected in a higher market value of the remainder, then there is no net harm to the remainder so no compensation is owed for damages. The marginal benefit to the remainder may be offset against compensation for the part of the property that the government actually took. Courts should not rely on the unhelpful distinction between special and general benefits even though the Supreme Court has frequently used those terms. Rather than relying strictly on the general-special distinction, a closer analysis of the Court's precedent demonstrates that it has used benefit-influenced market value to measure compensation when the benefits are reasonably certain and capable of present estimation. 57 Put differently, in actual practice the Court relies on fair market value for determining if there are damages to the remainder, if there are benefits to the remainder, and if a benefit to the remainder can be subtracted from compensation for the part taken. Benefits that might accrue to a remainder are only relevant if they impact fair market value. Distant, unlikely, speculative, or unquantifiable benefits are not likely to impact fair market value and are therefore not relevant to compensation.

Calculating Fair Market Value

The Fifth Amendment of the Constitution requires just compensation when the government takes an individual's property; it does not require fair market value, but courts have identified fair market value as the best means of achieving justice. As Nichols on Eminent Domain explains, market value "is not an end in itself, but merely a means to an end; the ultimate object being the ascertainment of 'just compensation.'" Fair market value may not always give rise to perfect compensation, but it is a "relatively objective working rule."'The Nichols point is also a reminder that courts should not forget the constitutional requirements that give rise to the use of fair market value as the central test for just compensation.

The Court defines market value as the price a "willing buyer would pay in cash to a willing seller at the time of the taking." Market value is not necessarily the same as the owner's investment in the property because the owner may have paid too much or too little for it. Likewise, the property's value may have declined or increased since the owner's purchase and subsequent investments. In other words, it is the property and not the cost of it that is safeguarded by state and Federal Constitutions.'"Moreover, the fair market value does not depend on the current or past use of property, but on "all the uses for which it is suitable." Market value is not measured by loss of profits, goodwill, or the expense of relocation. It is likewise not measured by the cost of substitute property.

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A Newjersey Resilience Project Brings Focus To The Failings Of The Special-General Distinction

Chandan Sharma

ABSTRACT

Given its location along the mid-Atlantic coast, NewJersey faces a particular threat from the rising sea levels and intense storms that accompany climate change. New Jersey has 127 miles of coast, the vast majority of which has a "high" or "very high" vulnerability risk. Hurricane Sandy was a particularly devastating example of New Jersey's plight, destroying homes, historic and valuable commercial centers such as boardwalks and amusement parks, and otherwise battering much of the coast. The coast's vulnerability demands climate change adaptation and mitigation policies, but the state's disjointed and at times contradictory case law-which until recently mimicked the United States Supreme Court's doctrine-made effective resilience policies seem an even greater challenge.

INTRODUCTION

A barrier island at the southern end of Ocean County, New Jersey, Long Beach Island has a year-round population of roughly 12,000, which booms in the summer months when families fill the nearly 18,000 seasonal second homes. Tourism-related fields including real estate, food service, retail, and construction are the top industries in this region, contributing to the $14.2 billion gross county product for Ocean County.

Recognizing the value of Long Beach Island to the economy as a whole, the nine Long Beach Island municipalities, as well as the state of New Jersey and the federal government, jointly established a massive beach restoration and storm protection project for the island. 50 One of the key components of this effort was a dune nourishment effort that would significantly enlarge the existing dune system all along Long Beach Island, thereby protecting the structures behind the new dunes from storm surges and flooding.'51 These dunes were constructed adjacent to the private homes along the shore, in most cases on the homeowners' private property. Thus, while the Army Corps of Engineers carried out most of the technical aspects of this project under the federal-statelocal arrangement, the towns were responsible for acquiring the property rights to build the dunes that would cross each property.

In the Borough of Harvey Cedars, towards the northern end of Long Beach Island, town officials were responsible for gaining permissions on eighty-two properties. 54 Officials were able to reach agreements with sixty-six property owners, leaving sixteen properties on which the Borough had to exercise eminent domain. One of these properties in the latter category belonged to Harvey and Phyllis Karan. The Karans' property was 11,868 square feet on which the new dune would occupy a 3,381square foot strip on the ocean-side. The Borough offered the Karans $300 for the right to build and maintain a new dune on the land, which the Karans refused, arguing that they deserved compensation not only for the land the Borough would take to build the dune, but also for the damage to their remaining property. Specifically, the Karans asserted that the dune project would damage their remaining property by limiting their coveted ocean view.

When the Karans did not consent to the project, the Borough of Harvey Cedars began an eminent domain proceeding and acquired the property by condemnation. As New Jersey law requires, the trial court appointed a commission to determine just compensation after the acquisition. The commission set compensation at $700. The Karans rejected this sum of compensation -which, of course, was only $400 more than the initial offer-and demanded a jury trial.

As these legal proceedings progressed, it was no secret that the new dune system along Long Beach Island, and in Harvey Cedars in particular, would protect the Karans' home from a major storm. The Army Corps of Engineers' expert determined that without the new dunes, there was a 56% chance that in the next thirty years a storm would destroy the Karans' home. 65 With the dunes in place, however, the Karans could expect their house to be safe for the next two centuries.

The Karans understood the potential benefits of the dune system, but in order to maximize their monetary situation, or perhaps to stop the condemnation altogether, their strategy was to rely on New Jersey's existing just compensation jurisprudence. This jurisprudence seemed to command that when setting compensation for the property taken and the remainder, the judge, jury, or commission must ignore any benefits that accrue generally to the public at large even if those benefits also accrue to the specific property at issue. With respect to the Karans, even though a willing buyer would likely pay more to gain the storm protection benefit, the Karans relied on a line of benefit-offset cases suggesting that this fair market increase was not sufficient to lower their compensation since all the neighboring houses would also increase in value.

The Borough of Harvey Cedars might have explained to the jury that, indeed, the dune project would take away a piece of the Karans' property and, as to the remainder, it would have a severely diminished

view of the ocean. Nevertheless, the town would argue that the storm-protection benefit-the fact that the new dunes would enable the home to survive the next big storm-outweighed these costs. 168 Therefore, prior to the trial the Karans requested a hearing to determine whether the jury could consider any arguments regarding the benefits of the dune system. Ultimately, the judge determined that the jury should not consider the storm protection benefits. The case went to trial and the jury, instructed to ignore these benefits, calculated that the Borough of Harvey Cedars owed the Karans compensation in the amount of $375,000.

The Borough appealed this award, first to the New Jersey appellate court, which agreed with the trial judge that the court could not offset so-called "general benefits." The Borough then appealed to the New Jersey Supreme Court, which considered New Jersey's occasional practice of ignoring general benefits, but opted to change the law.

The question presented to the New Jersey Supreme Court in the case of Harvey Cedars v. Karan was how to calculate just compensation considering both the Karans' reduced ocean view and improved storm protection. Lest there be any question about the reality of the improved storm protection, the parties argued this case on May 13, 2013, only six months after Hurricane Sandy made landfall in New Jersey. The Army Corps of Engineers constructed the new dune system in front of the Karans' home in 2008. Because of that protective barrier, the Karans' home survived the storm that ravaged the coast and the neighboring towns without improved dune systems.

The New Jersey court began its analysis by distinguishing between two situations in which just compensation is due. In the first situation, the state government will owe just compensation when it takes an entire piece of property, when it acquires 100% of a lot in order to build a school or when it acquires a boat to use in a war effort. In the second situation, the government will owe just compensation when it takes a portion of the property, not only for that portion of property actually taken, but also for any reduction in value to the remaining property.

In New Jersey, when the government acquires an entire piece of property through eminent domain, "the measure [of just compensation] is the fair market value of the property as of the date of the taking, determined by what a willing buyer and a willing seller would agree to, neither being under any compulsion to act."

When, as with the Karans, the government takes less than the entire property, the analysis of New Jersey courts "has not necessarily reflected the straightforward fair market value approach that is evident in

total-takings cases." Generally in a partial takings case, the government will use eminent domain to acquire a segment of property, for which it would pay the fair market value. However, by severing the property and taking possession of a part, there may be damage to the portion of property that remains with the private owner. This damage may result from the government's use of the taken portion-for example, if noise and vibrations from a new rail line decrease the value-or from the fact that the remainder can no longer be used in the same manner-for example, if a rail line bifurcates a farm, making efficient harvest impossible.

But when the value of the remainder increases, can the government offset the compensation by the increase?

The compensation calculation for partial takings prior to Karan revolved around the special-general benefits distinction. 84 Recognizing both the troubling policy implications of this distinction-specifically, that the Karans could receive $375,000 from the government, while it protects the very existence of the home which they claim was damaged-and the subjective, malleable gradient on which the distinction relies, the Karan court looked carefully at New Jersey law to determine the roots of the special-general benefits distinction.

The court concluded that the special-general distinction "bedeviled" prior courts with varying definitions and inconsistent applications of the imprecise rule. The two cases that present the most confusion are two of the earliest.

The benefit-offset problem in New Jersey often focused on the railroads, much as it did in other states. In the 1889 case of Sullivan v. North Hudson County Railroad Company, authored by Justice Dixon, the railroad was building an elevated railway in front of two properties. The railroad argued that, when calculating compensation for damages to those properties, the court should offset any benefits, and consider the operation of the railroad as a benefit in itself.' The Sullivan court defined general benefits as "those which affect the whole community or neighborhood, by increasing the facility of transportation, attracting population, and the like."' Special benefits, on the other hand, were defined as "those which directly increase the value of the particular tract crossed." The court ruled that only special benefits should be set off from compensation.

Mangles v. Hudson County Board of Chosen Freeholders reexamined the issue in 1892 and exacerbated the confusion in the way it described general benefits. In Mangles the state took a portion of several properties for the purpose of widening a highway. The Court considered the certainty of the highway's benefits, and the ability to calculate those benefits, without considering the breadth.

It is with Mangles that New Jersey law begins to confuse the scope of the benefit-that is, whether the benefit is common to all neighbors or unique to the property at issue-with the nature of the benefit-whether the benefit is reasonably certain and reasonably calculable. This same type of confusion in the United States Supreme Court's jurisprudence is likely the reason the Court the avoided tackling the benefit-offset problem in Home. In New Jersey, this exact confusion forced the New Jersey Supreme Court to finally resolve the benefit-offset problem in Karan.

To further highlight the Mangles-induced confusion in its jurisprudence, the Karan court proceeded to consider three additional New Jersey cases in which the courts respectively:

1) disallowed the offset of what they termed "general benefits" without defining that term or considering whether the benefits in the case were capable of calculation and were non-conjectural;
2) disallowed what they termed "general benefits" but defining that term as those benefits "which a property owner may enjoy in the future in common with all other property owners in the area;" 204 and similarly
3) Disallowed offsetting because benefits can only offset if they provide "an advantage likely to accrue to [the remaining] property over and above the advantages to other property in the vicinity."

This degree of inconsistency around offsetting benefits, paired with the growing concern over coastal adaptation generally and dune replenishment more specifically, forced the New Jersey Supreme Court to articulate a clear and administrable rule.

Despite the confusion it helped create, Mangles did introduce a standard, one focused on the fair market value as set by real and calculable benefits, 20 6 from which the New Jersey Supreme Court could begin to fashion its modern rule. As described above, the articulation of this standard, side-by-side with Sullivan, created significant confusion in New Jersey's jurisprudence for more than a century, but Karan offers clarity, consistency with many other jurisdictions including the United States Supreme Court's analysis if not nominal rules, and important public policy outcomes.

In its unanimous opinion, the Karan court declared that it "need not pay slavish homage to labels that have outlived their usefulness" and explained "the terms special and general benefits do more to obscure than illuminate the basic principles governing the computation of just compensation in eminent domain cases." 208 Eschewing the distinction, the court held that "[t] he fairmarket considerations that inform

computing just compensation in partial-takings cases should be no different than in total-takings cases. They are the considerations that a willing buyer and a willing seller would weigh in coming to an agreement on the property's value at the time of the taking."

Relying on the intent of Mangles, which was a focus on certainty and calculability, the court laid out a clear rule, doing away with the special-general distinction 210 and instead holding that 'just compensation should be based on non-conjectural and quantifiable benefits.., that are capable of reasonable calculation at the time of the taking.'" 211 With that rule in mind, it was not a stretch for the court to reason that "[a] willing purchaser of beachfront property would obviously value the view and proximity to the ocean. But it is also likely that a rational purchaser would place a value on a protective barrier that shielded his property from partial or total destruction. '21 2 In other words, the government taking offers benefits to the Karans' property at the same time that it causes damages and courts should not provide compensation based on the damages, while ignoring the benefits. Relying on a specialgeneral distinction, which allows offsetting of only a limited number of real and calculable benefits, would ignore too many benefits and therefore provide owners like the Karans with a windfall when their property actually increases in value because of the taking. By relying on a market value approach to compensation, the New Jersey court settled on a rule that takes cognizance of the real value of a remainder. If a purchaser would pay more, then the taking has not only harmed the remainder, it has also produced a non-speculative benefit that the court can subtract from compensation. If a purchaser would pay less, then there has been damage, and the government must pay compensation.

Because the lower court prohibited the jury from considering evidence of how the dune replenishment project would actually and quantifiably benefit the Karans' property remainder, the New Jersey Supreme Court ordered a new trial.213 Prior to that trial, the Karans agreed to settle with the Borough of Harvey Cedars for $1, putting an end to this particular conflict and to their windfall. 214 The larger confusion over the benefit-offset problem still lingers.

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12. *Id. at 2434 (Breyer,J., dissenting).*
13. *See Home, 135 S. Ct. at 2436 (Breyer, J., dissenting) ("In my view, however, the relevant precedent indicates that the Takings Clause requires compensation in an amount equal to the value of the reserve raisins adjusted to account for the benefits received.").*
14. *The idea of fair market value may seem inappropriate in the context of such a highly regulated market. Nevertheless, the value of the Hornes' raisins was set at a level that a willing buyer would pay a willing seller. That amount is highly influenced by the government-managed supply program, but the individual transactions are not compelled and the prices are merely influenced by the program, not set thereunder.*
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