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ANNALS OF HEALTH LAW
Advance Directive

**THE *STUDENT* HEALTH POLICY AND LAW REVIEW OF
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

Beazley Institute for Health Law and Policy

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ANNALS OF HEALTH LAW AND LIFE SCIENCES
Advance Directive

Editors' Note

The *Annals of Health Law and Life Sciences* is proud to present the twenty-first issue of our online, student-written publication, *Advance Directive.* As in past practice, this issue's article topics coincide with the Beazley Institute for Health Law and Policy and *Annals of Health Law and Life Sciences*, Twelfth Annual Health Law Symposium topic: 'Serving the Needs of Medicaid Populations.'

Access to healthcare in the United States has been, and is currently, a topic of much debate. How an individual obtains healthcare for one's self and family is a top priority. For many American families, the only option available is state-sponsored Medicaid coverage. This *Fall 2018 Advanced Directive* issue will divulge into whether the current Medicaid system is adequately serving the needs of its target populations, and how social determinents of health affect access to care for those people.

The World Health Organization defines determinants of health as the range of behavioral, biological, socioeconomic, and environmental factors that influence the health status of individuals or populations. Scientist generally recognize five determinants of health of a population by assessing, biology, individual behavior (i.e. alcohol use and smoking), social environment (i.e. education and community life), physical environment, and health services. In sum, the quality of our health can be determined by our access to social and economic opportunity, the resources and supports available in our homes, the cleanliness and safety of our environment including our water, food, and air and access to doctors and medical centers.

Encompassed in the social determinant of health services is healthcare. Americans' access and quality of healthcare is often dictated by their insurance coverage. While many Americans have privatized insurance, a great number rely on Medicaid for their health needs. The intersectionality of this, and the many other social determinants faced by low-income populations leaves people with Medicaid coverage particularly vulnerable to adverse health risks.

This issue critically assesses the state of Section 1115 Medicaid Demonstration Waivers. Specifically, focusing on how successfully Section 1115 waivers are in catering to the mental health needs of the Medicaid population. The mental health for the Medicaid population is further assessed within the context of the Medicaid beneficiaries being at a higher risk of developing opioid addition. In order to counteract the effect of over proscribing opioids, this Issue explores the potential benefits of Medicaid beneficiaries gaining access to medical marijuana while also explaining what the government should be doing in order to establish a better procedure for directing individuals afflicted by Substance Use Disorders to appropriate care.

Next, this issue takes into consideration the effects that the environment has on Medicaid populations. Specifically, how environmental hazards like polluted drinking water adversely affect and perpetuate illness. Environmental disasters are also explored, specifically the effects that Hurricane Harvey had on the Texas Medicaid population. We hope to increase knowledge and awareness about the temporary coverage solution provided with the Section 1135 wavier. The issue expands its exploration of the Symposium theme through environmental effects like food insecurity and its disproportionate negative impacts on Medicaid populations.

Further, this issue takes an interesting look at how "socially isolated" individuals are, in fact, creating higher costs both Medicaid and Medicare programs. Lastly, it takes into account certain factors and issues that are needed for low-income populations to have the safest options when it comes to oral health care – an often overlooked but essential health benefit.

We would like to thank Kara Simon, our Technical Production Editor. Without her knowledge and commitment this issue would not have been possible. We would like to give a special thanks to our *Annals* Editor-in-Chief, Mary Hannosh, for her leadership and support. The *Annals* Executive Board Members, Kaleigh Ward, Allyson Thompson, and Chloe Cunningham, and the *Annals* Senior Editors, Abigail Elmer, Victoire Iradukunda, John Meyer, and Jessica Sweeb for providing additional invaluable editorial assistance with this issue. The *Annals* members deserve recognition for their hard work, dedication and well-thought articles. Lastly, we must thank the Beazley Institute for Health Law and Policy and our faculty advisors, Professor Lawrence Singer, Megan Bess, and Kristin Finn for their guidance and support.

We hope you enjoy this issue of *Advance Directive.*

Sincerely,

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Legal Interventions For Alleviating Food Insecurity Among Medicaid Populations

Ardag Hajinazarian

INTRODUCTION

Obesity is one of the largest public health concerns plaguing this country.[1] Obesity-related health conditions like heart disease, stroke, type two diabetes, and certain cancers, are some of the leading causes of preventable, premature death in the United States.[2] In 2015 - 2016, the Centers for Disease Control and Prevention (CDC) estimated that obesity was prevalent in 39.8 percent of all Americans, and affected roughly 93.3 million US adults.[3] Consequently, the federal government spends approximately $91.6 billion annually to treat Medicaid and Medicare patients with obesity-related health conditions, costing state Medicaid programs almost $8 billion a year.[4] Individuals who do not regularly consume healthy foods such as fruits and vegetables rely more on convenience foods that are laden with sugar and fat for their dietary intake.[5] A diet consitsting of convenience foods tends to result in caloric overconsumption and the health conditions that subsequently

[1] *Adult Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/obesity/data/adult.html (last updated Aug. 13, 2018).
[2] *Id*.
[3] *Id.*
[4] *Medicare, Medicaid, and CHIP*, THE STATE OF OBESITY (Aug. 2018), https://stateofobesity.org/policy/medicaid-medicare.
[5] Dorotea Sotirovska & Elizabeth Philip, *Why Eating Healthy is so Expensive in America,* VOX (Mar. 22, 2018, 1:30 PM), https://www.vox.com/videos/2018/3/22/17152460/healthy-eating-expensive; *See* Thomas A. Brunner et al., *Convenience Food Producrs. Drivers For Consumption*. APPETITE 55 (2010) (defining convenience foods as food products that help consumers minimize time, the physical and mental effort required for food preparation, consumption, and cleanup, at 498).

follow.[6] Food-insecure and low-income individuals are particularly susceptible to obesity-related health conditions because of poor dietary intake.[7]

A specific population that is adversely affected by food insecurity is the Medicaid population.[8] Food insecurity disproportionately impacts many individuals who qualify for Medicaid because they typically lack the physical or financial means to afford a healthier diet.[9] Lawyers have the ability to act as a conduit for public health officials to enact change in alleviating food insecurity.[10] By working with local policy makers and properly educating community leaders on the long-term benefits of a healthier diet, lawyers can have a tangible effect on the millions of Medicaid individuals currently dealing with food insecurity.[11]

This article will discuss legal interventions lawyers can advocate for to address the ongoing issue of food insecurity in this country. It will first address legal interventions that improve affordability of fresh fruits and

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[6] *See generally* Heather Hartline-Grafton, *Understanding the Connections: Food Insecurity and Obesity*, FOOD RES. AND ACTION CTR. (Oct. 2015), http://frac.org/wp-content/uploads/frac_brief_understanding_the_connections.pdf (discussing relevant findings linking food insecurity to poor health outcomes) [hereinafter Hartline-Grafton *Understanding the Connections*].

[7] Heather Hartline-Grafton, *The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being*, FOOD RES. & ACTION CTR., at 6 (Dec. 2017), http://www.frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf [hereinafter Hartline-Grafton *Impact of Poverty*]; *Facts & Statistics,* U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.hhs.gov/fitness/resource-center/facts-and-statistics/index.html (defining food insecurity as "a limited availability to safe and nutritionally adequate foods.")

[8] *Facts and Statistics*, *supra* note 7, at 2.

[9] *Key Statistics and Graphs*, U.S. DEP'T OF AGRIC. ECON. RES. SERV., https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#insecure (last updated Sept. 5, 2018).

[10] *See Improving Food in the Neighborhood,* HARVARD T.H CHAN SCH. OF PUB. HEALTH, https://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/food-environment/supermarkets-food-retail-farmers-markets/#ref4 (last visited Nov. 3, 2018) (discussing various interventions and recommendations for communities interested in alleviating food access issues) [hereinafter *Improving Food in the Neighborhood*].

[11] *Id.*

vegetables, namely through re-structuring federal farming subsidies and federal nutrition-assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP). Next, the article will focus on interventions that improve accessibility to fresh food, namely by expanding local zoning ordinances and improving public transportation routes to ensure that low-income populations can obtain a healthier diet with less barriers preventing them to do so.

Lawyers have a unique contributive role in society as mediators between policy makers and those working in the community. Grounded in ethical principles of advocating for those unable to represent themselves, lawyers are in an ideal position to implement systemic change. In addition, given food insecurity's wide-sweeping impact on the healthcare industry, lawyers must act now before rising costs cripple the U.S. healthcare system.[12] By improving food affordability and accessibility, lawyers can be agents of change and alleviate the effects of food insecurity in Medicaid populations.[13]

I. FOOD AFFORDABILITY

In the United States, fresh produce has historically been more expensive to purchase than convenience foods.[14] Convenience foods are generally less expensive because farmers receive government subsidies for cultivating crops that are basic ingredients in those foods, such as corn, wheat, and soy.[15] This practice has led to a mass-production of convenience foods that are higher in calories, lower in nutritional value, and cheaper for consumers.[16] A study from the University of Washington suggested that a 2,000-calorie diet could cost as low as $3.52 a day if comprised of higher-calorie convenience

[12] *Adult Obesity*, *supra* note 1, at 1.
[13] *Id*.
[14] Sotirovska & Philip, *supra* note 5, at 1.
[15] Sotirovska & Philip, *supra* note 5, at 1.
[16] Sotirovska & Philip, *supra* note 5, at 1.

foods; compared to a cost of $36.32 a day for a 2,000-calorie diet consisting of low-calorie nutritious foods.[17] The average American spends roughly $7 a day on food, whereas low-income individuals spend about $4 a day.[18] These findings suggest the affordability of higher-calorie convenience foods is a primary driver for dietary decisions made among low-income populations.[19] Lawyers can ensure that Medicaid populations can more easily afford fresh fruits and vegetables by driving down the cost of these foods through modified USDA subsidies.[20] Lawyers can further advocate for the federal government to utilize SNAP to influence beneficiaries in choosing healthier food options over convenience foods.[21] With these interventions, lawyers can directly impact the affordability of fresh fruits and vegetables and make them more affordable to Medicaid populations.[22]

The Agricultural Act of 2014 created two new policies, Price Loss Coverage (PLC) and Agriculture Risk Coverage (ARC), to subsidize farmers and manage financial risk.[23] These subsidies are given based on a variety of factors including crop type, crop prices, acreage, and farm revenue.[24]

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[17] Tara Parker-Pope, *A High Price for Healthy Food,* N.Y. TIMES (Dec. 5, 2007), https://well.blogs.nytimes.com/2007/12/05/a-high-price-for-healthy-food/.
[18] *Id.*
[19] *Id.*
[20] *See* Scott Fields, *The Fat of the Land: Do Agricultural Subsidies Foster Poor Health?*, 112 ENV. HEALTH PERSPECTIVES A820, A820 – 23 (2004) (discussing the impacts that farming subsidies have on compelling farmers to grow primarily corn, wheat, and soy).
[21] *See* Andrew P. Black et al., *Food Subsidy Programs and The Health and Nutritional Status of Disadvantaged Families In High Income Countries: A Systematic Review*, 12 BMC PUB. HEALTH 1099, 1-24 (2012) (finding that food subsidy programs for pregnant women and children should aim to improve nutritional status in the longer term).
[22] *Improving Food In The Neighborhood*, *supra* note 10, at 1.
[23] *Crop Commodity Programs*, U.S. DEP'T OF AGRIC. ECON. RES. SERV., https://www.ers.usda.gov/agricultural-act-of-2014-highlights-and-implications/crop-commodity-programs/ (last updated May 1, 2017) (defining PLC's as payments provided to producers with base acres of wheat, feed grains, rice, oilseeds, peanuts, and other covered commodities on a commodity-to-commodity basis when market prices fall below the reference price as listen in the 2014 Farm Act, and defining ARC's as payments provided to producers on a commodity-to-commodity basis when the farm's revenue falls below a certain county-based or individual-farm-based benchmark).
[24] *Id.*

Subsidies that insure against farmers' financial loss is a sound approach to incentivizing farmers to continue growing vital crops and deterring farmers from entering more lucrative lines of business.[25] However in practice, the farm-subsidy system only benefits large agricultural producers with a median farm household income of $347,000 and $842,000, and not small family farms.[26] Large-scale farms make up 2.9 percent of all farms in the United States, yet receive over one- third of commodity payments (35 percent) and almost half of crop insurance indemnities (46 percent).[27] In addition, 94 percent of farm support subsidies go to farms producing just six crops: corn, cotton, peanuts, rice, soybeans, and wheat.[28] By incentivizing the production of these specific crops, the government has encouraged farmers to over-produce them.[29] This consequently allows manufacturers to inexpensively produce byproducts such as ethanol, high-fructose corn syrup, soybean oil, and animal feed.[30] Meanwhile, prices for nutritional fresh fruits and vegetables are expected to increase by 2.0 to 3.0 percent and 2.5 to 3.5 percent respectively, by the year 2019.[31]

If USDA subsidies were modified to provide more money to small family farms growing fresh fruits and vegetables, small family farmers would feel more financial security growing a more diverse array of crops and selling

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[25] Daren Bakst, *What You Should Know About Who Receives Farm Subsidies,* THE HERITAGE FOUND. (Apr. 16, 2018), https://www.heritage.org/agriculture/report/what-you-should-know-about-who-receives-farm-subsidies.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *See Soy and Corn: Healthy Choices or Hidden Ingredients?!,* CO+OP STRONGER TOGETHER, https://www.strongertogether.coop/fresh-from-the-source/soy-and-corn-healthy-choices-or-hidden-ingredients (last visited Nov. 3, 2018) (explaining that corn and soy derivatives, ingredients made from soy and corn, are used as "filler" in food production and provide very little nutritional value).
[30] *Id*.
[31] *Summary Findings: Food Price Outlook, 2018-19,* U.S. DEP'T OF AGRIC. ECON. RES. SERV., https://www.ers.usda.gov/data-products/food-price-outlook/summary-findings.aspx (last updated Sept. 25, 2018).

them at lower prices.[32] Incentivising the production of more fruits and vegetables could also lead to larger-scale farms including these crops in their annual harvests.[33] The USDA could further subsidize those selling their crops in food deserts,[34] for similar reasons. If financial incentives can drive change from the perspective of food producers, similar approaches may be successful for food consumers as well.[35]

A systematic review of federally subsidized nutrition-assistance programs found a positive correlation between qualifying for the program and improved nutritional intake.[36] Recipients of nutrition-assistance subsidies increased their targeted foods and nutrients consumption by 10-20 percent once qualifying for the programs.[37] Further expansions of these programs can lead to individuals consuming healthier foods as these foods become more affordable to lower-income Medicaid populations.[38]

SNAP, commonly known as food stamps, provides nutrition assistance benefits to about 46.5 million low-income individuals and families, or 14.5 percent of the American population.[39] The USDA reported that SNAP

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[32] Fields, *supra* note 20, at A823.
[33] Fields, *supra* note 20, at A823.
[34] The CDC defines food deserts as "areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet." A food desert is also commonly defined as "an area that is more than one mile away from a supermarket." *A Look Inside Food Deserts,* CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/features/fooddeserts/index.html (last updated Aug. 21, 2017); *Facts and Statistics, supra* note **Error! Bookmark not defined.**, at 2.
[35] Black et al., *supra* note 21, at 22.
[36] Black et al., *supra* note 21, at 1.
[37] Black et al., *supra* note 21, at 1.
[38] Kevin Concannon, Agriculture Undersecretary for Food, Nutrition and Consumer Services, stated, "[t]he results of this study reinforce the critical role of USDA programs designed to increase access to healthy foods and nutrition education among low-income children and families to help make the healthy choice, an easy choice." *New Research Shows Supplemental Nutrition Assistance Program Supports Healthy Diet Choices Among Participants*, U.S. DEP'T OF AGRIC. FOOD AND NUTRITION SERV., https://www.fns.usda.gov/pressrelease/2013/fns-000713 (last modified Aug. 10, 2018).
[39] Maria Godoy, *How America's Wealth Gap Shows Up on Our Dinner Plates,* NAT'L PUB. RADIO (Sep. 18, 2015, 12:59 PM),

participants were 23 percent more likely to consume whole fruit when they received SNAP benefits as opposed to when they did not.[40] SNAP provides many Americans with access to fresh food; however, this is offset by the fact that many utilizers of SNAP still cannot afford to consume a healthy diet.[41] It is estimated that a family of four would still need to spend an additional $600 a month to eat a healthy diet of fresh produce, grains, meat, and dairy.[42] This is an amount many SNAP recipients simply cannot afford.[43] In addition, a 2010 study completed by the Harvard School of Public Health found obesity rates among SNAP participants were 30 percent higher than non-participants.[44] Reorganizing the structure of how SNAP operates would have a noticeably positive effect on its recipients.[45]

Allowing benefits to arrive weekly, including USDA suggestions on how much participants should budget for produce, and providing small financial incentives for choosing to purchase healthier foods, can influence SNAP recipient behavior by reinforcing healthier eating habits.[46] Such changes, alongside restructured USDA farming subsidies, would have a demonstrable effect on food choices by making healthier food a more affordable option than the convenience foods many recipients currently rely on.[47] As healthier food consumption increases, Medicaid costs associated with treating obesity-

https://www.npr.org/sections/thesalt/2015/09/18/441143723/people-on-food-stamps-eat-less-nutritious-food-than-everyone-else.

[40] *New Research Shows Supplemental Nutrition Assistance Program Supports Healthy Diet Choices Among Participants*, *supra* note 38.

[41] Lindsey Haynes-Maslow, *Low-Income Americans on SNAP Still Can't Afford to Eat Healthy,* CIVIL EATS (July 20, 2018), https://civileats.com/2018/07/20/low-income-americans-on-snap-still-cant-afford-to-eat-healthy/.

[42] *Id.*

[43] *Id*.

[44] *SNAP and Obesity: The Facts and Fictions of SNAP Nutrition,* SNAP TO HEALTH!, https://www.snaptohealth.org/snap/snap-and-obesity-the-facts-and-fictions-of-snap-nutrition/ (last visited Nov. 4, 2018) [hereinafter *SNAP and Obesity*].

[45] Black et al., *supra* note 21, at 22.

[46] *SNAP and Obesity*, *supra* note 44, at 6.

[47] *SNAP and Obesity*, *supra* note 44, at 6.

related health conditions would dramatically lessen because proper nutrition has proven to lead to more positive health outcomes in improved quality of life and cost savings.[48] The affordability of fresh fruits and vegetables is vital to lessening the effects of food insecurity.[49] Lawyers have the ability to drastically improve food affordability by advocating for these changes to be implemented by federal administrations. Although food accessibility can make fresh food more available, it is essential that the costs of a healthier diet are lessened to alleviate the burdens associated with food insecurity.[50]

II. FOOD ACCESSIBILITY

In 2008, an estimated 49.1 million Americans, including 16.7 million children, experienced food insecurity multiple times throughout the year.[51] By 2010, over 23 million Americans, including 6.5 million children, experienced food insecurity almost every day.[52] Food insecurity is attributable to a myriad of socioeconomic factors including living in areas known as food deserts.[53] Bridging the Gap found that higher-income communities are 14 percent more likely to open grocery stores, 30 percent more likely to welcome farmers' markets, and 11 percent more likely to permit urban agriculture than lower-income communities.[54] As a result, many food insecure individuals live far from a supermarket and do not have

[48] Mary Carey & Sandra Gillespie, *Position of The American Dietic Association: Cost-effectiveness of Medical Nutrition Therapy,* 95 J. OF THE AM. DIETIC ASS'N. 88, 88 – 89 (1995) (discussing how medical nutrition therapy provided by dietetics professionals results in health benefits for the public and reduced health care costs).
[49] *Improving Food In The Neighborhood*, *supra* note 10, at 1.
[50] *SNAP and Obesity*, *supra* note 44, at 6.
[51] *Id.*
[52] *Facts and Statistics, supra* note 7, at 2.
[53] *A Look Inside Food Deserts*, *supra* note 34, at 1.
[54] JF Chriqui et al., *Zoning for Healthy Food Access Varies by Community Income,* BRIDGING THE GAP (Apr. 2012), http://www.bridgingthegapresearch.org/_asset/n5qtpc/btg_food_zoning_final-0612.pdf.

easy access to transportation.[55] Reducing the effects of food deserts and food insecurity is a priority for many organizations such as Feeding America,[56] because of the widespread impact it has on health outcomes in adults and children.[57] Food-insecure individuals have higher healthcare utilization, spending $1,863 more in health care expenditures a year than those who have access to fresh food.[58] This is because food-insecure individuals have a 32 percent higher chance of being obese.[59] Measures must be taken in order to alleviate this burden and make fresh food more accessible for those living in food deserts. Utilizing local zoning ordinances and improving financial incentives for food retailers must be used in conjunction with improved public transportation routes to increase access to grocery stores and farmers' markets in food deserts.[60]

Zoning ordinances regulate the use of real property by restricting particular territories for residential, commercial, industrial, or other uses.[61] To address food insecurity, municipalities can utilize zoning ordinances to facilitate changes to the current environment that may increase access to healthy foods.[62] For example, implementing zoning ordinances that

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[55] Hartline-Grafton *Understanding the Connections, supra* note 6, at 3.
[56] *See About Feeding* America, FEEDING AMERICA, https://www.feedingamerica.org/about-us (last visited Dec. 4, 2018) (explaining that Feeding America is the largest hunger-relief organization in the United States with a network of more than 200 food banks feeding over 46 million people nationwide).
[57] *See* Diana F. Jyoti et al., *Food Insecurity Affects School Children's Academic Performance, Weight Gain, and Social Skills*, 135 THE J. OF NUTRITION 2831, 2838 (2005) (finding "strong empirical evidence link[ing] food insecurity with developmental consequences for school-aged children, particularly impair[ing] social skills development and reading performance for girls"); *Understanding Hunger and Food Insecurity*, FEEDING AMERICA, http://www.feedingamerica.org/hunger-in-america/food-insecurity.html (last visited Nov. 4, 2018).
[58] Hartline-Grafton *Impact of Poverty*, *supra* note 7, at 5.
[59] Hartline-Grafton *Understanding the Connections, supra* note 6, at 2.
[60] *Improving Food In The Neighborhood*, *supra* note 10, at 2.
[61] Vill. of Euclid, Ohio v. Ambler Realty Co., 47 U.S. 114, 119 (1926).
[62] Maryam Abdul-Kareem et al., *Using Zoning to Create Healthy Food Environments in Baltimore City,* JOHNS HOPKINS URB. HEALTH INST. (Dec. 2009), http://urbanhealth.jhu.edu/_pdfs/hbr_index_food/baltimorecity_2010_zoningcreatinghealthyfoodenvironments.pdf.

designate parcels of land solely for grocery stores can improve access to fresh fruits and vegetables in areas currently considered food deserts.[63] These changes would be considered a constitutional extension of police power as long as the restrictions are not clearly arbitrary, unreasonable, and without substantial relation to public health, safety, morals, or general welfare.[64]

Restructuring zoning ordinances has been a successful intervention for public health issues in the past.[65] In the mid-1980s, California cities passed zoning laws limiting alcohol availability in response to the high rates of liver cirrhosis, motor vehicle crashes, and violence in the community.[66] These zoning laws restricted the density and location of alcohol retailers and were later upheld in California courts as a lawful extension of the state police power.[67] As an intervention that has proven successful in the past, restructuring zoning laws is a practicable long-term solution to combat the detrimental public health impact of living in food deserts.[68] Local officials can restructure zoning ordinances to allow supermarkets and other food producers to enter food deserts and alleviate the stress of food insecurity by making fresh food more accessible.[69] Localities can further offer financial incentives to food retailers.[70] These include discounted land, expedited and reduced costs for permits, discounts on utilities, and/or offering credits or abatements on state and local taxes to offset hesitation regarding financial viability and place food markets in areas considered unprofitable.[71]

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[63] *Id*.
[64] Vill. of Euclid, Ohio v. Amber Realty, *supra* note 61, at 121.
[65] Julie Samia Mair et al., *Fast Food Outlets: A Potential Strategy To Combat Obesity*, THE CTR. FOR L. & THE PUB.'S HEALTH AT JOHNS HOPKINS & GEO. U.S, (Oct. 2005), at 4.
[66] *Id.* at 1.
[67] *Id*.
[68] *Id*, at 4.
[69] *Improving Food in the Neighborhood*, *supra* note 10, at 1.
[70] Maggie Turek, *Increasing Access To Health Foods: Grocery Stores and Mobile Markets,* HEALTH CARE FOUND. OF GREATER KANSAS CITY (2016), https://hcfgkc.org/wp-content/uploads/2017/09/7_20-HCF_GroceryStoresMobileMarkets.pdf.
[71] *Id*, at 2.

While restructuring zoning ordinances may be a long-term approach to alleviating food insecurity and increasing food access in food deserts, improving public transportation is a viable short-term solution as well.[72] In general, low-income populations face transportation barriers, which is often cited as a major barrier to health care access.[73] In 25 separate studies, anywhere from 10 to 51 percent of patients in poorer populations reported that transportation was a barrier to health care access.[74] Low-income individuals in urban areas, although physically closer to a doctor or hospital, still report difficulty obtaining reliable transportation.[75] This is because many households either do not have a vehicle, or must share one between family members.[76] A 2013 review published in the *Journal of Community Health* found that roughly 25 percent of lower-income patients have missed or rescheduled a doctor's appointments because of a lack of transportation.[77] This translates to 3.6 million Americans missing or delaying non-emergency and preventive medical care each year because of transportation problems.[78] These transportation barriers follow low-income individuals when trying to purchase food on a daily basis.[79]

A study in Melbourne, Australia found that residents in the nearby City of

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[72] Hartline-Grafton *Understanding the Connections*, *supra* note 6, at 3.
[73] Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. OF COMMUNITY HEALTH 976, 976 – 93 (2013) (discussing transportation barriers to health care access for primary and chronic disease care).
[74] *Id.*
[75] Imran Cronk, *The Transportation Barrier,* THE ATLANTIC (Aug. 9, 2015), https://www.theatlantic.com/health/archive/2015/08/the-transportation-barrier/399728/.
[76] *Id.*
[77] *Id.*
[78] JoNel Aleccia & Heidi de Marco, *No Car, No Care? Medicaid Transportation At Risk In Some States,* WASHINGTON POST (Jan. 30, 2018), https://www.washingtonpost.com/national/health-science/no-car-no-care-medicaid-transportation-at-risk-in-some-states/2018/01/30/7e5e52d6-05a6-11e8-aa61-f3391373867e_story.html?utm_term=.754baf0deeea.
[79] *Mayors' Guide To Fighting Childhood Obesity,* THE U.S. CONF. OF MAYORS, https://www.sophe.org/wp-content/uploads/2017/01/guide-200908.pdf (last visited Nov. 4, 2018).

Casey had proper access to healthy food if the resident owned a car.[80] As many on Medicaid struggle with reliable transportation,[81] this study is difficult to apply in the U.S. The lack of supermarkets in food deserts forces shoppers to take multiple buses or pay for expensive taxis to reach supermarkets in another part of town.[82] Lack of transportation prompts infrequent shopping trips, inabilities to purchase fresh food with a shorter shelf life, and inabilities to buy in bulk, as shoppers must carry their groceries back home.[83]

Providing more effective public transportation routes can maximize supermarket access, allowing individuals living with this weekly or monthly predicament to improve their diets without being nearly as inconvenienced. This would alleviate transportation barriers for residents without a car or for those otherwise unable to physically access an outlet that provides fresh fruits and vegetables.[84] Improving public transportation in tandom with restructuring municipal zoning ordinances and creating financial incentives for food retailers, can begin to be reduce the effect of food insecurity among Medicaid-eligible populations.[85] Lawyers are in a unique position to enact these changes as they can act as a conduit between privately owned supermarket chains and local government officials. Once fresh food becomes more accessible, the detrimental health effects of food deserts and food inscurity can begin to improve in the Medicaid population.[86]

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[80] C.M. Burns & A.D. Inglis, *Measuring Food Access In Melbourne: Access To Healthy and Fast Foods By Car, Bus and Foot In An Urban Municipality In Melbourne*, 13 HEALTH & PLACE 877, 887 (2007) (finding that residents living within an 8-10 minute car ride have good access to a healthy diet).
[81] Cronk, *supra* note 76, at 3.
[82] *Mayors' Guide To Fighting Childhood Obesity*, *supra* note 79, at 12.
[83] *Mayors' Guide To Fighting Childhood Obesity*, *supra* note 79, at 12.
[84] *Mayors' Guide To Fighting Childhood Obesity*, *supra* note 79, at 12.
[85] *Improving Food in the Neighborhood*, *supra* note 10, at 2.
[86] *Id*.

CONCLUSION

Obesity-related health conditions continue to take a toll on the U.S. healthcare system and affect a higher percentage of Americans each year.[87] Low-income Medicaid-eligible populations are particularly susceptible to these conditions due to the effects of food insecurity.[88] This has lead to high spending in the healthcare sector as the direct and indirect health-related costs of food insecurity were estimated to be as high as $160 billion in 2014 alone.[89] Improving food affordability and food accessibility would act as preventative measures that would proscribe food-insecure individuals from becoming susceptible to obesity-related health conditions.[90] If these interventions are tied with furthering educational efforts by schools and medical care providers, eating nutritiously can be effectively used to eradicate these conditions altogether.[91]

Currently, much of the Medicaid population is unable to afford and/or access the proper nutrition needed to live a long, healthy life. While clinicians and the public health community must act swiftly in educating this

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[87] *Adult Obesity*, *supra* note 2, at 1.
[88] Hartline-Grafton *Understanding the Connections, supra* note 6, at 2.
[89] Hartline-Grafton *Impact of Poverty*, *supra* note 7, at 5.
[90] Malinda Ellwood et al., FOOD IS MEDICINE: OPPORTUNITIES IN PUBLIC AND PRIVATE HEALTH CARE FOR SUPPORTING NUTRITIONAL COUNSELING AND MEDICALLY-TAILORED, HOME-DELIVERED MEALS at 38 (2014).
[91] *Improving Food in the Neighborhood*, *supra* note 10, at 1; *See generally* Robert Greenwald, *Food as Medicine: The Case for Insurance Coverage for Medically-Tailored Food Under the Affordable Care Act*, CTR. FOR HEALTH LAW AND POL'Y INNOVATION HARVARD L. SCH. (Jan. 2015), https://www.chlpi.org/wp-content/uploads/2013/12/CA-Greenwald-Hunger-Summit-1-26-15.pdf (explaining the benefits involved with a proposed medically tailored food program); *See* David R. Just & Joseph Price, *Using Incentives to Encourage Healthy Eating in Children,* 48 J. OF HUM. RES. 855, 855 – 72 (2013) (discussing that incentives increase the fraction of children eating a serving of fruits or vegetables during lunch by 80 percent and that further expansion of these programs can encourage children to consume more fresh fruits and vegetables while also teaching beneficial nutritional strategies children can use in the future).

population on the benefits of consuming a nutritional diet,[92] lawyers can play a pivotal role in advocating for widespread change.[93] It is in the lawyers' personal charitable mission that they must find the motivation to represent a Medicaid population that cannot advocate for itself. Lawyers must work with policy-makers to introduce measures that make fresh fruits and vegetables more affordable.[94] Lawyers must also bring appropriate parties together and allow them to find solutions that ensure low-income individuals have easier access to fresh produce.[95] While no single solution exists, legal interventions can provide an effective starting point to improving food affordability and accessibility; alleviating the harmful effects of food insecurity among low-income Medicaid-eligible populations.[96]

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[92] *See* Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. OF PUB. HEALTH 590, 592 (2010) (describing the impact of different types of public health interventions and a framework to improve health).
[93] *Improving Food in the Neighborhood*, *supra* note 10, at 1.
[94] *Improving Food in the Neighborhood*, *supra* note 10, at 1.
[95] *Improving Food in the Neighborhood*, *supra* note 10, at 1.
[96] *Improving Food in the Neighborhood*, *supra* note 10, at 1.

Medical Marijuana Access for Medicaid Populations

Alesandra Hlaing

INTRODUCTION

Medicaid beneficiaries are at a high risk of developing opioid addiction through overprescribing and the failure of healthcare providers to effectively implement and monitor pharmaceutical therapies in patients.[1] The Centers for Disease Control (CDC) indicated Medicaid beneficiaries are at a higher risk than non-enrollees, and the Department of Health and Human Services (HHS) concluded that Medicaid beneficiaries are more likely to be prescribed opioids at higher doses, leading to increased risk of addiction.[2] Medical marijuana contributes to many positive health outcomes, and recent studies indicate that medical marijuana may be an appropriate alternative to opioids for pain management without risk of addiction and overdose.[3] In states that have legalized medical marijuana, research demonstrates that there has been

[1] Sara E. Heins et al., *High-Risk Prescribing to Medicaid Enrollees Receiving Opioid Analgesics: Individual- and County-Level Factors*, 53 SUBSTANCE USE & MISUSE 1591, 1597 (2018).
[2] U.S. DEP'T OF HEALTH & HUMAN SERVICES, ADDRESSING PRESCRIPTION DRUG ABUSE IN THE UNITED STATES: CURRENT ACTIVITIES AND FUTURE OPPORTUNITIES, 11 (2013).
[3] *See* Yuyan Shi, *Medical Marijuana Policies and Hospitalizations Related to Marijuana and Opioid Pain Reliever,* 173 DRUG ALCOHOL DEPEND. 144, 144–50 (2017) (showing that in states with medical marijuana laws, there was a reduced incidence in opioid-related hospitalizations); *See also* Bob Roehr, *Cannabinoids Offer Alternatives to Opioids for Pain Relief, Experts Say*, 359 BMJ 5140, 5140 (2017) (demonstrating that medical marijuana may be used as a concurrant treatment with opioids for pain relief while significantly reducing the intake of opioids); *See also* Marcus A. Bachuber et al., *Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States 1999 – 2010,* 174 JAMA INTERN MED. 1668, 1668 – 673 (2014) (indicating that where medical marijuana is legalized, incidence of opioid prescriptions decreased)

a decrease in prescriptions given to Medicaid beneficiaries in care areas that medical marijuana has proven to show effect.[4]

Currently, thirty-one states have implemented some form of medical marijuana law in order to allow access to its health benefits.[5] However, there are many hurdles that must be overcome in order for medical marijuana to become more accessible to Medicaid populations. Despite these challenges, policymakers must work towards easier access to medical marijuana as an alternative treatment to opioids for pain treatment in Medicaid populations. In order to accomplish this goal, it is imperative that policymakers not only increase the number of entities allowed to cultivate and distribute marijuana for research and remedial purposes but also through reclassifying marijuana from a Schedule I drug to Schedule II. This article will examine the benefits, challenges, and current trends in reclassification. Part I of this article provides background and discusses the risks associated with the Medicaid population in regard to opioid addiction and overdose.[6] Part II addresses the clinical benefits of medical marijuana and the research indicating its benefit in combatting the opioid epidemic.[7] Part III addresses the challenges providers and patients face due to the various laws and regulations surrounding marijuana as a treatment.[8] Part IV examines potential federal efforts being made to expand access to research and supply of medical marijuana, and Part V analyzes policy solutions and the barriers to those solutions.[9]

I. THE RISK OF OPIOID ADDICTION IN MEDICAID POPULATIONS

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[4]Ashley C. Bradford & W. David Bradford, *Medical Marijuana Laws May Be Associated With a Decline in the Number of Prescriptions For Medicaid non-*, 36 HEALTH AFF. 945, 945 – 948 (2017).
[5]*State Medical Marijuana Laws,* NAT'L CONFERENCE OF STATE LEGISLATURES (Jun. 27, 2018), http://www.ncsl.org/research/health/state-medical-marijuana-laws.asp
[6] *See generally infra* Part I.
[7] *See generally infra* Part II.
[8] *See generally infra* Part III.
[9] *See generally infra* Part IV; *infra* Part V.

In 2017, the Department of Health and Human Services declared the opioid epidemic a nationwide public health emergency due to its substantially negative effects on communities throughout the United States.[10] In 2016 alone, 11 million Americans misused prescription opioids and 2.1 million Americans had an opioid use disorder, with the risk of opioid-related deaths continuing to rise.[11] The Centers for Disease Control and Prevention ("CDC") considers Medicaid beneficiaries to be at a high risk of opioid overdose and opioid-related death.[12] Medicaid beneficaries have higher rates of opioid use disorder, with Medicaid beneficaries comprising twenty-five percent of the overall population with opioid use disorder.[13] Socioeconomic factors, including poverty and unemployment, are known risk factors of individuals with opioid use disorders.[14] Medicaid spends roughly $9.4 billion on care and services for beneficiaries with opioid addiction, and as of 2015, covers three in ten individuals with opioid addiction.[15] These high rates of opioid use disorder coupled with the steep costs of care and services demonstrate why there must be reform in access to medical marijuana in Medicaid populations through reclassification.

Multiple state-based studies of local Medicaid populations indicate that

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[10] *Testimony from Brett P. Giroir & Kimberly Brandt on Tracking Opioid and Substance Use Disorders in Medicare Medicaid, and Human Services Programs before Committee on Finance,* DEP'T HEALTH & HUMAN SVCS. (Apr 19, 2018), https://www.hhs.gov/about/agencies/asl/testimony/2018-04/tracking-opioid-and-substance-use-disorders-medicare-medicaid-hhs-programs.html#.

[11] *Id.*

[12] Ctrs. for Disease Control & Prevention, *CDC Grand Rounds: Prescription Drug Overdoses — A U.S. Epidemic*, 61 MORBIDITY & MORTALITY WKLY. REP. 1, 10 (2012).

[13] MEDICAID & CHIP PAYMENT AND ACCESS COMMISSION, REPORT TO CONGRESS ON MEDICAID AND CHIP, CHAPTER 2, MEDICAID AND THE OPIOID EPIDEMIC (June 2017).

[14] *How Opioid Addiction Occurs*, MAYO CLINIC (Feb. 16, 2018), https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372.

[15] Katherine Young & Julia Zur, *Medicaid and the Opioid Epidemic: Enrollment, Spending, and the Implications of Proposed Policy Changes*, THE HENRY J. KAISER FAMILY FOUND. (Jul. 14, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-and-the-opioid-epidemic-enrollment-spending-and-the-implications-of-proposed-policy-changes/.

the mortality rate in prescription overdose deaths is eight times higher for Medicaid beneficaries than non-enrollees.[16] Medicaid beneficaries have higher rates of mental health and substance abuse disorders than the general population and are more likely to be on treatment for pain-management.[17] The Department of Health and Human Services further concludes that Medicaid beneficiaries are more likely to be prescribed opioids for longer durations than non-enrollees.[18] In addition to long-term use, Medicaid benefciaries have higher rates of high-risk prescribing of opioids in comparison to non-enrollees.[19] A 2018 study concluded that high-risk prescribing occurred in 39.4 percent of Medicaid beneficiaries engaged in opioid-related treatment.[20] With the growing awareness of Medicaid beneficiaries being an at-risk population, marijuana as an alternative treatment option for pain management must not only be explored and researched, but must be rescheduled to allow for proper medical use.

II. Medical Marijuana as an Alternative Pain Treatment

In order to combat the prevalence of opioid abuse and addiction in the Medicaid population, policymakers must explore new alternatives to reduce or replace the use of opioids for pain treatment. Certain studies have identified marijuana as a possible nonopioid alternative that can help treat

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[16] Timothy Pham et al., *Overview of Prescription Opioid Deaths in the Oklahoma State Medicaid Population, 2012–2016*, 56 Medical Care 727, 728 (2018).
[17] *Id.*
[18] U.S. Dep't of Health & Human Svcs, Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities 11 (2013).
[19] Heins et al., *supra* note 1, at 1597 (defining high-risk prescribing as prescriptions of high doses or a variety of opioids being prescribed concurrently. High-risk prescribing increases the risk of opioid-related mortality due to increased heightened risk of addiction from continued use).
[20] Heins et al., *supra* note 1, at 1593.

pain at reduced risk of addiction and overdose.[21] Specifically, medical marijuana has been shown to work best for neuropathic pain, which is more common in psychiatric patients who may be at higher risk of opioid addiction.[22] Opioids and cannabinoids, a compound found in marijuana, work similarly to relieve pain through a reduction of stress reactivity and an increase in dopamine.[23] Additionally, medical marijuana has been shown to have a synergistic effect on opioids, which greatly enhances the potency of the opioid for pain relief, but in much lower doses.[24] By utilizing marijuana as an alternative by either complete replacement or in combination with opioids, individuals are at less risk to misuse opioids or develop an opioid abuse disorder.[25] For these reasons it is necessary that we open up research to better utilize these cures. Despite the challenges of researching marijuana, the conclusions of researchers strongly implies that marijuana is a viable alternative and barriers to access must be removed.

In addition to the clinical benefit of medical marijuana as an alternative therapeutic treatment, the implementation of medical marijuana laws is beneficial to medicine. Medical marijuana laws have positive effects on reducing opioid-related deaths and hospitalizations.[26] A JAMA Internal Medicine study concluded medical marijuana laws were associated with

[21] Heifei Wen & Jason M. Hockleberry, *Association of Medical and Adult-Use Marijuana Laws with Opioid Prescribing for Medicaid Enrollees,* 178 JAMA INTERN MED. 673, 673 (2018).
[22] Marie J. Hayes & Mark S. Brown, *Legalization of Medical Marijuana and Incidence of Opioid Mortality*, 174 JAMA INTNL. MED. 1673, 1674 (2014).
[23] *Id.*
[24] Bob Roehr, *supra* note 3, at 5140.
[25] Bob Roehr, *supra* note 3, at 5140.
[26] Marcus A. Bachuber et al., *supra* note 3*; see also* Yuyan Shi, *Medical Marijuana Policies and Hospitalizations Related to Marijuana and Opioid Pain Reliever,* 173 DRUG ALCOHOL DEPEND. 144, 144 – 50 (2017) (demonstrating that states with medical marijuana laws compared with states without medical marijuana laws had a lower opioid analgesic overdose mortality rate).

lower opioid prescribing rates and spending in Medicaid populations.[27] A Health Affairs study analyzed prescribing behaviors to Medicaid beneficiaries in clinical areas where research has shown medical marijuana may be a potential alternative.[28] The study concluded there was a reduction of overall prescriptions in areas where marijuana is an alternative, indicating both physicians and patients consider medical marijuana as a form of alternative medicine.[29] With providers proving to be more receptive to using this method of treatment, it is imperative that the challenges to prescribing be alleviated for Medicaid populations at risk.

III. MEDICAID CHALLENGES TO USE OF MEDICINAL MARIJUANA

Despite the clinical benefit of medical marijuana and the growing number of state medical marijuana laws, access to medical marijuana faces many challenges for providers who wish to use it as an alternative treatment for pain relief. Under the Controlled Substances Act of 1970, marijuana is classified as a Schedule I drug.[30] Under this Act, Schedule I substances are those with a high potential for abuse, are not currently accepted medical use in treatment, and have a lack of accepted safety for use of the substance under medical supervision.[31] Schedule I drugs may not be "prescribed, administered, or dispensed for medical use."[32] Due to accreditation through the Centers for Medicare & Medicaid Services, hospitals can face penalties, lose federal funding, and/or be excluded from participation by allowing

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[27] Bradford & Bradford, *supra* note 4, at 949 (estimating that if all states had medical marijuana laws, the reduction in Medicaid spending would be $3.89 billion annually).
[28] Bradford & Bradford, *supra* note 4 (Analyzing the reductions in spending on prescription drugs approved by the FDA in nine clinical areas, including anxiety, depression, glaucoma, nausea, pain, psychosis, seizure disorders, sleep disorders, and spasticity).
[29] Bradford & Bradford, *supra* note 4, at 949.
[30] Controlled Substances Act, 21 U.S.C. §1308.11 (1971).
[31] Controlled Substances Act, 21 U.S.C. §812(b)(1) (1971).
[32] DRUG ENFORCEMENT AGENCY, OFFICE OF DIVERSION CONTROL, PRACTITIONER'S MANUAL §2 (2006).

patients to use medical marijuana.[33] Though physicians may recommend marijuana as a treatment, patients may not bring their own supply into hospitals because hospitals are required to monitor outside substances and medications that are brought into the hospital for use.[34]

For Medicaid beneficiaries, this inability to be prescribed medical marijuana due to its schedule substantially limits the possibility of accessing marijuana's benefits. In addition to provider concerns for the practical use of medical marijuana, patients face steep out-of-pocket expenses for the treatment.[35] For Medicaid beneficiaries, providers must certify they are in compliance with all state and federal law when billing for services.[36] Due to its Schedule I status, the federal government will not allow Medicaid to cover medical marijuana for its beneficiaries.[37] The cost of medical marijuana may be too steep for patients seeking to use its benefits, especially when the less expensive opioid medications are covered under Medicaid.[38] Not including the cost of the product itself, patients seeking to get a referral from a new physician may pay anywhere from $100 to $450 for the initial appointment alone, which is unlikely to be covered by any type of insurance.[39] Without rescheduling marijuana to validate its medical use, Medicaid populations will

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[33] Laura M. Borgelt & Kari L. Franson, *Considerations for Hospital Policies Regarding Medical Cannabis Use*, 52 HOSP. PHARM. 89, 89 (2017).
[34] *Id.*
[35] *See* Ty Russell, *Out-of-Pocket Costs for Medical Marijuana Mounts for Patients,* ABC (Aug. 29, 2018), https://www.wftv.com/news/local/out-of-pocket-costs-for-medical-marijuana-mounts-for-patients/823272514 (discussing an epilepsy patient required to pay $700 a month for medical marijuana due to lack of insurance coverage for the treatment)
[36] Condition of Participation: Compliance with Federal, State and Local Laws and Regulations, 42 C.F.R. § 485.608 (2011).
[37] DRUG ENFORCEMENT AGENCY, *supra* note 32 (stating that Schedule I drugs may not be prescribed for medical use).
[38] *See* Sarah Gantz, *Medical Marijuana Costs Too Much for PA Mom Who Fought For Her Daughter's Epilepsy Treatment,* THE INQUIRER (Aug. 29. 2018), http://www2.philly.com/philly/health/health-costs/medical-marijuana-cost-pennsylvania-new-jersey-discounts-epilepsy-20180829.html ("So many patients have been impoverished by their illness — they may be on Social Security and surviving on $15,000 a year. To spend that amount of money for medical marijuana really becomes an unworkable situation.").
[39] *Id.*

have virtually no way to reasonably access the medication for pain treatment.

Currently, the Food and Drug Administration (FDA) has not approved marijuana as a safe and effective drug for clinical use.[40] The FDA states that it supports formal medical marijuana research through the agency's drug review and approval process.[41] However, this process involves a series of review processes through multiple agencies on both a federal and state level.[42] In order for the FDA to approve a new drug, the FDA must receive and review an investigational new drug (IND) application.[43] In the IND, the investigator must lay out the protocol describing the proposed studies and the qualifications of the proposed investigators.[44] The FDA must ensure that the IND's clinical trials will be conducted appropriately and that these trials will produce acceptable scientific data in order for FDA to make a decision on its approval.[45]

However, an investigator looking into researching medical marijuana must concurrently receive authorization from both the National Institute on Drug Abuse (NIDA) as well as the U.S. Drug Enforcement Administration (DEA), and in some cases, may even have to apply for state-specific restrictions on research due to marijuana's Schedule I status.[46] This process has proven extraordinarily challenging for researchers who have been discouraged from pursuing medical marijuana research due to the layers of

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[40] *FDA and Marijuana*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/newsevents/publichealthfocus/ucm421163.htm.
[41] *Id.*
[42] NAT'L ACAD. OF SCIENCES, ENGINEERING, & MEDICINE , THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS 378 (2007).
[43] FOOD & DRUG ADMIN., INVESTIGATIONAL NEW DRUG (IND) APPLICATION, https://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvalapplications/investigationalnewdrugindapplication/default.htm (last updated Oct. 5, 2017).
[44] *Id.*
[45] *Id.*
[46] *See* NAT'L ACADEMIES OF SCIENCE, ENGINEERING, & MEDICINE, *supra* note 42.

complications that marijuana's Schedule I status brings to the process.[47] Daniel Friedman, an NYU neurologist who went through process described his struggle, stating, "all that infrastructure makes it prohibitive to do studies in other conditions by people who may want to do so, but don't have the resources."[48] Currently, the only way to access marijuana for research purposes is through the NIDA's Drug Supply Program.[49] NIDA's sole source of marijuana for research purposes is from the University of Mississippi[50], which has limited scope in the variety, quantity, and quality of the marijuana researchers can utilize.[51] Reclassifying marijuana to Schedule II will allow more thorough and expansive research into treatment outcomes, while also benefitting Medicaid populations who need a more accessible alternative non-opioid treatments for pain.

IV. Current Marijuana Policy Reform Climate

Current trends have begun to open doors to medical marijuana policy reform beyond the state level that heavily imply that reclassification of

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[47] See NAT'L ACADEMIES OF SCIENCE, ENGINEERING, & MEDICINE, supra note 42.

[48] Angela Chen, *This Cannabis-Derived Drug Just Got Approved, But That Won't Make it Easier to Get Edibles,* THE VERGE (Oct. 3, 2018), https://www.theverge.com/2018/10/3/17932624/dea-epidiolex-schedule-v-cannabis-marijuana-research-health-policy.

[49] NAT'L INSTITUTE ON DRUG ABUSE, *NIDA's Role in Providing Marijuana for Research*, https://www.drugabuse.gov/drugs-abuse/marijuana/nidas-role-in-providing-marijuana-research; NAT'L ACADEMIES OF SCIENCE, ENGINEERING, & MEDICINE, *supra* note 42.

[50] *See* NAT'L ACADEMIES OF SCIENCE, ENGINEERING, & MEDICINE, *supra* note 42, at 77 (identifying the sole producer of marijuana under contract with NIDA as the University of Mississippi, with limited type and quantity of marijuana available to researchers); *See also* Caleb Hellerman, *Scientists Say the Government's Only Pot Farm Has Moldy Samples — and No Federal Testing Standards,* PBS NEWS HOUR (Mar. 8, 2017), https://www.pbs.org/newshour/nation/scientists-say-governments-pot-farm-moldy-samples-no-guidelines ("There's only one source of marijuana for clinical research in the United States.").

[51] *See* Daniela Vergara et al., *Compromised External Validity: Federally Produced Cannabis Does Not Reflect Legal Market*, SCIENTIFIC REP. 1, 4 – 5 (Apr. 19, 2017) (stating "The cannabinoid levels in NIDA and the state markets differ in several ways. Indeed, THC levels on average in NIDA were 27–35% of those in the state markets, while CBN levels are 11–23 times higher.").

marijuana must occur. In 2016, under the Obama administration, the DEA took steps to implement a process where additional entities could license to become cultivators for medical marijuana research.[52] However, upon the change in administration, Attorney General Jeff Sessions shut down this program in 2017 despite at least twenty-five applications submitted.[53] The Medical Cannabis Research Act of 2018, a bill currently set for Congressional vote, requires the federal government issue more licenses for cultivating marijuana for research purposes.[54] If Congress passes this bill, the NIDA and the University of Mississippi will no longer be the sole provider of marijuana for research purposes as it has been for more than 50 years.[55] Additionally, some barriers researchers face may be alleviated to allow more capability to more accurately research the therapeutic effect of medical marijuana.[56]

Earlier this year, the FDA approved its first marijuana-based drug, Epidiolex, which successfully underwent clinical trials for treatment of epilepsy.[57] Epidiolex is derived from cannabidiol (CBD), which is a chemical component of the Cannabis sativa plant, but does not contain

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[52] Applications To Become Registered Under the Controlled Substances Act to Manufacture Marijuana to Supply Researchers in the United States, 81 Fed. Reg. 53,846 (Aug. 12, 2016) (to be codified at 21 C.F.R. pt. 1301). *See also* NAT'L ACADEMIES OF SCIENCE, ENGINEERING, AND MEDICINE, *supra* note 42, at 78 (stating that the DEA will increase the number of private entities allowing to grow marijuana for research purposes).
[53] Matt Zapotosky & Devlin Barrett, *Justice Department at Odds with DEA on Marijuana Research, MS-13,* WASH. POST (Aug. 15, 2017), https://www.washingtonpost.com/world/national-security/justice-department-at-odds-with-dea-on-marijuana-research-ms-13/2017/08/15/ffa12cd4-7eb9-11e7-a669-b400c5c7e1cc_story.html?utm_term=.20697ef10362.
[54] Medical Cannabis Research Act of 2018, H. R. 5634, 115th Cong. (2018).
[55] Tom Angell, *Marijuana Bill Approved by Congressional Committee, Despite Drug Conviction Restriction Dispute,* FORBES (Sep. 13, 2018), https://www.forbes.com/sites/tomangell/2018/09/13/marijuana-bill-approved-by-congressional-committee-despite-drug-conviction-restriction-dispute/#4d2e04083482.
[56] *Id.*
[57] U.S. FOOD & DRUG ADMIN., *FDA Approves First Drug Comprised of an Active Ingredient Derived from Marijuana to Treat Rare, Severe Forms of Epilepsy* (Jun. 25, 2018), https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm611046.htm.

tetrahydracannibidiol (THC), a primary component of marijuana.[58] Due to this groundbreaking approval, the DEA will soon have to make a scheduling determination in regards to CBD, as this indicates there is now an accepted medical use for CBD.[59] Though this reclassification will likely not apply to all forms of marijuana, DEA officials have expressed that the reclassification will unleash a "sea change" for the marijuana industry as a whole.[60] It is imperative that this smaller step of reclassification serves as a gateway to complete reform in marijauna's reclassification and accepted medical use.

Though there are trends to indicate that marijuana reform may be on the horizon, there may be public concerns of more easily accessible marijuana. Expanding access to marijuana, whether medical or recreational, may lead to increased use by adolescents.[61] Currently, between thirty and forty percent of high school seniors report smoking marijuana within the last year, and opposing parties to marijuana legalization fear that this number could grow with more access.[62] For many, marijuana in the medical market appears to be a "means to access products for recreational, or non-medical use".[63] Some healthcare providers have stepped out in opposition of marijuana reform due to the gaps in current research on medical marijuana and its benefits.[64] Though some providers believe that waiting for the FDA approval process is too slow towards getting patients relief through medical marijuana, not all

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[58] *Id.*
[59] *Id.*
[60] Eric Brodwin, *A Drug Derived from Marijuana has Become the First to Win Federal Approval, and Experts Predict an Avalanche Effect*, BUS. INSIDER (Jun. 25, 2018), https://www.businessinsider.com/marijuana-epilepsy-drug-approved-fda-2018-5.
[61] Judith Grisel, *POT HOLES: Legalizing Marijuana is Fine. But Don't Ignore The Science on Its Dangers,* WASH. POST. (May 25, 2018), https://www.washingtonpost.com/news/posteverything/wp/2018/05/25/feature/legalizing-marijuana-is-fine-but-dont-ignore-the-science-on-its-dangers/?noredirect=on&utm_term=.d2cc77df7634.
[62] *Id.*
[63] Scott Gavura, *Medical Marijuana: Where is The Evidence?*, SCI. BASED MEDICINE (Jan. 11, 2018), https://sciencebasedmedicine.org/medical-marijuana-where-is-the-evidence/.
[64] *Id.*

clinicians are on the same page.[65] As stated by Mary Haag, RN, CEO of PreventionFIRST!,

> “We can't really call marijuana medicine. It's not a legitimate medicine… It needs to go through the FDA process. There is no drug that can or should be smoked, but when we get to potential components of marijuana that might have medicinal benefits, then let's find out what that is."[66]

Haag, like other providers, doesn’t believe the future of medical marijuana should be left to lawmakers or voters without the explicit backing of the FDA.[67] However, the opposition to marijuana reform demonstrates that more research must be conducted to determine the therapeutic benefit of marijuana, and the most effective way to generate that research is through reclassification.

V. NEXT STEPS

With the growing need for alternative treatments to opioids, it is imperative that policymakers take efforts to expand access to research, supply, and funding for medical marijuana. In order to meet these goals, the most effective first step must be the reclassification of marijuana from Schedule I to Schedule II to allow further research in determining marijuana’s therapeutic benefit. Without a Schedule change, large-scale clinical trials continue to face nearly impossible barriers towards becoming

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[65] Todd Dykes, *Should Fate of Medical Marijuana in Ohio be Left in Hands of Lawmakers, Voters?*, NBC (Feb. 19, 2016), https://www.wlwt.com/article/should-fate-of-medical-marijuana-in-ohio-be-left-in-hands-of-lawmakers-voters/3562625 (“Mary Haag is president and CEO of PreventionFirst!, an organization that encourages people throughout Greater Cincinnati to make healthy lifestyle choices.”).
[66] *Id.*
[67] *Id.*

a clinically accepted medication. Congress has continued to introduce bills in support of rescheduling marijuana. In just the 2017–2018 session, Congress introduced nearly fifty marijuana-related bills.[68] In particular, the Compassionate Access, Research Expansion, and Respect States Act of 2015 (CARERS) seeks to offer patient protection in medical marijuana programs and expanded opportunities for research.[69] Among the goals of the Act included rescheduling marijuana from Schedule I to Schedule II and a re-structuring of the licensure registration for researchers who wanted to study marijuana.[70] Through this restructuring, NIDA would no longer have the monopoly on research-grade marijuana.[71]

Similarly, The Medical Cannabis Research Act of 2018 requires the federal government issue more licenses for cultivating marijuana for research purposes.[72] Both of these bills show the importance of providing access to researchers trying to study the therapeutic benefit of marijuana. Policymakers must work to pass bills like the CARERS Act and The Medical Cannabis Research Act of 2018 into the legislature in order to efficiently reclassify marijuana for research purposes.

Alternatively, policymakers could put pressures on the DEA to reschedule marijuana to Schedule II. Under the Controlled Substances Act, the Attorney General has the power to reschedule any drug or other substance if he or she finds, through scientific evidence and other factors, that the drug has a currently accepted medical use or treatment.[73] In order to initiate this

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[68] Melissa Schiller, *Here's the 2017-2018 Federal Legislation That Could Affect Your Cannabis Business*, CANNABIS BUS. TIMES (Jul. 16, 2018), https://www.cannabisbusinesstimes.com/article/2017-2018-federal-legislation-cannabis/.
[69] John Hudak, *Why The CARERS Act Is So Significant For Marijuana Policy Reform*, BROOKINGS INST. (Apr. 13, 2016), https://www.brookings.edu/blog/fixgov/2016/04/13/why-the-carers-act-is-so-significant-for-marijuana-policy-reform/.
[70] *Id.*
[71] *Id.*
[72] Medical Cannabis Research Act of 2018, H. R. 5634, 115th Cong. (2018).
[73] Statute Title, 21 U.S.C. § 811(a) (2012); *see also* Statute Title, 21 U.S.C. § 811 (c)(2)–(3*)* (stating that, when rescheduling a drug, the Attorney General must consider the following

process, and if the Attorney General elects to reschedule a drug, he or she forwards a request for scientific and medical evaluation to the Secretary of HHS.[74] In addition to the Attorney General, the Secretary of HHS or the petition of an interested party may also in some circumstances suffice as a request.[75] The FDA, under HHS, considers the scientific evidence presented, any risk the drug may pose, and other medical considerations.[76] Once this recommendation is complete, the Attorney General reviews the information and initiates the proceedings for the transfer between schedules.[77] Though this is a more demanding process than through the legislature, it has been shown to be a successful process.[78] In 2014, hydrocodone products were rescheduled from Schedule III to Schedule II.[79] Though the process is rigorous, it is necessary to utilize all routes to rescheduling that are available to make medical marijuana accessible to the Medicaid population.

CONCLUSION

Ultimately, the growing support for medical marijuana policy reform further substantiates the need for policymakers to reevaluate the unnecessary burdens placed on marijuana researchers. In the Medicaid population, where

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factors: "(1) Its actual or relative potential for abuse; (2) Scientific evidence of its pharmacological effect, if known; (3) The state of current scientific knowledge regarding the drug or other substance; (4) Its history and current pattern of abuse; (5) The scope, duration, and significance of abuse; (6) What, if any, risk there is to the public health; (7) Its psychic or physiological dependence liability").

[74] John Hudak & Grace Wallack, *How to Reschedule Marijuana, and Why It's Unlikely Anytime Soon*, BROOKINGS INST. (Feb. 13, 2015), https://www.brookings.edu/blog/fixgov/2015/02/13/how-to-reschedule-marijuana-and-why-its-unlikely-anytime-soon/.

[75] U.S. DRUG ENFORCEMENT AGENCY, *DEA To Publish Final Rule Rescheduling Hydrocodone Combination Products* (Aug. 24, 2014), https://www.dea.gov/press-releases/2014/08/21/dea-publish-final-rule-rescheduling-hydrocodone-combination-products.

[76] Hudak & Wallack, *supra* note 74.

[77] Hudak & Wallack, *supra* note 74.

[78] U.S. DRUG ENFORCEMENT AGENCY, *supra* note 75.

[79] U.S. DRUG ENFORCEMENT AGENCY, *supra* note 75.

the risk for opioid-related mortality is higher than in the general population, access to alternative treatment must be made possible. Marijuana must be rescheduled in order to provide coverage for the Medicaid beneficiaries who are unable to receive coverage for this treatment. The continued research on the viability of medical marijuana as an effective alternative to opioids for pain relief supports the need for more formalized research that isn't barricaded by outdated barriers imposed by the federal government. Through reclassification and government-approved clinical research, medical marijuana may serve as a cost effective and safer alternative for Medicaid beneficiaries.

Controlling Crime through Medicaid Expansion: The Convergence of Medicaid and the Criminal Justice System in the Effort to Reduce Re-Incarceration

Arielle McPherson

I. Introduction

A person is usually released from prison or jail with less than 50 dollars to their name, and little help to secure employment, housing, or medical treatment for illnesses or addictions.[1] The lack of transitional support from release to reentry to society contributes to the "revolving door" of recidivism.[2] Approximately 10.6 million individuals cycle through local jails, and roughly 626,000 people are released from prison annually.[3] Of these 10 million, approximately 90 percent are uninsured upon release.[4]

The United States has the highest rate of imprisonment in the world with approximately

[1] Susan K. Gauvey & Katerina M. Georgiev, *Reform in Ex-Offender Reentry: Building Bridges and Shattering Silos*, 44 MD.B.J. 14, 15 (2011).
[2] *Id.*; *See Recidivism*, NAT'L INST. OF JUST. 2014, https://www.nij.gov/topics/corrections/recidivism/Pages/welcome.aspx. (defining recidivism as a person's "relapse into criminal behavior, often after the person receives sanctions or undergoes interventions for a previous crime").
[3] Peter Wagner & Wendy Sawyer, *Mass Incarceration: The Whole Pie 2018*, PRISON POL'Y INITIATIVE (Mar. 24, 2018), https://www.prisonpolicy.org/reports/pie2018.html.
[4] Elizabeth Snyder, *Medicaid and Prisoner Reentry: Suspension Is the New Black*, 26 KAN. J.L. & PUB. POL'Y 84, 88 (2016); *How Medicaid Enrollment of Inmates Facilitates Health Coverage after Release*, THE PEW CHARITABLE TRUSTS 2, https://www.pewtrusts.org/-/media/assets/2015/12/statesfiscalhealth_medicaidcoverageinmatesbrief-(1).pdf (defining jails as "facilities that house inmates awaiting trial and those convicted of misdemeanors who are serving sentences of less than one year." Whereas, prisons "are state (or federal) facilities that incarcerate convicted inmates serving sentences of more than one year").

2.3 million people incarcerated.[5] Behind the crisis of mass incarceration, a public health crisis is unfolding.[6] Compared to the general population, individuals who are incarcerated have disproportionately higher rates of chronic health conditions, infectious diseases, mental illness, substance abuse, and co-occurring substance abuse and mental health disorders.[7] Despite the high rates of illness among prisoners, health care in prisons is disturbingly inadequate.[8] The conditions of confinement inside jails and prisons such as, overcrowding, violence, sexual assault, solitary confinement, and poor medical care are harmful to the physical and mental health of incarcerated individuals.[9] These plaguing conditions can, and do, contribute to recurring criminal behaviors.[10]

Studies show that continuous health care for former prisoners – particularly for those plagued by substance abuse, addiction, and mental illness – helps to reduce criminal behaviors.[11] Approximately two-thirds of prisoners are re-arrested within three years of release, by providing continuous health care such as Medicaid in jails and prisons, criminal behavior will be reduced and repeated arrests associated with their chronic health conditions will be expected.[12] This will lead to safer communities and in turn, will provide taxpayer savings by way of a less burdened criminal

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[5] Wagner & Sawyer, *supra* note 3.
[6] Evelyn Malavé, *Prison Health Care After the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 N.Y.U. L. REV. 700, 701 (2014).
[7] Maureen McDonnell et al., *Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations* 1 (Cmty. Oriented Corr. Health Servs., Issue Paper, 2011), http://www.cochs.org/files/CHJ%20Final.pdf.
[8] Malavé, *supra* note 6, at 703.
[9] David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration*, VERA INSTITUTE OF JUSTICE (Nov. 2014), https://storage.googleapis.com/vera-web-assets/downloads/Publications/on-life-support-public-health-in-the-age-of-mass-incarceration/legacy_downloads/on-life-support-public-health-mass-incarceration-report.pdf.
[10] *Id*.
[11] Sabeena Bali, *The Economic Advantage of Preventative Health Care in Prisons*, 57 SANTA CLARA L. REV. 453, 478 (2017).
[12] *Id*. at 470; McDonnell et al., *supra* note 7, at 2.

justice system.[13]

This article will begin by explaining how inadequate prison health care has created a significant health crisis for prisoners. Providing a continuum of health care for inmates from the day when they are first incarcerated to the months post-release will lead to a reduction in recidivism rates. This article seeks to first assert that the duty to provide medical care to prisoners extends both during incarceration and the months post-release. This duty should be imposed on correctional agencies and community service providers and agencies to ensure that prisoners receive the necessary resources to have a successful transition into the community. Due to the vast majority of inmates who are uninsured upon their release from jail or prison, prisoners should be afforded Medicaid when released because providing a continuum of health care for inmates from the day when they are first incarcerated to the months post-release will lead to a reduction in recidivism rates. Then, this article will then turn its attention to the framework of the Affordable Care Act (ACA) and argue that Medicaid should be provided and expanded to provide coverage for incarcerated individuals upon their release in order to reduce recidivism.

II. THE HEALTH CRISIS: INADEQUATE PRISION HEALTH CARE INCREASES THE NUMBER OF REENTERING PRISONERS

There is pressing need for health care services among prisoners suffering from mental illnesses and substance use disorders.[14] Thus, inadequate health care in prisons has created a health crisis for prisoners reentering into society.[15] While much has been done to remedy the crisis amongst other

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[13] McDonnell et al., *supra* note 7, at 2.
[14] Malavé, *supra* note 6, at 701.
[15] Malavé, *supra* note 6, at 704.

populations, the crisis remains un-remedied for reentering prisoners.[16]

People in correctional institutions are the only group in the United States with a constitutional right to healthcare.[17] The Supreme Court concluded, in *Estelle v. Gamble*, "the Eight Amendment's prohibition against cruel and unusual punishment…mandates that states provide adequate medical care to all of their prisoners."[18] Under *Estelle*, the Court stated that the Constitution imposes a duty on States to assume responsibility for the safety and general well-being for a person in custody, including the right to provide basic human needs such as, medical care.[19]

The primary goals of the criminal justice system and the health care system are premised on different objectives.[20] The criminal justice system has the primary goal to protect the public and provide safer communities; whereas, the health care system has the goal "to protect or improve individual and community health."[21] When the health care system and the criminal justice system intersect, it is often disorganized and sporadic.[22]

The differing objectives of the criminal justice system and the health care system present challenges in providing adequate care for incarcerated individuals, specifically when addressing mental illness and substance

[16] Malavé, *supra* note 6, at 704 (describing that "the prevalence of chronic illness, communicable diseases, and severe mental disorders among people in jails and prisons is far greater than among other people of comparable ages.")
[17] Cloud, *supra* note 9, at 12.
[18] *See* Estelle v. Gamble, 429 U.S. 97, 97 (1976) (the respondent brought a civil rights action against the petitioners, the state corrections department medical director and two correctional officials, asserting that he was subjected to cruel and unusual punishment for inadequate medical treatment for a back injury that he sustained while engaging in prison work. The Supreme Court held that "deliberate indifference by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment in violation of the Eighth Amendment").
[19] Snyder, *supra* note 4, at 86; Wakefield v. Thompson, 177 F.3d 1160, 164 (1999) (*citing* Estelle v. Gamble, 429 U.S. at 103-105).
[20] McDonnell et al., *supra* note 7, at 3.
[21] McDonnell et al., *supra* note 7, at 3.
[22] McDonnell et al., *supra* note 7, at 2.

abuse.[23] The prevalence of serious mental illness is two to four times higher among those incarcerated in state prisons than among members of the general public.[24] Additionally, nearly 68 percent of individuals in jail, and more than 50 percent of those in state prisons, have a diagnosable substance use disorder, in comparison to the 9 percent of the general population.[25] Additionally, "most people who have a serious mental illness also have a co-occurring substance-use diagnosis", for example, 72 percent of people in jail have a serious mental illness and substance use disorder.[26] Prisons are "incubators" for mental illness, because many people who have not previously shown any sign of mental illness become symptomatic in prison.[27]

Compounding this issue, mental health care in prisons is abysmal.[28] Despite the high number of individuals dealing with these disorders and addictions, only 15 percent of people who are incarcerated receive treatment.[29] Most correctional facilities choose not to offer pharmacological treatments such as methadone and buprenorphine, despite research showing that these drugs are effective in treating opioid addictions.[30] This subjects people with chronic addictions to higher risks of withdrawal while in custody and of overdose when released.[31] Thus, these groups of offenders need to be provided with access to diversionary programming, in addition to

[23] McDonnell et al., *supra* note 7, at 2-3.
[24] Cloud, *supra* note 9, at 9.
[25] Cloud, *supra* note 9, at 10.
[26] Cloud, *supra* note 9, at 9.
[27] Malavé, *supra* note 6, at 705.
[28] Malavé, *supra* note 6, at 706. (providing that "many prisons have inadequately trained staff and tend to rely on medication-based treatment rather than emphasizing therapy and counseling." And, "correctional officers' frequent punishment of inmates for behavioral manifestations of mental illness [further] exacerbating the effects of prisoners' inadequate mental health care").
[29] Cloud, *supra* note 9, at 9.
[30] Cloud, *supra* note 9, at 9.
[31] Cloud, *supra* note 9, at 9.

pharmacological treatments.[32]

A. Inadequate Discharge Planning

Despite the urgent need for medical and mental health services for prisoners, the health care afforded in prisons is atrociously inadequate. In a study by the Urban Institute, "49 percent of men and 67 percent of women had chronic physical health conditions requiring long-term management and care at the time of their release."[33]

Discharge planning is crucial because the most critical hours for an inmate upon release are the first 48 hours.[34] Further, even the first six months after being released from jail or prison is a vulnerable and dire time in many inmates' lives.[35] Discharge planning includes correctional facilities providing prisoners with written discharge plans that include a list of referrals for health care providers and making appointments with health care providers.[36] When inmates are discharged with prescriptions, they typically receive little guidance on how to access healthcare and medications.[37] Thus, the most damaging aspect of the prison health care crisis is inadequate

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[32] Cloud, *supra* note 9, at 24.
[33] Malavé, *supra* note 6, at 704-705 ("The conditions most reported were 'asthma, high blood pressure, and diabetes'." Beyond prisoners' disproportionately high rates of substance abuse and mental health disorders, prisoners are also at higher risks of dealing with infectious diseases. Due to the alarming rates of sexual assault, intravenous drug use, and unsafe tattooing, not only does this facilitate the risk of contracting HIV, but also tuberculosis).
[34] Gauvey, *supra* note 2, at 15.
[35] Snyder, *supra* note 4, at 85; *see* Malavé, *supra* note 6, at 708 (inmates are twelve times more likely to die from health problems in the two weeks of being released, and 129 times more likely to die of a drug overdose in the first two weeks after being released.)
[36] Malavé, *supra* note 6, at 708.
[37] Malavé, *supra* note 6, at 708; Snyder, *supra* note 4, at 99 (prisons usually provide inmates after being released with a supply of medication; however once the medication supply runs out, many former inmates turn to alcohol or drugs as a form of self-medication, eventually becoming homeless and recidivating).

discharge planning.[38] This type of planning "is particularly hampered by the fact that many prisons do not enroll eligible prisoners in Medicaid before they are released, which decreases the chance that these prisoners will be able to access health care upon their reentry into the community."[39] States and local jurisdictions as well as correctional facilities need to be proactive in notifying the state Medicaid agency of an inmate's release, to ensure timely enrollment in Medicaid.[40] This will ensure that newly released inmates have not only active Medicaid coverage at release but also timely access to Medicaid-covered services upon release.[41]

Some argue that the health care provided in prisons is not causing a health crisis for re-entering prisoners, because prisoners were already in a health crisis.[42] Others may argue that this ignores the fact that "laws and policies send a disproportionate number of people suffering from substance abuse and other illnesses to prison by punishing drug use and mental illness."[43] Yet, even if a health crisis exists, prison health care still exacerbates the poor health of prisoners and it misses opportunities to improve health outcomes for the prison population.[44] Prisons should have the goal of releasing prisoners in better health, in an attempt to decrease rates of illness in their communities. Instead, the health care system in prisons misses the "public health opportunity" and operates more like a "public health disaster," by not only "missing opportunities to improve health outcomes, [but also] actively

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[38] Malavé, *supra* note 6, at 708 (defining discharge planning as the process of "connecting prisoners – either right before their release or as early as the day they are incarcerated – with health care services").
[39] Malavé, *supra* note 6, at 709.
[40] Letter from Vicki Wachino, Director of Center for Medicaid & Medicare Services, to State Health Official (Apr. 28, 2016) https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf [hereinafter Wachino Letter].
[41] *Id*. at 8.
[42] Malavé, *supra* note 6, at 710.
[43] Malavé, *supra* note 6, at 711.
[44] Malavé, *supra* note 6, at 712.

making health outcomes worse for reentering prisoners and their communities."[45]

B. Lack of Insurance

Without continuous access to services, former prisoners become more likely to recidivate.[46] One of the largest contributing factors to the diminished health status among prisoners, a significant portion whom are racial and ethnic minorities,[47] is the lack of insurance.[48] Nearly 80 percent of inmates, [49] are released each year without medical coverage, therefore limiting their access to adequate health care.[50] These individuals are attempting to secure housing and employment, but they also must go through the tedious process of applying for Medicaid coverage.[51] This process requires providing the proper documentation to enroll.[52] Medicaid agencies often require some form of identification for enrollment, and inmates face barriers in obtaining proper forms of identification for enrollment, which may have been confiscated at booking.[53] Time and cost pose additional barriers because obtaining the necessary documents such as birth certificates

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[45] Malavé, *supra* note 6, at 712.
[46] Juhie L. Kumar, *Criminal Justice and Public Health: A Need for Cross-System Collaboration between Jails and Medicaid to Reduce Recidivism* (2015) (thesis, University of Washington) https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/33958/Kumar_washington_0250O_14351.pdf?sequence=1.
[47] Cloud, *supra* note 9, at 28.
[48] Sachini Bandara et al., *Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid: State and Local Efforts*, 34 HEALTH AFFAIRS 1, 2 (2015).
[49] THE PEW CHARITABLE TRUSTS, *supra* note 4, at 1 (offenders have returned from their communities uninsured because they are unemployed – and lack employer-sponsored insurance, unable to afford insurance in the individual market, or did not qualify for Medicaid).
[50] Snyder, *supra* note 4, at 87.
[51] Snyder, *supra* note 4, at 87.
[52] Bandara et al., *supra* note 48, at 9.
[53] Bandara et al., *supra* note 48, at 9.

may have fees associated and take several months.[54] Upon release correctional agencies should assist ex-offenders in applying for Medicaid, provide them with any necessary medications to cover the time period until their medical benefits begin, provide specific referrals for physical and mental health treatment, and "[assist] with setting up necessary appointments as well as securing transportation to them."[55]

III. PROVIDING PRISONERS WHO ARE REENTERING SOCIETY WITH MEDICAID UPON RELEASE WILL LEAD TO A REDUCTION IN RECIDIVISM RATES

A. History and Overview of Medicaid

Medicaid covers roughly 74 million Americans, and it is the primary means by which states and localities provide health care access to vulnerable populations.[56] However, such coverage has historically been unavailable to most jail and prison inmates because they did not meet many states' eligibility criteria.[57] The passage of the Affordable Care Act (ACA) in 2010 created the opportunity for health care systems and justice systems to develop partnerships in order to abate health disparities and enhance public safety.[58]

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[54] Bandara et al., *supra* note 48, at 9.
[55] Adrienne Lyles-Chockley, *Transitions to Justice: Prisoner Reentry as an Opportunity to Confront and Counteract Racism*, 6 HASTINGS RACE & POVERTY L.J. 259, 301 (2009).
[56] Amanda Lee & Beth Jarosz, Majority of People Covered by Medicaid, and Similar Programs, are Children, Older Adults, or Disabled, POPULATION REFERENCE BUREAU (Jun. 29, 2017) https://www.prb.org/majority-of-people-covered-by-medicaid-and-similar-programs/.
[57] THE PEW CHARITABLE TRUSTS, *supra* note 4, at 2.
[58] The Affordable Care Act (ACA) aims to provide affordable health care for all Americans. Specifically, the ACA seeks to provide coverage for the uninsured with the expansion of Medicaid coverage to all individuals with incomes below [138%] below the federal poverty level. Malavé, *supra* note 6, at 728. The ACA has direct and indirect impacts on the criminal justice system; for instance, success in implementing the ACA has the potential to decrease crime, recidivism, and criminal justice costs, while also improving the health and safety of

Prior to the passage of the ACA, societal standards "did not require that prisoners have unfettered access to health care, in part because society did not expect anyone—prisoners or free people—to have unfettered access to health care."[59] With the passage of the ACA, it "change[d] this calculus by mandating that every person enroll in a health insurance plan, and by expanding Medicaid to make this possible…."[60] The ACA has provided the opportunity to address low rates of insurance coverage among individuals returning to their communities after incarceration.[61] In particular, the ACA creates critical opportunities for states, local governments, and healthcare stakeholders to expand the eligibility criteria and capacity of Medicaid to better meet the needs of medically-underserved populations in jails and prisons.[62] Medicaid expansion is not required, but the ACA gives states the option to expand Medicaid eligibility to people at or below 138 percent of the Federal Poverty Level.[63] Nearly all inmates' income level "falls below this threshold while they are in jail or prison, and most continue to be eligible for at least the first [few] weeks after release."[64] The expansion of Medicaid eligibility removes a barrier so that states can enroll more inmates – or at least keep them enrolled during incarceration with suspended coverage.[65]

No federal statute, regulation, or policy exists that prevents individuals from applying for, enrolling in, or renewing Medicaid coverage while incarcerated, so individuals may be actively enrolled in Medicaid while

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communities. Cloud, *supra* note 9, at 21; Andrea A. Bainbridge, *The Affordable Care Act and Criminal Justice: Intersections and Implications*, BUREAU OF JUST. ASSISTANCE 3 (2012).
[59] Malavé, *supra* note 6, at 727.
[60] Malavé, *supra* note 6, at 727.
[61] Bandara et al., *supra* note 48, at 2.
[62] Cloud, *supra* note 9, at 21.
[63] Cloud, *supra* note 9, at 22; THE PEW CHARITABLE TRUSTS, *supra* note 4, at 2 (describing that nearly 30 states and the District of Columbia have expanded Medicaid eligibility).
[64] THE PEW CHARITABLE TRUSTS, *supra* note 4, at 3.
[65] THE PEW CHARITABLE TRUSTS, *supra* note 4, at 3.

incarcerated.[66] The only pertinent federal regulation in effect provides that Medicaid funds cannot be used to cover health services while a person is incarcerated.[67] As a result, when a person is incarcerated, an individual's Medicaid enrollment must be either suspended or terminated.[68]

In a letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) in 2016, encouraged states not to terminate coverage for inmates simply because of their status as inmates but rather to temporarily suspend their coverage status until they were released from the correctional facility.[69] The letter emphasized that Medicaid coverage is crucial to ensuring a successful re-entry and transition into the community following incarceration.[70] The letter further clarified that individuals who are on parole or probation, or individuals who have been released from custody pending trial, are not considered inmates, and thus they are not subject to the prohibition on Medicaid covered services to inmates.[71] In fact, states have no authority under Medicaid law to drop inmates from eligibility upon incarceration.[72] The suspension process maintains the inmates' eligibility for Medicaid and provides for continuity of Medicaid, so that the

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[66] Jennifer Ryan et al., *Connecting the Justice Involved Population to Medicaid Coverage and Care: Findings from Three States*, KAISER FAMILY FOUND. (Jun. 1, 2016), https://www.kff.org/medicaid/issue-brief/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-findings-from-three-states/view/print/.
[67] Bandara et al., *supra* note 48, at 3.
[68] Bandara et al., *supra* note 48, at 3.
[69] Wachino Letter, *supra* note 40, at 6 (2016 guidance letter from CMS reiterated that incarceration does not preclude individuals from being deemed Medicaid-eligible, and that states must accept applications and process renewals of Medicaid services for incarcerated individuals. Further, the guidance letter reiterated that if the individual meets the Medicaid eligibility requirements, the state must enroll or renew the individual that would go in effect before, during, or after their release. Once they are released, the state may mark the inmate in a suspended eligibility status during their period of incarceration).
[70] Wachino Letter, *supra* note 40, at 1.
[71] Wachino Letter, *supra* note 40, at 4.
[72] Wachino Letter, *supra* note 40, at 6.

individual can immediately access the services after re-entry.[73] The suspension must be promptly lifted when the inmate is released or upon their admission to inpatient treatment in a medical institution.[74] However, a state may terminate Medicaid benefits – which some may argue termination is the better solution – despite, federal guidance that allows just for the suspension of Medicaid for incarcerated individuals.[75] Policies allowing for the suspension, rather than the termination of Medicaid benefits can function to ease transitions from incarceration to society, and in turn, prevent rearrests by reentering prisoners.[76]

B. Solutions to Promote Medicaid Expansion to Incarcerated Populations

Given the changing landscape of Medicaid eligibility and the overlap between individuals that are newly eligible for Medicaid and the prison population, a small group of state and local jurisdictions have begun to create innovative programs to ensure incarcerated individuals are enrolled in Medicaid upon their release.[77] However, more states should expand Medicaid coverage to inmates, instead of terminating their coverage and benefits altogether. Suspension rather than termination eases re-entry to coverage upon release.[78]

The letters in 2016 from CMS clarified federal policy and encouraged state action in this area.[79] Yet, as of December 2014, only twelve states developed a policy to suspend Medicaid coverage for incarcerated individuals, yet the remaining 38 states chose to terminate Medicaid following a period of

[73] Wachino Letter, *supra* note 40, at 7-8.
[74] Wachino Letter, *supra* note 40, at 8.
[75] Bainbridge, *supra* note 58, at 14.
[76] Bainbridge, *supra* note 58, at 14.
[77] Bandara et al., *supra* note 48, at 3.
[78] *Returning Home: Access to Health Care after Prison*, NATIONAL CONFERENCE OF STATE LEGISLATURES 3 (2009), http://www.ncsl.org/documents/health/returninghome.pdf.
[79] *Id*.

incarceration.[80] The termination creates a perilous gap for people as they reenter the community when they are already at an increased risk of death, overdose, and disability.[81]

Studies have revealed the benefits of access to health care during periods of transition. One study found that "enrollment in Medicaid upon release from corrections facilities contributed to reduced recidivism; inmates enrolled in Medicaid on the day of release, in comparison to inmates not enrolled in Medicaid on the day of release, committed fewer repeat offenses, and the time between offenses was longer."[82]

Because prisoners are "high users of health care services, ensuring that prisoners have better access to care—both while they are incarcerated and when they are released through discharge planning—could actually benefit society as a whole."[83] Upon release, ex-offenders should receive assistance in applying for Medicaid; they should be provided with any necessary medications to cover the time period until their Medicaid benefits begin; they should receive specific referrals for physical and mental health treatment; and they should receive "assistance with setting up necessary appointments as well as securing transportation to them."[84]

C. Solutions for Mentally Ill Offenders

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[80] Cloud, *supra* note 9, at 19.
[81] Cloud, *supra* note 9, at 19.
[82] NATIONAL CONFERENCE OF STATE LEGISLATURES, *supra* note 78, at 2; Snyder, *supra* note 4, at 98–99 (emphasizing a study that found inmates in jail who received treatment for mental illness after release spent 51 fewer days in jail per year than those who did not receive treatment. Thus, the findings from this study show that, "[w]ithout access to housing, income, necessary mental health care or safety net programs, the mentally ill former inmate will almost certainly be re-incarcerated, typically within the first six months following release.").
[83] Malavé, *supra* note 6, at 732.
[84] Lyles-Chockley, *supra* note 55, at 301.

Because of the difficulty of maintaining a treatment regimen on release, mentally ill offenders are one of the populations most prone to recidivism on discharge.[85] Therefore, these groups of offenders need to be provided with access to diversionary programming.[86] Simply diverting the mentally ill to generic mental health counseling in the community is unlikely to have a positive impact on their ability to be free of criminal behaviors and involvements.[87] The generic services are not intensive enough.[88] Police, correctional facilities, and courts are forming partnerships with community health providers to develop solutions to provide people with treatment instead of jail or prison time.[89] The diversionary programs are helping to reduce the number of people that are incarcerated.[90] In many jurisdictions, due to inadequate funding the diversion programs are insufficient to serve everyone who would benefit from participating.[91] However, through Medicaid expansions, the ACA "creates a critical funding stream that can be used to support and expand these front-end diversion programs."[92] This creates opportunities for police agencies, prosecutors, and community health providers to collaborate to develop new responses to drug offenses or low-level crimes, and instead serve in rehabilitating these offenders.[93]

D. Promoting Cross-System Collaboration between the Criminal Justice System and Medicaid Agencies

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[85] Gauvey, *supra* note 1, at 14, 19.
[86] Cloud, *supra* note 9, at 24.
[87] Joseph P. Morrisey, *Medicaid Benefits and Recidivism of Mentally Ill Persons Released from Jail*, NAT'L CRIM. JUST. REFERENCE SERV. 21, https://www.ncjrs.gov/pdffiles1/nij/grants/214169.pdf.
[88] *Id*.
[89] Cloud, *supra* note 9, at 24.
[90] Cloud, *supra* note 9, at 24.
[91] Cloud, *supra* note 9, at 24.
[92] Cloud, *supra* note 9, at 24.
[93] Cloud, *supra* note 9, at 24.

Increasing the availability of health coverage will not only improve health, but also stabilize behavior which will decrease the risk of re-arrest and incarceration.[94] In order to make the transition from incarceration to society, there needs to be a cross-system collaboration. Specifically, jails should partner with Medicaid agencies. Further, states should encourage this partnership with public defenders, prosecuting attorneys, and probation and parole services.[95] In order to promote enrollment in Medicaid, state Medicaid agencies should work with their local departments of corrections, prisons, and jails to assist formerly incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration, to apply for Medicaid.[96] States and local jurisdictions, "need to be proactive in notifying the state Medicaid agency of an inmate's release, to ensure timely removal of suspension."[97] This will ensure that newly released inmates have not only active Medicaid coverage at re-entry, but also timely access to Medicaid-covered services upon release.[98]

Some may argue that prison officials are only responsible for prisoners up until the moment of release.[99] Yet, in two cases, *Wakefield v. Thompson* and *Lugo v. Senkowski*, federal courts have held that prison officials remain accountable for serious medical needs past the moment of release.[100] The courts reasoned that prisons cannot be oblivious to the fact that prisoners do not become instantly able to obtain or seek medical upon release.[101] Thus, if correctional facilities are not able to enroll prisoners in Medicaid before

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[94] Kumar, *supra* note 46, at 5.
[95] Kumar, *supra* note 46, at 10.
[96] Wachino Letter, *supra* note 69, at 8.
[97] Wachino Letter, *supra* note 69, at 8.
[98] Wachino Letter, *supra* note 69, at 8.
[99] Malavé, *supra* note 6, at 734-35.
[100] Malavé, *supra* note 6, at 734-35.
[101] Malavé, *supra* note 6, at 735.

release, then prisoners will likely face a delay in obtaining coverage, ultimately leading to their ability to recidivate.[102]

IV. CONCLUSION

The complexity of the criminal justice system requires a variety of policies to successfully implement and expand Medicaid enrollment. Historically, the health care system and the criminal justice system have operated separately, in silos, with different agendas, priorities, and funding.[103] The divide between these two systems hinders delivering continuous health care, with a marked lack of coordination between correctional institutions and community health providers.[104] The passage of the ACA provided the tools necessary to bridge the divide between the two systems and rethink strategies to promote outreach, increase enrollment in Medicaid, and address the barriers to Medicaid.[105] Further, if more newly released inmates were enrolled in Medicaid services, it would increase their health outcomes and decrease their likelihood to recidivate because they are receiving continued treatment for their mental illnesses, infectious diseases, addictions, and substance use disorders. These recommendations are intended to increase awareness about the health crisis that exists among a vulnerable group, maximize Medicaid enrollment, and identify opportunities where stronger connections to care are possible.

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[102] Malavé, *supra* note 6, at 736.
[103] Cloud, *supra* note 9, at 24.
[104] McDonnell et al., *supra* note 7, at 2, 3.
[105] Malavé, *supra* note 6, at 728.

Measuring Up?: Failure to Assess Mental Health Services Accessibility Through Section 1115 Medicaid Demonstration Waivers

Haley Comella

I. INTRODUCTION

Awareness surrounding the need of accessibility to mental health services in the United States has been recently popularized by a series of tragedies connected to mass shootings such as Sandy Hook Elementary School in 2012, the Las Vegas Harvest country music festival in 2017, First Baptist Church in 2017, and Pulse Nightclub in 2016.[1] The phrase "mental illness" has grown to include a plethora of subjective meanings, stemming it's broad definition,[2] and the call for increased mental health services accessibility has

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[1] Vincent Del Giudice, *U.S. Mass Shootings From 1949 to 2018: Summary of Incidents*, BLOOMBERG (June 28, 2018), https://www.bloomberg.com/news/articles/2018-06-28/u-s-mass-shootings-from-1949-to-2018-summary-of-incidents.

[2] *Mental Health: A State of Well-Being*, WORLD HEALTH ORG. (last updated Aug., 2014), https://www.who.int/features/factfiles/mental_health/en/ (stating that the World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."); *Mental Health: Mental Disorders*, WORLD HEALTH ORG., https://www.who.int/mental_health/management/en/ (last visited Dec. 4, 2014) (stating that WHO defines mental disorders as "comprise[d of] a broad range of problems with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behavior and relationships with others."); *What Is Mental Illness?,* AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/what-is-mental-illness (last visited Dec. 4, 2018) (stating that the American Pyschiatric Association defines mental illness as "health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities."); Ronald W. Manderscheid, et al., *Evolving Definitions of Mental Illness and Wellness*, 7 PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., AND POL'Y 1 (2010).

been objectively overwhelming throughout the country.[3] A dominant component of mental health service is accessibility through Medicaid.[4] Approximately 43.8 million, or one in five adults in the United States experiences mental illness in a given year.[5] In 2015, Medicaid covered 21 percent of adults with mental illness and 26 percent of adults with serious mental illness, though overall Medicaid covers a comparative fourteen percent of the total population.[6] The issue of mental health accessibility examined through the lens of Medicaid Section 1115 Demonstration Waivers displays the discrepancy in objective measurement standards among states and Centers for Medicare and Medicaid Services (CMS) that inhibit assessing the true impact of Section 1115 Demonstrations. The Centers for Medicare and Medicaid Services (CMS) should implement mandatory qualitative and quantitative methodological standards for state internal evaluations of Section 1115 Demonstrations in order to create objective outcome evaluations, assess the impact of Section 1115 Demonstrations on mental health services, and determine if demonstrations should be re-approved at the end of the five-year initial approval period.

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[3]Jennifer Walter, *DPI Calls for More Than $60 Million Boost for School Mental Health Services*, MILWAUKEE J. SENTINEL (last updated July 27, 2018), https://www.jsonline.com/story/news/education/2018/07/23/wisconsin-dpi-calls-60-million-boost-school-mental-health/818224002/; *NAMI-MN Calls for Increase in Community-Based Mental Health Services*, PEOPLE INC. NEWS (July 30, 2014), https://www.peopleincorporated.org/2014/07/nami-mn-calls-for-increase-in-community-based-mental-health-services/; Ricardo Alonso-Zaldivar & Maria Davilova, *Budget Undercuts Trump Focus on Mental Health, School Safety*, U.S. NEWS & WORLD REPORT (Feb. 15, 2018), https://www.usnews.com/news/business/articles/2018-02-15/budget-undercuts-trump-focus-on-mental-health-school-safety; Fred Osher, *We Need Better Funding for Mental Health Services,* N.Y. TIMES (last updated May 9, 2016), https://www.nytimes.com/roomfordebate/2016/05/09/getting-the-mentally-ill-out-of-jail-and-off-the-streets/we-need-better-funding-for-mental-health-services.

[4] Julia Zur et al., *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals*, KFF (June 29, 2017), https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/ [hereinafter *Financing Behavioral Health*].

[5] *Mental Health By The Numbers*, NATIONAL ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers (last visited Sept. 23, 2018).

[6] *Financing Behavioral Health*, *supra* note 4.

Mental health services are categorized in Medicaid under behavioral health, and include a variety of illnesses including mood disorders, anxiety disorders, personality disorders, and substance abuse disorders (SUD).[7] SUD is a major component of behavioral health as it is frequently co-occurring with a variety and mixture of mental illness.[8] In fact, more than half of individuals with a history of SUD have a lifetime history of a mental disorder and have more than four times the risk of having a mental disorder comparted to those with no history of SUD.[9] However, due to lack of access and increased awareness for purely mental health services, a directed review of accessibility of these services specifically is due.

A. History of Section 1115 Demonstration Waivers

Since 1962, states have been able to apply for Section 1115 Medicaid Demonstration Waivers (Section 1115 Demonstrations) that provide an avenue to test and implement coverage approaches that do not meet federal program rules.[10] Section 1115 Demonstrations were first enacted "to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes."[11] From that original statutory definition, Congress has expanded the waivers throughout the last 50 years to now grant authority to the Secretary of Health and Human Services (the Secretary) to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance

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[7] Kaiser Comm'n, *Key Facts: Medicaid and the Uninsured*, KAISER FAMILY FOUNDATION (Nov. 2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf [hereinafter *Key Facts*].
[8] Darrel A. Regier et al., *Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse. Results from the Epidemiologic Catchment Area (ECA) Study*, 19 J. MED. ASS'N 2511, 2518 (1990), https://jamanetwork.com/journals/jama/article-abstract/383975.
[9] *Id*.
[10] *Id*.
[11] Pub. L. No. 87-543, 76 Stat. 172 (1962).

Program (CHIP).[12] The Secretary may waive certain provisions of CHIP or Medicaid to give states additional flexibility to design and improve their programs.[13] By increasing flexibility, the Medicaid program hopes to further its core objective in serving the health and wellness needs of the nation's vulnerable and low-income families and individuals.[14] States that propose reforms under Section 1115 Demonstrations are encouraged to submit applications that further the core goal of Medicaid and its additional objectives some of which include: improving access to high-quality; person-centered services that produce positive health outcomes for individuals; promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term; and enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition.[15] Proposals submitted by states, or "Demonstrations", in addition to promoting Medicaid's core objectives, must also be 'budget neutral' to the federal government, or not require more expenditures than if there were not a Section 1115 wavier in place.[16]

In addition to the requirements that a Section 1115 Demonstration proposal coincide with Medicaid's core objectives and achieve budget neutrality, a transparency requirement must be fulfilled which "establishes a process for ensuring public input into the development and approval of new Section 1115 Demonstrations as well as extensions of existing demonstrations".[17] To fulfill this requirement, states must provide at least a

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[12] Demonstration Projects, 42 U.S.C. § 1315 (2014).
[13] *Id.*
[14] *Section 1115 Demonstrations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/index.html
(last visited Sept. 23, 2018).
[15] *About Section 1115 Demonstrations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Sept. 23, 2018).
[16] *Id.*
[17] *1115 Transparency Requirements*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/transparency/index.html (last visited Sept. 24, 2018).

thirty-day public notice and comment period for applications for new Demonstrations.[18] In addition to this state comment period, there is a second thirty-day federal public notice and comment period prior to CMS approval or denial of the demonstration.[19] Initial approval length typically begins at five years and can be extended depending on the outcome of the demonstration and the populations served.[20] Section 1115 Demonstrations are used in a wide variety of categories such as Medicaid expansion, enrollment eligibility and restrictions, work requirements, benefit restrictions, delivery system reform, managed long-term services and supports, and behavioral health.[21]

B. Behavioral Health Section 1115 Demonstration Waivers

Behavioral health Section 1115 Demonstrations are the most sought-after waivers.[22] As of August 2018, thirty-seven states have currently approved Section 1115 Demonstrations, while twenty-three states are pending approval.[23] Within behavioral health Section 1115 Demonstrations

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[18] *Id*.

[19] *Section 1115 Waivers*, AM. SOC'Y OF ADDICTION MED., https://www.asam.org/advocacy/advocacy-principles/cover-it/section-1115-waivers (last updated Feb. 5, 2018); *See 1115 Transparency Requirements*, *supra* note 17 (describing the 30-day Federal comment period for the general public and stakeholders to submit comments); *see also* 5 U.S.C.A § 553(b) (1966) (explaining that general notice of proposed rule making must be published as statutorily required by the Administrative Procedure Act which contains among several requirements, the terms or substance of the proposed rule or a description of the subjects and issues involved).

[20] *Section 1115 Waivers*, *supra* note 19.

[21] KAISER FAMILY FOUND., LANDSCAPE OF APPROVED VS. PENDING SECTION 1115 MEDICAID DEMONSTRATION WAIVERS, AUGUST 29, 2018, KFF (2018), htpp://files.kff.org/attachment/Landscape-of-Approved-vs-Pending-Section-1115-Medicaid-Waivers [hereinafter LANDSCAPE OF WAIVERS].

[22] MaryBeth Musumeci, *Key Questions about Medicaid Payments for Services in "Institutions for Mental Disease"*, KFF, https://www.kff.org/report-section/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease-issue-brief/#endnote_link_254760-2 (last updated June 18, 2018) [hereinafter *Key Questions*].

[23] *See* KAISER FAMILY FOUND., APPROVED SECTION 1115 MEDICAID WAIVERS, AS OF AUGUST 29, 2018, KFF (2018), http://files.kff.org/attachment/Which-States-Have-Approved-and-Pending-Section-1115-Medicaid-Waivers-Approved [hereinafter APPROVED 1115 WAIVERS];

specifically, there are twenty-three states with approved Section 1115 Demonstrations, and sixteen pending.[24] For comparison, the second most applied for Section 1115 Demonstrations focus on Delivery System Reform with sixteen approved and five pending for a total of twenty-one.[25]

Behavioral health Section 1115 Demonstrations address four main areas which include 1) using Medicaid funds to pay for substance abuse services and/or mental health services in "institutions for mental disease" (IMDs), 2) expanding community-based behavioral health benefits, 3) expanding Medicaid eligibility to cover additional people with behavioral health needs, and 4) financing delivery system reforms such as physical and behavioral health integration or alternative payment models.[26] Out of these four categories, IMD payment waivers are currently the most frequently applied for.[27] IMDs generally include institutions with more than sixteen beds that provide inpatient behavioral health services for mental illness and SUDs.[28] Historically, states have been prohibited from using Medicaid funds for IMD services for non-elderly adults from the ages of twenty-one to sixty-four.[29] As Medicaid increases its support for experimental Demonstrations, states

KAISER FAMILY FOUND., PENDING SECTION 1115 MEDICAID WAIVERS, AS OF AUGUST 29, 2018, KFF (2018), http://files.kff.org/attachment/Which-States-Have-Approved-and-Pending-Section-1115-Medicaid-Waivers-Pending (reporting all states with approved and pending Section 1115 Medicaid Waivers) [hereinafter PENDING 1115 WAIVERS].

[24] LANDSCAPE OF WAIVERS, *supra* note21.

[25] *Id*; *see* Zirui Song & Thomas H. Lee, *The Era of Delivery System Reform Begins*, 309 J. OF AM. MED. ASS'N 1, 1 (2013) (explaining that traditional delivery systems focus on fee-for-service payments to providers and reforms move away from this traditional delivery through a variety of ways including for example, payments to lump-sum bundles organized under Accountable Care Organizations (ACOs), or payment for quality of services, rather than payment for services).

[26] MaryBeth Musumeci, *Key Themes in Medicaid Section 1115 Behavioral Health Waivers*, KFF (Nov. 2017), http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers.

[27] *Key Questions, supra* note 22.

[28] 42 U.S.C. § 1396d (i); *Key Questions, supra* note 22.

[29] *Key Questions, supra* note 22.; *see also* 42 U.S.C. § 1396d (a)(29)(B), 42 U.S.C. § 1396d (a)(14), 42 U.S.C. § 1396d (a)(16)(A) (illustrating it is statutorily proscribed that states can use federal Medicaid funds for inpatient hospital and nursing facility services in IMDs for individuals age 65 and older and inpatient psychiatric hospital services for individuals under age 21).

have sought funds for expanded IMD services outside of the traditional statutory restrictions.[30] Notably, IMD waivers distinguish between payments for SUD services and mental health services, with funds for SUD services more frequently sought after and approved.[31]

Since June 2018, twelve states hold approved IMD waivers to pay for IMD SUD services.[32] Only one state, Vermont, also holds a waiver for IMD mental health services, and these payments are required to be phased out between 2021 and 2025.[33] To prevent this phase out, Vermont applied for additional waiver authority for IMD mental health services and expanded SUD authority.[34] In reviewing Vermont's application for additional waiver authority, CMS only approved the SUD authority expansion.[35] Illinois also sought waiver approval for IMD services for both mental health services and

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[30] Robin Rudowitz et al., *How Medicaid Section 1115 Waivers Are Evolving: Early Insights About What to Watch*, KFF (Oct. 25, 2017), https://www.kff.org/medicaid/issue-brief/how-medicaid-section-1115-waivers-are-evolving-early-insights-about-what-to-watch/; See also MaryBeth Musumeci et al., *Current Landscape of Approved and Pending Waivers*, KFF (Sept. 20, 2018), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/ (listing notable demonstrations for the purposes of illustration to include conditioning Medicaid eligibility on meeting work requirements, approval to charge premiums up to 4% of family income, shifting compensation to providers from fee-for-service to quality-based care, and implementing cost sharing).

[31] *Key Questions, supra* note 22.

[32] *Figure 3: Approved and Pending Section 1115 IMD Payment Waivers, June 12, 2018*:*Key Questions, supra* note 22.

[33] Valerie Brankovic, *Mental Health Treatment Options Expanded Under Changes to Medicaid IMD Exclusion*, JUSTICE CTR.: THE COUNCIL OF STATE GOV'TS (Nov. 27, 2018), https://csgjusticecenter.org/mental-health/media-clips/mental-health-treatment-options-expanded-under-changes-to-medicaid-imd-exclusion/; *Key Questions, supra* note 22.

[34] Letter from CMCS Acting Director Timothy B. Hill to Vermont Agency of Human Services Secretary Al Gobeille, *in* 8 (Sept. 27, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf; *Key Questions, supra* note 22.

[35] Letter from CMCS Acting Director Timothy B. Hill to Vermont Agency of Human Services Secretary Al Gobeille, *in* 1 (Sept. 27, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf; *Key Questions, supra* note 22.

SUD services.[36] Once again, CMS only approved the SUD authority expansion.[37] CMS reasoned that it is their policy to not allow Medicaid payments for individuals who only receive mental health treatment in IMDs.[38]

Further stifling access to IMD mental health services is the fact that states with pending approvals are primarily seeking IMD SUD services rather than IMD mental health services.[39] Thirteen states have pending waivers which include requests for approval to use Medicaid funds to pay for IMD SUD services.[40] Out of those thirteen, only four states are also seeking IMD mental health services.[41] The surge in IMD payment waivers and approval thereof is in reaction to the opioid crisis ravishing the United States as the federal government and states attempt to find solutions or at least minimize the human damage and economic cost of the crisis.[42] This reveals a disparate

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[36] Letter from CMS Administrator Seema Verma to Illinois Healthcare and Family Services Director Felicia Norwood, *in* 1 (May 7, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf; *Key Questions, supra* note 22.

[37] Letter from CMS Administrator Seema Verma to Illinois Healthcare and Family Services Director Felicia Norwood, *in* 1 (May 7, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf; *Key Questions, supra* note 22.

[38] Letter from CMS Administrator Seema Verma to Illinois Healthcare and Family Services Director Felicia Norwood, *in* 1 (May 7, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf; *Key Questions, supra* note 22.

[39] *Key Questions, supra* note 22.

[40] *Figure 3: Approved and Pending Section 1115 IMD Payment Waivers, June 12, 2018:Key Questions, supra* note 22.

[41] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5

[42] *See Key Questions, supra* note 22 (reporting that Congress is considering amending the IMD payment exclusion, including a House bill that restricts IMD SUD services to those with opioid disorders); *see also* Julian Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KFF (Apr. 11, 2018), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/ (explaining that Medicaid has a large role in attempting to mitigate the opioid crisis); *see also* Patricia Boozang et al*., Medicaid's Critical Role in Addressing the Opioid Crisis*, MANNATT: MEDICAID EDITION (Mar. 28, 2018), https://www.manatt.com/Insights/Newsletters/Manatt-on-Health-Medicaid-Edition/Medicaids-Critical-Role-in-Addressing-the-Opioid-C (reporting "The Medicaid

level of IMD payment waivers for mental health because while SUDs and mental illness frequently coincide, public policy focus skews specifically to SUDs.

II. Current Section 1115 Demonstration Evaluation Process

In order to evaluate the impacts of a Section 1115 Demonstration, CMS utilizes a variety of techniques to conduct reviews and evaluations.[43] However, the evaluation process of Section 1115 Demonstrations is where the waiver program severely falters. One statutory technique is CMS's authority to conduct both individual and large-scale evaluations of Section 1115 Demonstrations.[44] In September 2014, to better determine whether Section 1115 Demonstrations achieve Medicaid's core objectives, CMS initiated an evaluation for each of the different types of Section 1115 Demonstrations which will continue through 2019.[45] The evaluations track both the general performance of the demonstrations of interest and evaluate Demonstration impacts and outcomes.[46] The evaluations focus specifically on only three types of demonstrations (1) alternatives to Medicaid expansion, (2) long term services and supports to people who are frail or disabled under managed care, and (3) delivery system reform incentive payment (DSRIP) programs.[47] While behavioral health falls generally into these categories as subsets, most distinctively under DSRIP, there is no evaluation process

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program has proven to be one of the most critical tools in the fight against crisis by serving as a major source of coverage and payment for SUD services across all states.").

[43] *Section 1115 Demonstration Evaluations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/index.html (last visited Nov. 3, 2018).
[44] 42 C.F.R. § 431.420(f) (2012).
[45] *1115 Demonstration Evaluations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/index.html (last visited Sept. 24, 2018).
[46] *Id.*
[47] *Id.*

specifically for behavioral health.[48] Because behavioral health is the basis for most Section 1115 Demonstrations, objective results must be complied using standard evaluation methods in order to provide transparency of the programs overall effectiveness. The last federal evaluation of Section 1115 Demonstrations that focused specifically on behavioral health was conducted in 2010 on Medicaid Emergency Psychiatric Demonstration.[49]

A second technique CMS uses in evaluating Section 1115 Demonstrations is state-provided interim reports, or state-led evaluations, that are submitted when a state files an application to renew a Section 1115 Demonstrations.[50] First, states must submit a final evaluation report for review and approval at the end of the Section 1115 Demonstration which CMS publishes within thirty days of receipt.[51] Second, states are required to perform internal evaluations that consist of "periodic reviews of the implementation of the demonstration" including quarterly and annual reports, which are then provided to CMS.[52] Finally, within six months of the Section 1115 Demonstration implementation, a state must solicit comments from the public on the progress of a demonstration project and provide a comment forum at the submission of each quarterly and annual report to CMS.[53] The Secretary of Social Security has the authority to suspend or terminate a demonstration in whole or in part if he or she determines that the state has materially failed to comply with the terms of the demonstration project.[54]

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[48] *Id*.
[49] *See 1115 Transparency Requirements, supra* note 17; EDWARD M. DROZD ET AL., IMPACTS ASSOCIATED WITH THE INPATIENT PSYCHIATRIC FACILITY PPS (2010), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Drozd_Psych2_Final_2010.pdf (showing the last federal report on behavioral health §1115 Demonstrations specifically).
[50] 42 C.F.R. § 431.424(d)(1) (2012).
[51] 42 C.F.R. § 431.424(g) (2012).
[52] 42 C.F.R. § 431.420(b) (2012); 42 C.F.R. § 431.420(b)-(c) (2012).
[53] 42 C.F.R. § 431.420(c) (2012).
[54] 42 C.F.R. § 431.420(d) (2012).

The practical and actual result of the evaluation system is that evaluations of impact and effectiveness of Section 1115 Demonstrations are left to each individual state. The important question at the heart of the issue is how increased access to behavioral health services are objectively measured, particularly mental health services. As stated succinctly by the U.S. Government Accountability Office (GAO), states and the federal government simply do not fully know if Section 1115 Demonstrations improve care.[55]

One of the underlying problems in the CMS and internal state evaluation system is the lack of specific objective standards, results, and impact of the Section 1115 Demonstration to be measured by.[56] In 2018, the GAO released a report expressing this exact weakness in both state-led and federal CMS evaluations.[57] The GAO found that "state led evaluations in selected states often had significant methodological weaknesses and gaps in results that affected their usefulness for federal decision making."[58] Additional issues were identified in result gaps for significant aspects of the demonstrations, such as not answering key hypotheses and not reporting on key outcome measures.[59] Since 2014, CMS has taken steps in an attempt to strengthen state-led evaluations, such as recommending the use of independent evaluators, providing more specific expectations for evaluations, and requiring discussion of methodological limitations.[60] As of 2018, CMS does not have written procedures for implementing their planned policy.[61]

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[55] U.S. GOV'T ACCOUNTABILITY OFFICE, FAST FACTS: MEDICAID DEMONSTRATIONS (2018), https://www.gao.gov/products/GAO-18-220.
[56] U.S. GOV'T ACCOUNTABILITY OFFICE, HIGHLIGHTS: MEDICAID DEMONSTRATIONS (2018), https://www.gao.gov/products/GAO-18-220.
[57] *Id.*
[58] U.S. GOV'T ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAID DEMONSTRATIONS 12 (2018), https://www.gao.gov/assets/690/689506.pdf.
[59] *Id.* at 14.
[60] *Id.* at 19.
[61] *Id.* at 21.

Without establishing specific procedures to include standardized results in any Section 1115 Demonstration evaluation, information gaps and methodological weaknesses will continue to pervade the evaluation system.

The GAO identified several other key issues within the evaluation system, but this single example alone is sufficient to illustrate the challenges of evaluation of Section 1115 Demonstrations, which are key to assessing the impact of the Section 1115 Demonstrations on services access.[62] Obviously, in the face of the current weakness in general evaluations, attempting to assess the impact Section 1115 Demonstrations on mental health services specifically presents an additional variety of challenges.

III. Evaluation of State Behavioral Health 1115 Demonstration Enrollment Numbers

In attempting to establish an overview of how behavioral health Section 1115 Demonstrations include or focus on mental health services specifically, Hawaii, Kansas, and Rhode Island were selected to examine overall enrollment numbers in behavioral health Section 1115 Demonstration programs. Each of these states' Section 1115 Demonstrations will expire at the end of 2018.[63]

A. Hawaii QUEST

Hawaii's QUEST Section 1115 Demonstration (QUEST) states that it offers mental health safety-net programs that serve Medicaid beneficiaries by providing standard health services to all Medicaid beneficiaries.[64] QUEST's behavioral health programs include 1) Community Care Services

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[62] *See Id.* at 23 (reporting data challenges in the quality of CMS data and delays in obtaining data directly from states).

[63] *See* Approved 1115 Waivers, *supra* note 23.

[64] *Integration of Behavioral Health Services*, Dep't of Human Serv., http://humanservices.hawaii.gov/mqd/home/behavioral-health-integration/ (last visited Sept. 24, 2018).

(CCS) which focuses on adults with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet program criteria; 2) Early Intervention Program (EIP) which focuses on infant and toddlers until the age of three to assist in a variety of developmental areas; 3) Child and Adolescent Mental Health Division (CAMHD) which focuses on children and adolescents ages 3 – 18 or 20 who receive behavioral health services utilizing evidence-based practices and an evidence-based services committee; and 4) Adult Mental Health Division (AMHD) which focuses on uninsured, underinsured, and/or encumbered adults with SMI who meet the program criteria.[65] No EIP enrollee data was published by QUEST during annual or quarterly reports until 2018 and thus will not be included in the yearly comparisons.[66] In October to December of 2014, CCS had 4,582 enrollees, CAMHD had 1,166 enrollees; and AMHD had 283 enrollees.[67] In 2016, enrollment numbers dropped in both CAMHD and AMHD, but rose in CCS.[68] In 2017, enrollment numbers dropped in all three programs.[69] The

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[65] DEP'T OF HUMAN SERVICES, HAWAII QUEST INTEGRATION CMS QUARTERLY REPORT: FFY 2018 3RD QUARTER, at 13-14 (2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/QUEST-Expanded/hi-quest-expanded-qtrly-rpt-apr-jun-2018.pdf [hereinafter QUEST 2018].
[66] *Id.* at 13.
[67] DEP'T OF HUMAN SERVICES, HAWAII QUEST INTEGRATION SECTION 1115 QUARTERLY REPORT, at 6 (2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/QUEST-Expanded/hi-quest-expanded-qtrly-rpt-oct-dec-2014.pdf.
[68] *See* DEP'T OF HUMAN SERVICES, FFY 2015& 2016 HAWAII QUEST EXPANDED SECTION 1115 ANNUAL REPORT, at 47 (2015-16), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/QUEST-Expanded/hi-quest-expanded-qtrly-annl-rpt-2015-2016.pdf [hereinafter QUEST ANNUAL REPORT] (reporting 184 enrollees for AMHD, 1,136 for CAMHD, and 5,179 for CCS, up from 4,582 in 2014).
[69] *See* DEP'T OF HUMAN SERVICES, FFY 2017 HAWAII QUEST EXPANDED SECTION 1115 ANNUAL REPORT, at 47 (2017),
https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/cms-reports/2017/FY17_Annual.pdf (reporting 158 enrollees for AMDH, 1,073 for CAMHD, and 4,977 for CCS).

most recent data published is from April to June, 2018.[70] The results show that as of June, 2018 CCS, CAMHD, and AMHD all had less enrollees than in 2013.[71]

At first blush, this seem to reflect that QUEST did not increase access to Medicaid beneficiaries except under CCS, but the true problem again lies in the methodological methods. Within the quarterly and annual reports, there is no indication if the decrease in number of enrollees in CAMHD and AMHD is indicative of beneficiaries not being able to access these services under the qualifications, if the services were incredibly beneficial which allowed beneficiaries to thrive with the standard Medicaid provisions, if the beneficiaries had left the state, or if they were now able to access personal insurance plans.[72] The evaluations provide objective numerical results, but do not assist in determining if QUEST was successful in providing services to a large number of beneficiaries, or if the services were simply more targeted and effective.

B. Rhode Island "Comprehensive Demonstration"

The same problem presents itself in Rhode Island's Section 1115 Demonstration, "Comprehension Demonstration" (CD). In March 2012, the number of current enrollees in the eligibility system under "[u]ninsured adults with mental illness" was 9,006.[73] The number of enrollees jumped

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[70] *Hawaii QUEST Integration: Administrative Record*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8541 (last updated Sept. 24, 2018).

[71] *See* QUEST 2018, *supra* note 65, at 13 (reporting that in 2018, 1) CCS had 4,735 enrollees, or 153 more enrollees than 2013, 2) CAMHD had 1,106 enrollees, or 60 less enrollees than 2013, and 3) AMHD had 142 enrollees, or 141 less enrollees than 2013).

[72] *See* QUEST ANNUAL REPORT, *supra* note 68, at 47.

[73] RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., QUARTERLY OPERATION REPORT, at 5 (2012), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-qtrly-rpt-jan-mar-2012.pdf.

considerably by 2015, with 12,027 at the end of the year.[74] The number of enrollees stayed nearly consistent in 2017.[75] The last state-led evaluation published by CMS to the public concluded that, as of September 2017, there were 12,024 enrollees within the category of uninsured adults with mental illness.[76] As illustrated by the state-led evaluations, the number of enrollees jumped by several thousand between 2012 and 2015.[77] Though similarly to QUEST, there is no methodology present in Rhode Island's Section 1115 Demonstration to explain the heightened enrollment numbers followed by a stagnation of enrollees into context.[78] This leaves the question of why enrollment numbers stagnated between 2015 to 2017.

C. Kansas "Kancare"

The same issue is again illustrated with Kansas's "KanCare". In KanCare's state-led evaluations, behavioral health is not separated into mental health services and SUD services under the "KanCare Utilization" measurements which indicate the claims reported per 1000 beneficiaries.[79] This lack of separation singularly creates incredible difficulties in assessing impact access to mental health services under KanCare and the lack of

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[74] RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., ANNUAL OPERATIONS REPORT, at 6 (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-qtrly-rpt-jan-mar-2012.pdf (reporting the number of enrollees at 12,024 in 2017, down by 3 from 2015).
[75] There were 12,023 enrollees on the last day of December 2017. RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., ANNUAL OPERATIONS REPORT, at 5 (2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-annl-rpt-jan-dec-2017.pdf.
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] KANSAS DEP'T OF HEALTH & ENV'T, ANNUAL REPORT TO CMS REGARDING OPERATION OF 1115 WAIVER DEMONSTRATION PROGRAM, at 19 (2017), https://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms---3-31-18.pdf?sfvrsn=9b804d1b_6.

methodological discussion further complicates the assessment. From 2012 to 2016, there was a negative eight percent difference in claims reported under behavioral health.[80] Again, it is unclear why the reduction claims happened and what it indicates. Additionally, because behavioral health is not separated into mental health services and SUDs under the measurement, it is impossible to determine the differences in claims.[81] It may be possible that mental health services dropped significantly while SUDs rose a small amount, or that both types of claims dropped at the same rate, or any variation thereof.

IV. CONCLUSION

Determining the true impact of Section 1115 Demonstrations on mental health services accessibility is difficult at best and near impossible at its worst. Behavioral health under the demonstrations encompasses both mental health services and SUDs, making it very difficult to determine the impact of accessibility and effectiveness of each individual category. Though SUDs often co-occur with mental illness, there are many Medicaid beneficiaries who battle mental illness without SUDs as companions and vice versa. The difficulties in determining the actual impact of the Section 1115 Demonstrations is incredibly important as the purpose of the Demonstrations is to further Medicaid's core objective, serving the health and wellness needs of the nation's vulnerable and low-income families and individuals.[82]

In order to create objective outcome evaluations, assess the impact of Section 1115 Demonstrations on mental health services, and determine if demonstrations should be re-approved at the end of the five-year initial approval period, CMS should implement several mandatory requirements. First, mandatory objective methodological standards should be implemented for state-led evaluations which include recording the reasons for changes in

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[80] In 2012 there were 4,829 claims reported, and in 2016 there were 4,447. *Id.*
[81] *Id.*
[82] *Section 1115 Demonstrations*, *supra* note 14.

enrollment numbers. This can be established by categories such as: treatment no longer necessary, enrollee began treatment in a separate program, enrollee was unable to access a treatment center, and enrollee lost eligibility. If an enrollee lost eligibility, the reason for the loss should also be recorded. The ultimate goal is to assess the reasons behind enrollment fluctuation and if the Section 1115 Demonstration is reaching the populous concerned in Medicaid's core objectives.

Second, states should be required to separate SUD services and mental health services in state-led evaluations. Though SUD's and mental illness frequently co-occur, separating the services during assessment will again allow a more thorough analysis of impact. Third, as experimental programs, the validity and impact should be considered a foremost concern in re-authorizing or extending the authority of a Section 1115 Demonstration. CMS should conduct an in-depth evaluation which would continue over several years, analogous to the evaluations CMS is currently conducting through 2019 on long term services, delivery system reform, and alternatives to Medicaid expansion.[83] Though CMS has taken steps to strengthen both state-led and CMS-led evaluations, further guidance in methodological standards are needed if the current issues in evaluation of Section 1115 Demonstrations are to be mitigated and the true impacts of the experimental programs can be measured.

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[83] *1115 Demonstration Evaluations*, *supra* note 45.

Hurricane Harvey's Impact on Texas' Vulnerable Population

Isabella Masini

I. INTRODUCTION

In 2017, the United States (U.S.) experienced three tropical storms, eight severe storms, two inland floods, a crop freeze, drought and wildfire.[1] Each weather or climate-related event resulted in at least a billion-dollar disaster relief to assist the residents of the impacted area.[2] One of these sixteen disasters was Hurricane Harvey (Harvey).[3] After Harvey made landfall as a Category 4 hurricane, forty-one counties in Southeast Texas became disaster areas.[4] In the Federal Emergency Management Agency (FEMA)- Southeast Texas disaster designated counties[5], almost 2.4 million residents were covered by Medicaid during the year of 2017.[6]

Typically, after any natural disaster, Medicaid allows flexibility within its program, thus allowing individuals impacted by the storm to have health care

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[1] Sahil Chinoy**,** *The Places in the U.S. Where Disaster Strikes Again and Again*, N.Y. TIMES (May 24, 2018, 5:30 AM), https://www.nytimes.com/interactive/2018/05/24/us/disasters-hurricanes-wildfires-storms.html.
[2] *Id.*
[3] Chinoy*, supra* note 1; A Category 4 hurricane is defined as a hurricane that has extreme wind speed that can cause catastrophic damage *Simpson Hurricane Wind Scale*, NAT'L OCEANIC ATMOSPHERIC ADMIN., https://www.nhc.noaa.gov/aboutsshws.php (last visited Nov.6, 2018).
[4] LIZ HAMEL ET AL., AN EARLY ASSESSMENT OF HURRICANE HARVEY'S IMPACT ON VULNERABLE TEXANS IN THE GULF COAST REGION, 3 (Henry J. Kaiser Family Foundation et al. eds., 2017).
[5] Dep't of Homeland Sec. Fed. Emergency Mgmt. Agency, *TX Hurricane Harvey (DR-4332)*, https://www.fema.gov/disaster/4332.
[6] *Medicaid and CHIP Enrollment by Risk Group by County, Final*, TX HEALTH & HUMAN SERVS. (AUG. 31, 2017), https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics.

coverage.[7] However, Harvey occurred during a time of national political unrest, with almost twenty states, including Texas, refusing to expand their Medicaid coverage under the Patient Protection and Affordable Care Act of 2010 (ACA).[8] This paper will review how natural disasters, specifically hurricanes, impact the health of Medicaid recipients, how states ensure healthcare coverage for vulnerable populations after a tropical storm, and whether Texas made the right decision in not expanding its Medicaid program after the devastations of Hurricane Harvey.

II. NATURAL DISASTERS AND POPULATION HEALTH

Natural disasters are a serious disruption of a community's function causing widespread human material, economic, or environmental losses extending to the community's ability to cope using its own resources.[9] Based on the WHO definition of disaster, there is no limitation of who or what can cause a disaster.[10] The only requirement is that a serious disruption must occur that causes the community to need external resources.[11] United States' most recent tropical storms and hurricanes have caused some of the greatest destruction to communities along the coast.[12]

In 2017, three major hurricanes, Harvey, Maria, and Irma, cost the U.S. a

[7] *Hurricanes & tropical storms*, CTR. FOR MEDICARE & MEDICAID SERS., (Sept. 14, 2018, 2:40 PM), https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html.
[8] Victoria Pelham, *Will Post-Storm Medicaid Flexibility Include Expansi*on?, BLOOMBERG L. (August 29, 2017), https://www.bna.com/poststorm-medicaid-flexibility-n73014463882/.

[9] *Definitions: emergencies*, WORLD HEALTH ORG., http://www.who.int/hac/about/definitions/en/ (last visited Nov. 6, 2018).
[10] *Id.*
[11] *Id.*
[12] Chinoy, *supra* note 1; David Johnson, *Is This the Worst Hurricane Season Ever? Here's How it Compares*, TIME (Sept. 24, 2017) http://time.com/4952628/hurricane-season-harvey-irma-jose-maria/; Facts + Statistics: Hurricanes, INSURANCE INFORMATION INST., https://www.iii.org/fact-statistic/facts-statistics-hurricanes (last visited Nov. 6, 2018).

total of $265 billion in losses.[13] These hurricanes displaced a significant percentage of the population living in the affected areas, significantly damaged homes and businesses, and caused widespread flooding.[14] The financial loss from hurricanes displays the economic burden of these natural disasters that fall onto local, state, and federal governments.[15] For Harvey, the top local and state expenditures for physical damage recovery include University of Houston, Office of the Governor, and University of Texas MD Anderson Cancer Center.[16] Most federal expenditures in response to Harvey were federal grants given to local or state agencies.[17] Alternatively, the Health and Human Services (HHS) Commission total actual expenditure approached $1.3 billion dollars in aid, through FEMA funds to Medicaid and CHIP applicants.[18] This substantial expenditure by HHS exhibits the need for health care coverage for vulnerable populations, however it is necessary to understand the reasons for this need.[19]

Vulnerable Populations

Hurricanes and other natural disasters do not intentionally victimize

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[13] Chinoy, *supra* note 1; David Johnson, *Is This the Worst Hurricane Season Ever? Here's How it Compares*, TIME (Sept. 24, 2017) http://time.com/4952628/hurricane-season-harvey-irma-jose-maria/; Facts + Statistics: Hurricanes, INSURANCE INFORMATION INST., https://www.iii.org/fact-statistic/facts-statistics-hurricanes (last visited Nov. 6, 2018).

[14] Adam B. Smith, *2017 U.S. Billion-dollar Weather and Climate Disasters: A Historic Year in Context*, NAT'L OCEANIC ATMOSPHERIC ADMIN. (Jan. 8, 2018), https://www.climate.gov/news-features/blogs/beyond-data/2017-us-billion-dollar-weather-and-climate-disasters-historic-year.

[15] *Hurricane Harvey: Fiscal Analyses and Resources*, LEGISLATIVE BUDGET BOARD, http://www.lbb.state.tx.us/Harvey.aspx#ProjectedCosts (last visited Nov. 6, 2018).

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] *Id.*

vulnerable populations and do not care if you can afford health insurance.[20] Hurricanes will destroy a home no matter how rich, poor, old or young the homeowner.[21] Natural disasters disproportionally affected those who are in a lower socio-economic bracket.[22] One demonstration of this disparity is the effect of Hurricane Katrina on its victims. In 2005, Hurricane Katrina struck New Orleans, Louisiana, causing massive destruction in one of the poorest states in the country.[23] During this time, almost a quarter of the residents in New Orleans were living in poverty.[24] The average household income in the areas where Katrina claimed the most casualties was roughly $27,000.[25] Almost half of the bodies recovered were in neighborhoods with more than 30 percent of its residents living in poverty.[26] Similarly, Texas' low-income neighborhoods were more affected than wealthier ones due to the high concentration of poor communities living in flood-prone areas and near industrial facilities, which have chemical spills and toxic leaks.[27]

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[20] Dayna Bowen Matthew, *Disastrous Disasters: Restoring Civil Rights Protections for Victims of the State in Natural Disasters*, 2 J. HEALTH & BIOMEDICAL L. 213, 216-17 (2006); Vulnerable populations include children, pregnant women, elderly people, malnourished people, and people who are ill or immunocompromised, and have a relatively high risk of disease. Major contributors to vulnerable populations include poverty, homelessness, poor housing, and destitution. *Environmental health in emergencies: Vulnerable groups,* WORLD HEALTH ORG, http://www.who.int/environmental_health_emergencies/vulnerable_groups/en/ (Last visited Dec. 2, 2018).

[21] *Id.*

[22] *See* Matthew*, supra* note 20, at 217-18 (discussing how the United States government developed strategies that resulted in discrimination against minorities and poor communities before, during, and after Hurricane Katrina and other natural disasters); *See also* Richard M. Zoraster, *Vulnerable Populations: Hurricane Katrina as a Case Study*, 25 PREHOSPITAL DISASTER MED. 74, 76 (2010) (concluding there was an increased risk of environmental hazards for those who are impoverished following Hurricane Katrina).

[23] Robin Rudowitz et al., *Health Care in New Orleans Before and After Hurricane Katrina*, 25 HEALTH AFFAIRS w393, w393 (2006).

[24] *Id.* at w394.

[25] Matthew, *supra* note 20, at 220.

[26] Matthew, *supra* note 20, at 220.

[27] Susan Milligan, *The Forecast for Recovery*, U.S. NEWS & WORLD REP. (Sept. 21, 2018, at 6:00 AM), https://www.usnews.com/news/the-report/articles/2018-09-21/hurricanes-hit-everyone-but-the-poor-have-the-hardest-time-recovering; Eleanor Krause & Richard V. Reeves, *Hurricanes Hit the Poor the Hardest,* BROOKINGS (Sept. 18, 2017), https://www.brookings.edu/blog/social-mobility-memos/2017/09/18/hurricanes-hit-the-poor-the-hardest/.

This disparity is not mutually exclusive to Hurricanes Katrina and Harvey. Natural disasters cause immediate and long-term injuries to vulnerable populations.[28] Most of these injuries are due to the disadvantages in disaster preparation, evacuation, response, and recovery.[29] First, preparation and evacuation require economic resources that are not always available for underserved populations, therefore individuals must wait out the storm in an ill-equipped and unsafe shelter.[30] Second, those individuals are less likely to have insurance or resources to repair homes or quickly receive healthcare treatment.[31]

One form of recovery is providing health care for injuries caused by the natural disaster. Generally, disasters increase the number of visits at emergency departments and primary care providers, length of stay at hospitals, and need for psychiatric care.[32] More specifically, hurricanes cause immediate injuries once the storm makes landfall and will continue to cause injury years after they subside.[33] Immediate, treatable injuries are attributed to collapsed structures and debris, infectious diseases, and exposure to carbon monoxide and toxic water.[34]

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[28] Zoraster, *supra* note 22, at 74; Krause, *supra* note 27; *See also* Matthew *supra* note 20at 220-23 (describing how the United States failed to assist impoverished communities prior to and after earthquakes, floods, hurricanes, and droughts).
[29] Zoraster supra note 20, at 74.
[30]See Zoraster, *supra* note 20, at 75 (describing that high density housing, poor quality construction, rental units, and mobile homes are difficult to prepare and transportation, risk of missing work and the cost of food and a place to stay make it difficult to evacuate).
[31] Zoraster, *supra* note 20, at 76.
[32] Sue Anne Bell et al., *All-Cause Hospital Admissions Among Older Adults After a Natural Disaster,* 71 ANNALS OF EMERGENCY CARE 746, 746 (2018).
[33] Linda B. Bourque, et al., *Weathering the Storm: The Impact of Hurricanes on Physical and Mental Health*, 601 ANNALS AM. ACAD. POL. SOC. SCI. 129, 129-30 (2006). *See generally* Marisa Elena Domino et al., *Disasters and the Public Health Safety Net: Hurricane Floyd Hits the North Carolina Medicaid Program*, 93 AM. J. PUB. HEALTH 1122, 1122 (2003) (describing the short- and long-term effects of Hurricane Floyd in North Carolina).
[34] *Bourque, supra* note33, at 140-43; Mark E. Keim, *Building Human Resilience: The Role of Public Health Preparedness and Response as an Adaptation to Climate Change*, 35 AM. J. PREVENTATIVE MED. 508, 514 (2008); Aaron E. Carroll & Austin Frakt, *The Long-Term*

Additionally, flooding of homes and cleanup efforts can cause both short-term and long-term exposure to mold and other hazardous substances.[35] Living in damp, moldy housing is linked to asthma and chronic respiratory illnesses.[36] Also, months after the flooding and storm, there is an increase risk in gastrointestinal and skin infections, diabetes-related complications, and cardiovascular disease complications.[37] Hurricanes' destruction of homes and permanent relocation damages can impair behavioral and mental health through depression, anxiety, and posttraumatic stress disorder.[38] For example, Hurricane Sandy, that hit New Jersey, New York and other east coast states, caused displacement, relocation, and loss of property and personal finances which increased the risk of mental health problems.[39] As natural disasters, specifically hurricanes, become more destructive to vulnerable populations in the U.S. there is an increased need for health care services. Federal and state governments must prioritize and proactively plan for how to best serve these individuals.

III. MEDICAID COVERAGE AFTER A NATURAL DISASTER

For those affected by a natural disaster and require health care services, a common concern is health care coverage. Of the population that is likely to

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Health Consequences of Hurricane Harvey, N.Y. TIMES, (Aug. 31, 2017), https://www.nytimes.com/2017/08/31/upshot/the-long-term-health-consequences-of-hurricane-harvey.html.

[35] Keim, *supra* note 34, at 514; Carroll, *supra* note 34.

[36] James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUBLIC HEALTH 758, 758 (2002); Selena Gray, *Long-term Health Effects of Flooding.* 30 J. PUB. HEALTH. 353, 353. (Dec. 1, 2008); CENTER FOR DISEASE CONTROL AND PREVENTION, NIOSH ALERT: PREVENTING OCCUPATIONAL RESPIRATORY DISEASE FROM EXPOSURES CAUSED BY DAMPNESS IN OFFICE BUILDINGS, SCHOOLS, AND OTHER NONINDUSTRIAL BUILDINGS, 2-3 (2012); Dhitinut Ratnapradipa et al., *Implications of Hurricane Harvey on Environmental Public Health in Harris County, Texas*, 81 J. ENVT'L HEALTH 24, 27 (2018).

[37] Carroll, *supra* note 34.

[38] Keim, *supra* note 3434, at 514; Jean Rhodes et al., *The Impact of Hurricane Katrina on the Mental and Physical Health of Low-Income Parents in New Orleans*. 80 AM. J. ORTHOPSYCHIATRY. 237, 238 (2010); Gray, *supra* note36, at 353.

[39] Yuval Neria & James Shultz, Mental Health Effects of Hurricane Sandy: Characteristics, Potential Aftermath, and Response, 308 J. AM. MED. ASS'N 2571, 2572-73 (2012).

face hardship after a disaster, only a portion are covered by Medicaid.[40] The first issue Medicaid patients face is obtaining healthcare service from an out-of-state provider. For example, during Hurricane Katrina over 86,000 people covered under Louisiana Medicaid were evacuated to other states, like Texas, Mississippi, and Alabama, but remained on Louisiana's Medicaid roster.[41] For individuals enrolled in Medicaid at the time of a disaster and are displaced for care, under the Code of Federal Regulation's Payments for Services Furnished Out of State, the home state is required to pay for certain medical services provided by the new state.[42] The regulation's conditions that require a home state to pay for medical services include a medical emergency, a patient's health would be endangered if required to travel to the state of residence, the service or supplementary resource is more readily available in the other state, or it is a general practice for recipients in a particular locality to use medical resources in another state.[43] Thus, a home state is not required to pay for all services provided to patients while in another state, but only those that meet one of the four conditions.[44]

A second issue involves those who live in poverty but are ineligible for Medicaid.[45] Medicaid eligibility is dependent on two restrictions: finances and categories.[46] To qualify for Medicaid, one's income and assets must fall below a certain percentage and one must identify as being a part of one of the following categories: persons over 65, person with disabilities,

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[40] Rudowitz, *supra* note 23, at w398.
[41] Rudowitz, *supra* note 23, at w398-99; EVELYNE BAUMRUCKER, ET AL., HURRICANE KATRINA: MEDICAID ISSUE, CONGRESSIONAL RESEARCH SERVICE REPORT FOR CONGRESS, 12 (Nov. 18, 2005).
[42] Baumrucker, *supra* note 4141, at 9; Payments for services furnished out of State, 42 C.F.R. § 431.52 (2010).
[43] 42 C.F.R. § 431.52.
[44] Baumrucker, *supra* note 4141, at 9.
[45] Rudowitz, *supra* note 23, at w394.
[46] Baumrucker, *supra* note41, at 4.

dependent, children, parents of dependent children, and pregnant women.[47] For individuals who do not meet these requirements, they do not receive this public health care coverage. During a disaster, this group of uncovered individuals can increase due to those who previously had employer-sponsored health care coverage, but lost coverage from disaster destruction and job loss.[48]

Medicaid State Plan Amendments

After a disaster, states may submit a State Plan Amendment to materially alter "Medicaid eligibility, enrollment, and benefit requirements."[49] The State Plan Amendment must be approved by CMS.[50] Possible Medicaid State Plan Amendments include expanding coverage to populations with higher incomes or non-residents of the affected state.[51] A state may also develop a simplified paper application,[52] a presumption of eligible populations,[53] and additional optional benefits.[54] Due to the process' lack of timeliness and high burden, amending a State Plan is not the most efficient form of increasing Medicaid services to a state's population.[55] However, in preparation of Harvey, Texas submitted a State Plan Amendment for its CHIP program that extended CHIP enrollees access to services.[56] CMS

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[47] Baumrucker, *supra* note 4141, at 4.
[48] Rudowitz, *supra* note 23, at w398.
[49] INVENTORY OF MEDICAID AND CHIP FLEXIBILITIES AND AUTHORITIES IN THE EVENT OF A DISASTER 3 (Medicaid and CHIP Learning Collaboratives ed., 2018)[herein after Medicaid and CHIP Flexibilities]; DISASTER PREPAREDNESS TOOLKIT FOR STATE MEDICAID AGENCIES 3-4 (Medicaid and CHIP Learning Collaboratives ed., 2018)..
[50] Medicaid and CHIP Flexibilities, *supra* note 49, at 3.
[51] Medicaid and CHIP Flexibilities, *supra* note49, at *5,* 6.
[52] Medicaid and CHIP Flexibilities, *supra* note 49, at 7.
[53] Medicaid and CHIP Flexibilities, *supra* note 49, at 8.
[54] Medicaid and CHIP Flexibilities, *supra* note 49, at 16.
[55] See generally, *SPA and 1915 Waiver Processing*, MEDICAID.GOV, https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html (last visited Nov. 6, 2018) (explaining that CMS is working to improve the State Plan Amendment approval process).
[56] DISASTER PREPAREDNESS TOOLKIT FOR STATE MEDICAID AGENCIES, *supra* note 49, at 3.

approved Texas' submission, but only for a temporary duration of two months after Harvey.[57]

Verification Plans

States may change Medicaid verification processes, the process by which a state confirms its income and categorical eligibility of applicants.[58] The state may accept applicants who self-attest to their eligibility criteria and incurred medical expense and allow for individuals to reasonably explain any inconsistencies in documentation.[59] Unlike the State Plan Amendment process, the verification process does not require approval by CMS and goes into effect immediately, which allows for flexibility during a disaster.[60]

§1135 Waivers

Once the state's governor requests the President to declare a major disaster or emergency, the Secretary of HHS may declare, under the National Emergencies Act, that a Public Health Emergency exists.[61] Under §1135 of the Social Security Act, the Secretary's declaration authorizes temporary modifications to Medicaid.[62] The declaration also authorizes CMS to issue blanket waivers that permit providers to supply care to beneficiaries without applying for an individual waiver.[63] *§1*135 requests must be submitted by a state and typically terminates when the emergency period ends or 60 days

[57] *State Plan Amendment (SPA) #: CHIP 17-0043,* TX HEALTH AND HUMAN SERV., https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/state-plan/chip/chip-spa-17-0043.pdf (last visited Nov. 28, 2018).
[58] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.
[59] Medicaid and CHIP Flexibilities, *supra* note 49, 11-12.
[60] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.
[61] *Hurricanes & tropical storms*, *supra* note7; Medicaid and CHIP Flexibilities *supra* note49, at 4.; *1135*, CMS.GOV, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html (last visited Nov. 6, 2018).
[62] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.
[63] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.

after the waiver was authorized.[64]

The §1135 waiver may provide flexibility in beneficiary cost sharing, such as allowing providers located and licensed out-of-state to provide care to a disaster state's Medicaid enrollee.[65] The state can temporarily suspend fee-for-service reimbursements before authorization and require fee-for-service providers to extend prior authorizations until the termination of the emergency declaration.[66] Pre-admission screening, annual state-resident review, application fees, background checks, and site visits may be temporarily suspended.[67] For example, following the 2017 wildfires in California and Hurricane Irma in Florida, California and Florida used a *§1*135 waiver to waive health care provider screening requirements, such as payment of application fee and criminal background checks, to encourage non-Medicaid providers to temporarily provide health care.[68]

§1115 Waiver

A state may request the Secretary of HHS to waive compliance with provisions within the federal Medicaid law or authorize expenses not within the federal Medicaid law.[69] Under §1115 of the Social Security Act, the Secretary may only grant the waiver for an "experiment, pilot or demonstration project."[70] §1115 waivers requested by a state may expand Medicaid eligibility for specific categories of individuals living within a specific geographic region,[71] continuous eligibility for 12 months after a

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[64] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.
[65] Medicaid and CHIP Flexibilities, *supra* note 49, at 17, 25.
[66] Medicaid and CHIP Flexibilities, *supra* note 49, at 18.
[67] Medicaid and CHIP Flexibilities, *supra* note 49, at 24.
[68] DISASTER PREPAREDNESS TOOLKIT FOR STATE MEDICAID AGENCIES, *supra* note 49, at 3.
[69] Medicaid and CHIP Flexibilities *supra* note49, at 4; *Using Section 1115 Demonstrations for Disaster Response*, MEDICAID.GOV, https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/section-1115-demonstrations/index.html (last visited Nov. 6, 2018).
[70] Medicaid and CHIP Flexibilities, *supra* note 49, at 4.
[71] Medicaid and CHIP Flexibilities, *supra* note 49, at 5.

disaster for children or adults,[72] and modification of insurance co-payments and premiums.[73] For example, after Hurricane Irma and Maria, Puerto Rico submitted the "Puerto Rico Disaster Relief demonstration" project and CMS approved the demonstration under §1115.[74] The approval allowed for medical coverage to eligible Medicaid applicants who were temporarily relocated to New York and Florida.[75]

IV. HURRICANE HARVEY AND TEXAS' RESPONSE

In August 2017, Hurricane Harvey, a Category 4 hurricane, made landfall in Southeast Texas.[76] The unprecedented United States rainfall caused massive flooding that displaced over 30,000 people and damaged or destroyed over 200,000 homes and businesses.[77] FEMA designated 54 counties that required public and individual assistance as disaster areas.[78] Within these counties, almost 2.4 million residents of over 16.7 million were covered by Medicaid.[79] The other 14.4 million residents may be insured through employer-sponsored coverage, directly purchasing family or individual insurance, or uninsured.[80] During the year of Harvey, 2.97 million

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[72] Medicaid and CHIP Flexibilities, *supra* note 49, at 10.
[73] Medicaid and CHIP Flexibilities, *supra* note 49, at 14.
[74] Letter from CMS to Puerto Rico's Secretary of Health (Nov. 28, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pr/pr-disaster-relief-ca.pdf.
[75] *Id.*
[76] Smith, *supra* note 14.
[77] Smith, *supra* note 14; Christopher W. Landse, *Hurricane Harvey's Rainfall and Global Warming*, NAT'L OCEANIC ATMOSPHERIC ADMIN., http://www.aoml.noaa.gov/hrd/Landsea/harvey-global-warming.pdf (last visited Nov. 6, 2018) (stating that Hurricane Harvey set a new record for maximum amount of rainfall, at 60 inches, from a tropical storm or hurricane in the United States).
[78] Dep't of Homeland Sec. Fed. Emergency Mgmt. Agency, *supra* note 5.
[79] *See Medicaid and CHIP Enrollment by Risk Group by County, Final*, *supra* note 6 (listing Texas counties' population of Medicaid enrollees); *See also* Dep't of Homeland Sec. Fed. Emergency Mgmt. Agency, *supra* note 5 (mapping the Texas counties that received FEMA disaster assistance).
[80] *See Texas Population, 2017 (Projections)*, TEXAS DEP'T STATE HEALTH SERVICES, https://dshs.texas.gov/chs/popdat/ST2017.shtm (last visited Nov. 6, 2018) (listing Texas

residents within the disaster designated counties were uninsured.[81] One year after the disaster, the number of uninsured residents within the disaster designated counties decreased to 2.71 million.[82] The decrease in uninsured residents may be due to Texas' §1135 waiver or uninsured individuals moving after the disaster.[83]

Generally, a Texas adult resident can qualify for Medicaid coverage if they meet the income requirement and have a disability, care for children, who lives with them, get Medicaid, and are 17 or younger, or are 65 or older.[84] The U.S. residents that lack health insurance have a high likelihood of falling within at least one of the following groups: Young adults, age 16 to 34; Employees who work part-time or only part of the year; People with families with income below 200 percent of the poverty level; Hispanics.[85] In 2010, the ACA allowed states to expand their Medicaid program to cover families with incomes up to 133 percent of the federal poverty line (FPL).[86] The Texas Legislature rejected the Medicaid expansion, leaving many Texas

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counties populations); *Medicaid and CHIP Enrollment by Risk Group by County, Final*, *supra* note 6 (supplying the total population of Medicaid enrollees in disaster designated counties); *See* Mariah McGill & Gillian MacNaughton, The Struggle to Achieve the Human Right to Health Care in the United States, 25 S. CAL. INTERDIS. L. J. 625, 627 (2016) (describing how people in the U.S. are insured or uninsured).

[81] *2017 Texas Data*, COUNTY HEALTH RANKINGS, http://www.countyhealthrankings.org/app/texas/2015/downloads (last visited Nov. 6, 2018).

[82] *2018 Texas Data*, COUNTY HEALTH RANKINGS, http://www.countyhealthrankings.org/app/texas/2015/downloads (last visited Nov. 6, 2018).

[83] HURRICANE HARVEY: MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FREQUENTLY ASKED QUESTIONS, 3 (Texas Health and Human Services ed., 2017).; Abe Louise Young, *Displaced by the Storm: Texas Evacuees Without Option,* TEXASMONTLY (Oct. 9, 2017) https://www.texasmonthly.com/articles/displaced-by-the-storm-texas-evacuees-without-options/.

[84] *Medicaid and CHIP*, TX HEALTH AND HUMAN SERV., https://hhs.texas.gov/services/health/medicaid-chip (last visited Nov. 6, 2018); *Medicaid for an adult caring for a child*, TX HEALTH AND HUMAN SERV., https://yourtexasbenefits.hhsc.texas.gov/programs/health/young-adults-and-families (last visited Nov. 6, 2018).

[85] *The Uninsured in Texas,* TEXAS MED. ASS'N, https://www.texmed.org/Uninsured_in_Texas/ (last visited Nov. 6, 2018).

[86] Raj Salhotra, *Growing Inequality of Opportunity in Texas: Causes and Solutions*, 51 J. MARSHALL L. REV. 309, 329.

residents without health insurance.[87]

In response to Harvey, rather than expanding Medicaid to align with this new standard, Texas used the §1135 waiver to alter certain provisions in its existing Medicaid coverage provisions.[88] The §1135 waiver included a blanket waiver for skilled nursing facilities, home health agencies, and critical access hospitals.[89] For people who were evacuated or transferred as a result of Harvey and were being cared for by a skilled nursing facility, Texas Medicaid would cover the first three days of hospitalization.[90] For those who were uninsured and were permanent residents in one of the declared disaster counties, Texas extended Medicaid eligibility for six months.[91] Additionally, residents returning to areas affected by Harvey were given a 3-month coverage for mosquito repellent.[92]

Although Texas was granted a §1135 waiver, the health effects of Harvey will span beyond the few months covered by this temporary expansion. A survey assessing Harvey's impact on vulnerable Texans in the Gulf Coast region two to four months after the hurricane hit, reported that four out of ten residents had damage to their home,[93] and yet nine out of ten residents returned to their home.[94] Furthermore, one in eight residents within the Harvey-affected counties said someone in their household developed a new or worse health condition.[95] Even if there were no short-term health injuries, the exposure to the damaged environment left by Harvey will increase the

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[87] Salhotra, *supra* note 86, at 329; *See 2018 Texas Data*, *supra* note 82reporting 19 percent of Texans are uninsured in 2018). FA
[88] Harvey FAQ, *supra* note 83, at 3.
[89] Harvey FAQ, *supra* note 83, at 3-4.
[90] Harvey FAQ, *supra* note 83, at 3-4.
[91] Harvey FAQ, *supra* note 83, at 3-4.
[92] Harvey FAQ, *supra* note 83, at 19.
[93] HAMEL, *supra* note 4, at 5.
[94] *Id.* at 21.
[95] *Id.* at 28.

long term health care services needed for its residents.[96] In addition, Harvey disrupted peoples living situations and finances enough for 13 percent of residents to report that they feel that their mental health worsened as a result of the disaster.[97] A temporary §1135 waiver does not prepare Texas health care provides for the increased monitoring of post-Harvey long-term mental health needs.[98]

During the time of Harvey and the increased need for health care coverage, Texas was, and still is, one of 19 states that chose not to expand its Medicaid program after the passage of the ACA.[99] Although these uninsured residents could be eligible for Medicaid due to the §1135 waiver, this waiver is a quick-fix and the health care needs of residents will remain.[100] When Harvey pummeled through Texas, the state could have expanded Medicaid to secure public funding without waiting for a declaration of emergency to occur.[101] In addition, since Texas only chose to request a §1135 waiver, rather than multiple Medicaid solutions, individuals covered by this brief Medicaid expansion only have at most 180 days after the last day of declared emergency, which has yet to occur, before they become ineligible again.[102]

V. Conclusion

In 2010, when the ACA was signed into law, states were encouraged to expand their Medicaid program to include low-income families with income at or below 133 percent FPL.[103] Texas chose and continues to choose to not

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[96] Carroll, *supra* note 34;*see e.g.,* Domino et al., *supra* note 33 (describing the long-term health effects of Hurricane Floyd in North Carolina).
[97] Hamel, *supra* note 4, at 7.
[98] Pelham, *supra* note 8.
[99] Pelham, *supra* note 8.
[100] Lauren Clason, Harvey could pose challenges for exchange enrollees (Congressional Quarterly Inc. ed., 2017).
[101] Pelham, *supra* note 8.
[102] Harvey FAQ, *supra* note 83 (explaining that the 1135 waiver is temporary).
[103] *Eligibility*, Medicaid.gov, https://www.medicaid.gov/medicaid/eligibility/index.html (last visited Sept. 24, 2018).

expand its Medicaid program, leaving at least 19 percent of Texans without healthcare coverage.[104] Due to Texas' resistance in expanding its Medicaid program and only providing a temporary coverage solution with the §1135 waiver, individuals affected by Hurricane Harvey either currently lack healthcare coverage or will lose coverage soon.[105] Texas' failure to act in the best interest for the state's most vulnerable populations will increase the long-term impact of Hurricane Harvey with no damage mitigation in sight.[106]

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[104] Louise Norris, *Texas and the ACA's Medicaid Expansion*, (May 8, 2018) https://www.healthinsurance.org/texas-medicaid/; *See 2018 Texas Data*, *supra* note 82.
[105] CLASON, *supra* note 100100; Pelham, *supra* note 8.
[106] Carroll, *supra* note 34.

Missouri's Medicaid Program: The Adoption of Arkansas' Alternative

Loxley Keala

Salus populi suprema lex.

The welfare of the people is the ultimate law.

— Cicero, 106-43 BC, Roman orator & statesman

I. Introduction

Conservative states have been reluctant to expand its Medicaid despite access to healthcare being a constant problem for individuals in the Unites States.[1] Medicaid is a Federal and state-funded program that covers a variety of medically necessary procedures for individuals who meet certain qualifications.[2] One qualification depends is based on income, which requires individuals to fall within a low-income class, and varies by state.[3] In general, Medicaid applies to individuals that are: (1) 65 years of age or older; (2) permanently disabled as defined by the Social Security Act (SSA); (3) pregnant; or (4) a minor.[4]

In 2010, the Affordable Care Act (ACA) was passed, providing affordable

[1] Ken Alltucker, *Voters Expand Medicaid in red states; gridlock in Congress likely to protect Obamacare*, USA TODAY, https://www.usatoday.com/story/news/politics/elections/2018/11/07/health-care-politics-medicaid-expansion-affordable-care-act-obamacare/1916657002/ (Nov. 7, 2018).
[2] U.S. Dep't of Health and Human Serv., *General Medicaid Requirements*, ADMINISTRATION ON AGING, https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/general-medicaid-requirements.html. (last updated Oct. 10, 2017).
[3] *Id.*
[4] *Id.*

health insurance to a larger population than before.[5] However, this law was not without its legal challenges. In 2012, the Supreme Court case, *National Federation of Independent Business v. Sebelius* limited Congress' power to compel states when deciding to expand their Medicaid programs,[6] giving broad discretion to the individual states to adopt the Medicaid expansion.[7] After this decision, not all states elected to utilize the ACA to its full potential.[8] Thus far, 37 states have adopted Medicaid expansion,[9] Missouri being among the 13 states remaining who have rejected it.[10] One state, Arkansas, has developed an alternative expansion to Medicaid which has inspired several states to adopt a similar program.[11]

Arkansas' program uses Medicaid expansion funds to help newly eligible individuals purchase private insurance.[12] In contrast, Missouri's Medicaid program expands the coverage gap.[13] The coverage gap refers to individuals who are above the current Medicaid eligibility, either based on age or income, but are below the lower limit for Marketplace premium tax credits, and therefore, have little access to healthcare.[14] It becomes significant when these individuals could have received healthcare if his or her state chose to expand Medicaid. Indeed, if every state expanded Medicaid, over two million

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[5] *See, Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 530-31 (1987); *see also,* Affordable Care Act, 42 U.S.C.A. § 18091 (2010); *see also,* Affordable Care Act, 42 U.S.C.A. § 18091 (2010).
[6] *See, Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 530-31;
[7] *See, Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 530-31; *see also,* Affordable Care Act, 42 U.S.C.A. § 18091 (2010).
[8] *Id.*
[9] Henry K. Kaiser Famiy Foundation, *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Jan. 4, 2019), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
[10] *Id.*
[11] Louise Norris, *Arkansas and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Nov. 25, 2018), https://www.healthinsurance.org/arkansas-medicaid/ [hereinafter Norris].
[12] *Id*.
[13] Rachel Garfield, et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
[14] *Id.*

more low-income adults would receive healthcare.[15] Furthermore, it becomes problematic when, for example, coverage-gap individuals who require necessary medical attention prolong treatment until they reach the age of 65.[16] By waiting to qualify for Medicaid, the individual remains untreated and the illness will most likely worsen.[17]

Although Missouri has yet to expand Medicaid, there is still hope. One possible solution is to implement Arkansas' alternative method, just as many other states have done. By doing so, Missouri would not only satisfy its policy makers and citizens, but it would increase access to healthcare. This article discusses the evolution of Missouri's Medicaid program and argues for Missouri to adopt Arkansas' alternative way of expanding Medicaid.

II. Arkansas' Medicaid Program

A. The Healthcare Independence Act of 2013

Before January 2014, Arkansas expanded coverage to all low-income adults up to 138 percent of the federal poverty level.[18] However, Arkansas still had one of the smallest Medicaid programs in the country that excluded a large population of its citizens because it did not provide coverage to childless, nondisabled adults and only covered parents up to just 17 percent of the poverty level.[19] In an attempt to improve coverage, on April 24, 2013, Arkansas Governor Mike Beebe signed into law the Health Care Independence Act.[20]

This act expanded coverage to all low-income adults, all non-aged,

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[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] Andrew Allison, *Report on Health Reform Implementation: Arkansas's Alternative to Medicaid Expansion Raises Important Questions about How HHS Will Implement New ACA Waiver Authority in 2017*, 39 J. HEALTH POL., POL'Y AND LAW 1089, 1091-92 (2014) [herein after Allison].
[19] *Id.*
[20] *Id.*

nondisabled childless adults under 13 percent of the federal poverty level, and parents between 17 and 138 percent federal poverty level and included the "private option".[21] The "private option" was intended to reach a larger population by authorizing Medicaid eligible individuals to use federal funding to purchase private insurance through the Health Insurance Marketplace.[22] In doing so, Arkansas' private option takes federal funds for the expansion and uses them to purchase certified marketplace qualified health plans for low-risk participants.[23]

B. Alternative Medicaid Effects and Eligibility

Politicians in Arkansas who opposed the ACA and traditional Medicaid expansion accepted Arkansas' Medicaid expansion alternative because it provided individuals the ability to purchase private health insurance using federal Medicaid funding while also expanding the state's targeted population.[24] Through this policy, Arkansas successfully reduced its uninsured rate by more than half, resulting in the enrollment of nearly 300,000 Arkansans.[25] As early as March 2014, the private option constituted about 80 percent of total quality health provider enrollment, which was nearly five times it had been in the past.[26] Just in the first months of enrollment, Arkansas became the thirteenth largest healthcare marketplace in the United States, despite it being the thirty-second in population ranking.[27]

Generally, Arkansas' Medicaid covers individuals ages 65 and older who meet income requirements, as well as blind or disabled individuals, as

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[21] Allison, *supra* note 18.
[22] Allison, *supra* note 18; ARK. CTR. FOR HEALTH IMPROVEMENT, *Arkansas Health Care Independence Act ("Private Option")*, http://www.achi.net/pages/OurWork/Project.aspx?ID=58 (last visited Oct. 28, 2018).
[23] Allison, *supra* note 18.
[24] Norris, *supra* note 11.
[25] Norris, *supra* note 11.
[26] Allison, *supra* note 18.
[27] Allison, *supra* note 18, at 1090-1091.

defined by the Social Security Administration.[28] In order to determine whether an individual qualifies for state Medicaid coverage, the individual completes a qualified health provider questionnaire that identifies if the individual is "medically frail" or if the individual is predicted to be at a risk of high health care usage.[29] If the individual falls within one of those two categories, then he or she receives coverage through Medicaid.[30] Individuals who are not deemed "medically frail" are presented with other qualified health provider options, so long as he or she falls within Arkansas' Silver-Level bracket.[31] Arkansas' Silver Level-Bracket allows individuals to pay moderate monthly premiums and moderate costs when he or she needs care.[32] In contrast to other states' Medicaid expansions, this approach is unique because it uses Medicaid funding to purchase individual qualified health plans through the Health Insurance Marketplace for eligible individuals.[33]

C. Setback: Implimentaion of the Work Requirement

Despite Arkansas citizens' efforts to increase access to health, in June 2018, Arkansas became the first state ever to implement work requirements, after gaining approval from the Trump administration.[34] This was done in order to incentivize employment for individuals who qualified for Medicaid.[35] Under the new guidelines, recipients must work, go to school, volunteer or search for jobs for at least 80 hours per month for 10 months out

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[28] Allison, *supra* note 18, at 1090-1091.
[29] Allison, *supra* note 18, at 1093.
[30] Allison, *supra* note 18, at 1092.
[31] Allison, *supra* note 18, at 1092; *see also Individual Policy & Schedule of Benefits*, ARKANSAS BLUECROSS BLUESHIELD (explaining that Arkanas' silver-level bracket ranges from $400 to $3,500 in annual insurance deductables for "in-network" individuals and $800 to $7,000 for "in-network" families).
[32] *Silver Health Plan*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/silver-health-plan/ (last visited Jan. 13, 2019).
[33] Norris, *supra* note 11.
[34] Tami Luhby, *Thousands in Arkansas lose Medicaid because of new work requirement*, CNN POLITICS (Sept. 6, 2018), https://www.cnn.com/2018/09/06/politics/arkansas-medicaid-work-requirements/index.html.
[35] *Id.*

of the year.[36] In addition, individuals must also report their hours online.[37] If an individual fails to meet the requirements for three months, he or she will be locked out of the program for the remainder of the calendar year.[38] Since its implementation, roughly 46,000 Medicaid enrollees were originally estimated to be subject to the work requirement in July 2018.[39] Medicaid enrollees who are between the ages of 19 and 29 will become subject to the new rules in 2019.[40]

More than 30,000 of Medicaid recipients were already meeting the mandate by working or engaging in other qualifying activities and were exempt from reporting their hours each month. Because many individuals fell within the exemption the requirement's purpose of incentivaizing employment has not shown to be beneficial.[41] In addition, individuals qualified for other exemptions or had their cases closed for unrelated reasons, further demonstrating that the work requirement has no significant benefit for Arkasans and is simply intended to narrow Medicaid's reach.[42]

From the months of June to October 2018, over 8,400 Medicaid recipients in the state have lost Medicaid due to the work requirement.[43] Some issues that have arisen are indidivuals' inability to report and log his or her hours due to limited or no internet access and their unawareness of certain exemptions. Arkansas has made exceptions in limited circumstances when an individual is prevented from reporting by factors outside of their

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[36] *Id.*
[37] Dwyer Gunn, *Here's What Happened When Arkansas Implemented Work Requirements for Medicaid Recipients,* PACIFICSTANDARD (Oct. 16, 2018) https://psmag.com/economics/heres-what-happened-when-arkansas-implemented-work-requirements-for-medicaid-recipients.
[38] *Id.*
[39] Luhby, s*upra* note 34.
[40] J. Craig Wilson & Joseph Thompson, *Medicaid Expansion in Arkansas Continues Evolution, Adds Work Requirement*, HEALTH AFFAIRS (Mar. 16, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180314.646473/full/.
[41] Luhby, s*upra*, note 34.
[42] Luhby, s*upra*, note 34.
[43] Gunn, *supra* note 37.

control, but the exceptions do not address the common problems of lack of knowledge and inability to report.[44] Similar to other Medicaid provisions, the beneficiary bears the burden of knowing that such an exemption exists, must understand that it is applicable to him or her, and must email a request to the agency.[45] This may be difficult, or even impossible, for those with little to no internet access. Thus, the exemption for a limited circumstance is not actually helpful and does not provide a solution for an individual who is unable to report his or her hours.

While an individual's ability to report the work requirement may be a setback for Arkansas' Medicaid program, it's alternative Medicaid expansion is still a positive step in the direction of improving access to health, and can be used as a template for other states that are hesitant to expand its Medicaid.

III. MISSOURI'S MEDICAID PROGRAM

A. Elibility Requirements for Seniors, Blind or Visually Impaired Individuals and Individuals with Disabilities

In contrast to Arkansas' program, Missouri has rejected any sort of Medicaid expansion.[46] Therefore, the only individuals who are eligible for Medicaid are those who fall within the age range, who are blind or visually impaired, and individuals with disabilities.[47] To qualify as a senior, the indivudal must be "[65] years of age or older, must currently live in Missouri and intend to remain, [be] a United States citizen or an eligible qualified non-citizen who owns cash, securities or other total non-exempt resources with a

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[44] Luhby, s*upra*, note 34.
[45] *Id.*
[46] *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Nov. 26, 2018), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
[47] Louise Norris, *Missouri and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Apr. 15, 2018), https://www.healthinsurance.org/missouri-medicaid/ [hereinafter Norris, *Missouri*].

value of less than the resource threshold for an individual or couple."[48] An individual who meets the age requirement must also fall within the appropriate income range in order to qualify for Medicaid as a senior.

In order to qualify for Medicaid for being blind or visually impaired, the individual must be 18 years of age or older and must be determined by law to be blind (i.e. vision less than 5/200).[49] They must also fall into a similar income range such as those qualifying for Medicaid due to age.[50]

Lastly, to qualify for Medicaid under the category of persons with disabilities, the individual must be permanently and totally disabled (as definied by the SSA), such that the individual is unable to be "gainfully and substantially employed for one year or longer due to [his or her] physical or mental incapacity."[51] In addition, the individual must have a net income less than the monthly threshold for an individual or a couple, must live in Missouri and intend to remain, must be a United States citizen or an eligible qualified non-citizen and must not be a resident of a public institution except a public medical institution.[52]

B. Disadvantages of Rejecting Medicaid Expansion

Missouri has always been hesitant to expand its Medicaid.[53] Former Representative Jay Barnes believed that the existing Medicaid system has

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[48] *MO HealthNet (Medicaid) for Seniors*, MY DDS, https://mydss.mo.gov/healthcare/mo-healthnet-for-seniors (last visited Dec. 10, 2018).
[49] *MO HealthNet (Medicaid) for the Blind and Visually Impaired*, MY DDS, https://mydss.mo.gov/healthcare/mo-healthnet-for-the-blind-and-visually-impaired (last visited Dec. 10, 2018).
[50] *Id.*
[51] *MO HealthNet (Medicaid) for People with Disabilities*, MY DDS, https://mydss.mo.gov/healthcare/mo-healthnet-for-people-with-disabilities (last visited Dec. 10, 2018).
[52] *Id.*
[53] Lacapra Veronique, *Illinois Expanded Its Medicaid Program. Missouri Didn't How Are Those Choices Working Out?*, ST.LOUISPUBLICRADIO, https://news.stlpublicradio.org/post/illinois-expanded-its-medicaid-program-missouri-didn-t-how-are-those-choices-working-out#stream/0 (Mar. 26, 2014).

"major problems."[54] Further, he described it to be "on a path […] that is unsustainable for [Missouri and the] country."[55] Like many officials, Barnes was not willing to consider Medicaid expansion until he was assured that it would not financially ruin the state.[56]

Missouri's rejection of Medicaid expansion leads to a large coverage gap among its citizens.[57] Only Texas and Alabama have fewer Medicaid participants covering up to just 18 percent of the poverty level, illustrating how few individuals Missouri's Medicaid actually reaches.[58] This leads to over 87,000 Missouri citizens left in the coverage gap, with no realistic possibility of ever receiving health insurance.[59] If Missouri were to expand its Medicaid, an additional 352,000 individuals would receive healthcare.[60]

Not only does Missouri's refusal to expand its Medicaid hurt its citizens' access to health, but it also affects the state's budget.[61] If Missouri continues to reject Medicaid expansion, the state will give up roughly $17.8 billion in federal funding between the years of 2013 and 2022.[62] In addition, because residents in states not expanding Medicaid still have to pay federal taxes, Missouri residents have been paying for Medicaid expansion in other states since 2014.[63] Accordingly, by 2022, Missouri residents will have paid approximately $7.3 billion in federal taxes to pay for Medicaid expansion in other states.[64]

IV. MISSOURI ADOPTING ARKANSAS' MEDICAID EXPANSION ALTERNATIVE

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] Norris, *Missouri*, *supra* note 47.
[58] Norris, *Missouri*, *supra* note 47.
[59] Norris, *Missouri*, *supra* note 47.
[60] Norris, *Missouri*, *supra* note 47.
[61] Norris, *Missouri*, *supra* note 47.
[62] Norris, *Missouri*, *supra* note 47.
[63] Norris, *Missouri*, *supra* note 47.
[64] Norris, *Missouri*, *supra* note 47.

If Missouri does nothing to increase its Medicaid population, many low-income individuals will not receive necessary healthcare. One solution to allow more Missourans access to health insurance, is for the state to adopt Arkansas' alternative to Medicaid expansion. This will extend Missouri's Medicaid coverage to individuals who currently fall within the coverage gap. By improving the size and risk profile of Missouri's health insurance marketplace, the private option will also encourage entry of and competition among private carriers.[65] In addition, while the kinks of the work requirement, like access to the internet, is a setback for Arkansas' progress, Missouran policy makers can implement a similar condition that improves upon this setback that Arkansas is facing.

Unlike the traditional form of Medicaid expansion, this alternative is more politically feasible for states who are fiscally conservative. By allowing individuals to purchase private health insurance using federal Medicaid finds, the state would increase access to healthcare without negatively affecting its budget.[66] In fact, expanding Medicaid would increase the state's federal funding.[67] In addition, taxpayer money that is otherwise spent on other state's Medicaid programs would remain in Missouri.[68] Implementation of the "private option" would benefit Missouri's citizens without jeopardizing its economy.[69]

Studies show that more than two million low-income uninsured adults in the United States fall into the coverage gap due to states not expanding Medicaid.[70] The issue of Missouri and many other state's Medicaid expansion must be addressed. If Missouri policy makers remain silent, more citizens will lose access to healthcare. In order to extend coverage to a larger

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[65] *See,* Allison, *supra* note 18.
[66] Norris, *Missouri*, *supra* note 47.
[67] Norris, *Missouri*, *supra* note 47.
[68] Norris, *Missouri*, *supra* note 47.
[69] Norris, *Missouri*, *supra* note 47.
[70] Garfield, *supra* note 13, at 2.

population, and in turn, save its citizens from being unable to receive the medical services they need, Missouri should adopt Arkansas'alternative to Medicaid expansion.

The Cost of Loneliness: How Social Isolation Increases Healthcare Costs Among Medicaid and Medicare Patients

Mary Liberty

I. Introduction

In an age where everything has become digital and home delivery services have become prevalent in everyday life, individuals have become more isolated from each other than ever before.[1] For older, disabled, and lower-income populations, it has become increasingly difficult to bond with the community and feel a sense of connection.[2] Social isolation has become an international epidemic that has evidenced serious health concerns.[3] This crisis has been linked to heart disease, anxiety, substance abuse, strokes, cancer, and other severe health problems.[4]

Despite these health problems, Medicaid and Medicare populations lack adequate social interventions to combat this crisis.[5] As social isolation becomes more prevalent and health concerns continue to widen globally, governments and communities must consider solutions that will help reduce Medicaid and Medicare costs and improve the quality of life among older, disabled, and lower-income patients.[6] Increasing the availability of social

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[1] Corrine Lewis, *Sick and Alone: High-Need, Socially Isolated Adults Have More Problems, but Less Support,* COMMONWEALTH FUND (Jan. 12, 2018), https://www.commonwealthfund.org/blog/2018/sick-and-alone-high-need-socially-isolated-adults-have-more-problems-less-support.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*

services among these populations is imperative to reduce healthcare costs and substantially alleviate this problem.[7]

II. Social Determinants of Health

Social isolation and loneliness has become one of the forefront issues regarding social determinants of health.[8] Social determinants of health are conditions surrounding a person's life, work, and environment that affect different aspects of one's wellbeing including functional capacity and quality-of-life.[9] Social engagement, a sense of security, and a feeling of involvement can all affect multiple different sectors of one's life.[10] Social determinants encompass an individual's availability to resources, access to education, social support, social norms and attitudes, and socioeconomic conditions, among many others.[11] Understanding how these determinants can affect one's livelihood and wellbeing is the first step in addressing this issue.[12]

III. Defining Social Isolation and its Effects

Social isolation is widely associated with loneliness, yet the two are distinct concepts.[13] Social isolation is "an *objective* lack of interactions with others and the wider community".[14] It is an objective view or measurement of one's social interactions, relationships, and social support, or lack of

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[7] *Id.*
[8] Stephanie MacLeod et al., *Examining Approaches to Address Loneliness and Social Isolation among Older Adults*, 2 J Aging Geriatr Med 1 (2018).
[9] *Social Determinants of Health,* Office of Disease Prevention and Health Promotion 1,2 (2018), https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] MacLeod, *supra* note 8.
[14] Jolynne Bockman et al., *The Social Isolation Epidemic: A Public Health Concern*, Dept. of Social Work MSU 1,1 (2018), http://sbs.mnsu.edu/socialwork/social_isolation.pdf.

engagement with others, determined by the quantity of social relationships.[15] In contrast, loneliness tends to be associated with the quality of relationships versus their quantity.[16] Loneliness is "the *subjective* feeling of the absence of a social network or a companion." [17]

Loneliness and social isolation have gained increasing attention as social determinants of health, with impacts comparable to or even greater than those of several other health risk factors, such as smoking, alcohol consumption, physical inactivity, and obesity.[18] The research regarding the impact of loneliness and social isolation on health is growing, suggesting that loneliness leads to depression, sleep problems, functional decline, and mental impairments among other harmful conditions.[19] Furthermore, loneliness has been associated with various negative health outcomes, namely higher mortality, increased risk of dementia, poor mental health, disability, and reduced quality of life.[20] Real or perceived physical or emotional detachment can also result in a spectrum of harsh realities ranging from feelings of low self-worth to attempts to harm oneself.[21]

There are many theories as to how and why social isolation may lead to ill health, however three that have been widely accepted in the scientific community.[22] One such theory covers behavior.[23] This theory asserts that people may slide into unhealthy habits and behavior when people lack encouragement from family and/or friends.[24] A second theory relates to the

[15] MacLeod, *supra* note 13.
[16] MacLeod, *supra* note 13.
[17] Bockman, *supra* note 14.
[18] MacLeod, *supra* note 13.
[19] MacLeod, *supra* note 13.
[20] MacLeod, *supra* note 13.
[21] Bockman, *supra* note 14.
[22] Bockman, *supra* note 14.
[23] *Loneliness is a Serious Public Health Problem*, ECONOMIST (Sept. 1, 2018), http://www.economist.com/international/2018/09/01/loneliness-is-a-serious-public-health-problem.
[24] *Id.*

biological effects of loneliness.[25] The biological effect of loneliness can include elevated levels of stress and sleep problems that can ultimately harm one's overall health.[26] Lastly, a third theory ascertains that loneliness can have psychological effects.[27] For example, loneliness has been seen to increase the prevalence of depression and anxiety.[28]

A study conducted by Brigham Young University suggests that the effects of loneliness and weak social connections can been so severe as to shorten a person's life by 15 years, which can equate to the same impact as smoking 15 cigarettes a day.[29] In fact, the study concluded that a greater social connection corresponds to a 50 percent decreased risk of early death.[30] A similar report analyzed over 70 studies that represented populations from North America, Europe, Asia and Australia.[31] It found that loneliness or living alone can be more harmful to a person's health than obesity.[32] This report concluded that "loneliness is not just an undesirable way to live, it can kill you."[33]

IV. Rates of Loneliness Among Aging Adults and Lower Income Populations

While loneliness may affect almost every individual at some point in their lives, the prevalence among Medicare and Medicaid populations is considerably higher.[34] These populations are much more likely to feel a lack

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[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] Mattie Quinn, *Loneliness May Be a Bigger Public Health Concern Than Smoking or Obesity,* GOVERNING (May 2018), http://www.governing.com/topics/health-human-services/gov-the-loneliness-epidemic.html.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*

of companionship and feel isolated from others.[35] Loneliness among older and disabled adults has become so common that around 30 percent to 60 percent of this population reports that they feel lonely or isolated.[36] Since the 1980s, the general population of American adults who say they that they feel lonely doubled from 20 percent to 40 percent. [37]

Despite its prevalence, loneliness, social isolation, and the rate of people lacking close relationships will likely continue to rise.[38] The number of adults 65 years of age and older is expected to double by 2060, implying that it is likely that isolation among this population will also increase.[39] Additionally, isolation is also increasing because there is reduced intergenerational living, delayed marriage, social immobility, and an increase in the number of people living alone,[40] increased age-related disabilities, and increased dual-career families.[41] Further, individuals who are socially isolated "may develop a self-perpetuating state of daytime dysfunction, social hypervigilance, and self-preservation which drives them into deeper isolation", further worsening the effects of loneliness.[42] This has been linked to directly affect Medicaid and Medicare populations, as patients who receive these services are more likely to become isolated and suffer from these loneliness-related ailments.[43]

When people think of Medicaid, they do not usually think of aging and

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[35] MacLeod, *supra* note 8.
[36] MacLeod, *supra* note 8.
[37] MacLeod, *supra* note 8.
[38] Bockman, *supra* note 14.
[39] Mark Mather, *Fact Sheet: Aging in the United States,* POPULATION REFERENCE BUREAU (January 13, 2016), https://www.prb.org/aging-unitedstates-fact-sheet/.
[40] *See generally* National Council on Aging, *Crossing New Frontiers: Benefits Access among Isolated Seniors,* NCOA (May 2011), https://www.ncoa.org/wp-content/uploads/crossing-new-frontiers.pdf (One in six older adults live in social or geographical isolation).
[41] Bockman, *supra* note 14.
[42] Bockman, *supra* note 14.
[43] Lewis, *supra* note 1.

isolated populations.[44] Medicaid often serves people with complex clinical and behavioral health issues which are populations that are more likely to face social challenges.[45] Additionally, about 4.6 million seniors receiving Medicare are also enrolled in Medicaid — and that number does not include people in their fifties and early sixties, who will likely rely on Medicaid in the near future.[46] Around 8.3 million people are currently "dually eligible" for both Medicaid and Medicare, which makes up around 17% of all Medicaid enrollees[47] or around 11 million Americans.[48]

V. Lack of Preventative Social and Mental Health Services Among Medicaid and Medicare Populations

One of the reasons that loneliness and its resulting effects have reached epidemic proportions is because of the strong stigma that surrounds seeking help for mental and emotional difficulties.[49] As a result, many low-income patients with mental and emotional concerns do not recognize that they have a mental health problem that could benefit from treatment.[50] This further leads to a lack of patients receiving adequate social interventions that could possibly prevent future health problems.[51]

In addition to the strong stigma that surrounds mental illness, those who are socially isolated are less likely to receive timely, high-quality care than

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[44] *Seniors and Medicare & Medicaid Enrolles*, Medicaid (2018), https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html.
[45] Anna Spencer, et al., *Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons,* CENTER FOR HEALTH CARE STRATEGIES (December 2016), https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf.
[46] *Id.*
[47] *Id.*
[48] Richard Eisenberg, *How to Improve Health Care for People with Medicare and Medicaid,* NEXT AVENUE (Oct. 12, 2017), *https*://www.nextavenue.org/improve-health-care-medicare-medicaid/.
[49] Shanoor Seervai & Corinne Lewis, *Listening to Low-Income Patients: Mental Health Stigma is a Barrier to Care*, COMMONWEALTH FUND (Mar. 20, 2018), https://www.commonwealthfund.org/publications/publication/2018/mar/listening-low-income-patients-mental-health-stigma-barrier-care.
[50] *Id.*
[51] *Id.*

adults who do not report feeling alone.[52] Medicaid and Medicare finances do not provide for or require social integration in diagnostics meaning many patients are not screened for isolation and loneliness.[53] This lack of appreciation for the immense role of social determinants of health proves to be the critical obstacle to the expansion and sustainability of fully integrated care.[54] Ultimately, awareness for the need of social determinant-based diagnostics and health care would improve health outcomes for society's most vulnerable members.[55]

VI. COSTS RELATED TO LONELINESS

Experts at the AARP Public Policy Institute conducted one of the first studies to examine the effects of social isolation on health care spending.[56] They found that healthcare costs to remedy problems associated with loneliness and social isolation have drastically increased.[57] Medicare spends an additional $1,608 annually on adults who are socially isolated.[58] In 2012, "roughly 13 percent, or 4 million individuals enrolled in Medicare, were socially isolated resulting in national expenditures of $6.7 billion" for socially isolated individuals that year alone – and this did not include Medicaid populations.[59] According to the SCAN Foundation, dually eligible enrollees in both Medicare and Medicaid account for roughly 40% of Medicaid spending.[60] Experts suggest that there is a need for future research

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[52] Lewis, *supra* note 1.
[53] Spencer, *supra* note 45; Iyah Romm, *Weaving Whole-Person Health Throughout an Accountable Care Framework: The Social ACO*, HEALTH AFFAIRS (Jan. 25, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170125.058419/full/.
[54] Spencer, *supra* note 45.
[55] Spencer, *supra* note 45.
[56] Lynda Flowers, et al., *Medicare Spends More on Socially Isolated Older Adults*, AARP Public Policy Institute 1, 1 (November 2017), https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf.
[57] *Id.*
[58] Bockman, *supra* note 14.
[59] Bockman, *supra* note 14.
[60] Eisenberg, *supra* note 48.

regarding social isolation among Medicaid enrollees considering Medicaid is the primary payer of long-term services and supports.[61]

VII. Approaches to Social Intervention Services

Healthcare industry leaders have researched the issue of loneliness for many years.[62] Because social determinants have been seen to have a large impact on the health and well-being of individuals, it is increasingly important to establish policies and initiatives to support and encourage changes in individual behavior and in the community.[63] According to the HealthyPeople 2020 Initiative, "improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce."[64] As a result, Healthcare providers suggested ways in which the costs and health-related illnesses of loneliness can be reduced in simple and cost-effective ways.[65] Many of these interventions have come from campaigns launched internationally.[66] In 2011, the United Kingdom became one of the first countries to launch a campaign to fight loneliness and its effects.[67] Australia soon followed with their own program to address this problem.[68] Some countries have even introduced creative ideas such Denmark who introduced "Denmark Eats Together", a campaign to encourage people to host dinner parties and get-togethers.[69] However, the United States has not implemented similar large-scale efforts to address the health impacts of loneliness.[70] Most of the work that is being done in the United States is happening on a local level. For

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[61] Flowers, *supra* note 56.
[62] Bockman, *supra* note 14.
[63] Social Determinants of Health, *supra* note 9.
[64] Social Determinants of Health, *supra* note 9.
[65] Quinn, *supra* note 29.
[66] Quinn, *supra* note 29.
[67] Quinn, *supra* note 29..
[68] Quinn, *supra* note 29.
[69] Quinn, *supra* note 29.
[70] Quinn, *supra* note 29.

instance, multiple YMCAs have begun hosting social nights for seniors and some local animal shelters have begun foster programs for adults that are homebound.[71] Additionally, CareMore launched a program called the "Togetherness Program" which focused on helping high-need individuals build personal connections and connecting them with the community.[72] According to experts, "a local approach might not be a bad place to start" at tackling this epidemic.[73]

One of the main issues with Medicaid and Medicare is that health care providers tend to diagnose and look at diseases only through coding, but this method does not measure any type of social function.[74] According to Bruce Chernof, president of The SCAN Foundation, functional and social limitations can be twice as expensive as limitations associated with chronic conditions.[75] That explains why the SCAN Foundation has emphasized the importance of asking non-medical and social assessment questions during medical exams.[76] Given the poor health outcomes associated with loneliness, and even death, devoting time to this topic during medical visits would be extremely useful.[77] A study conducted by Rush University Medical Center has found that practices that spent time during medical visits asking questions relating to social determinants of health have evidenced better patient health outcomes than those that do not ask such questions.[78] These improved outcomes have included improved quality of life and fewer hospitalizations.[79]

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[71] Quinn, *supra* note 29.
[72] David Blumenthal, *The High Health Cost of Social Isolation – and How to Cure It,* WJS (Feb. 28, 2018), https://blogs.wsj.com/experts/2018/02/28/the-high-health-cost-of-social-isolation-and-how-to-cure-it/.
[73] Quinn, *supra* note 29.
[74] Eisenberg, *supra* note 48.
[75] *Id.*
[76] *Id.*
[77] Shannon Halloway, *Should Loneliness Be the Next Vital Sign?,* NEXT AVENUE (Dec. 21, 2017), https://www.nextavenue.org/loneliness-next-vital-sign/.
[78] *Id.*
[79] *Id.*

Experts suggest that "providers should assess high-need patients for loneliness, evaluate the impact it has on their health, mental health, and access to care and refer them as needed to appropriate supports."[80] This could include the collection of data for a person's activities of daily living, their habits, and their relationships.[81] Other professionals have suggested the use of interactive services and tools to help connect isolated individuals with the community in order to feel more connected.[82] These services and tools include specialized assessment tools, telephone-based interventions, community involvement, online and digital solutions, and resilience training.[83]

A. Specialized Assessment Tools

Multiple different national organizations are beginning to develop standardizes data collection and measurement protocols that medical providers can administer to patients.[84] Specialized assessment tools can help to capture data regarding social determinants of health in an individual's life.[85] The collection of data includes: identifying the greatest needs for participants (employment, education, housing needs, etc.), measuring for food insecurity, substance use, and social isolation, and developing individualized care plans.[86] This data can help screen high-risk individuals and can be used to link patients with different programs, treatment centers, and supports in their community.[87]

B. Telephone Based Interventions

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[80] Lewis, *supra* note 1.
[81] Lewis, *supra* note 1.
[82] MacLeod, *supra* note 8.
[83] MacLeod, *supra* note 8.
[84] Spencer, *supra* note 45.
[85] Spencer, *supra* note 45.
[86] Spencer, *supra* note 45.
[87] Spencer, *supra* note 45.

This method involves volunteers and therapists connecting to isolated populations over the phone on a daily or weekly basis.[88] Telephone-based interventions are a somewhat easy way to provide isolated adults with opportunities to build social connections.[89] Telephone services are less costly than in-person interventions and offer wider availability across the nation.[90] This service allows individuals who are disabled or immobile to improve isolating conditions without much effort.[91] In addition, they allow individuals who are isolated to improve isolating conditions without requiring participants to leave the comfort of their own home – which has been seen to be a barrier to success for adults with mobility issues.[92]

C. Community Involvement

Community involvement usually focuses on in-person interventions with volunteers and members of the community.[93] Community leaders invite adults within a community to participate in these special experiences.[94] Such programs typically include volunteering in the community, special events, and parties that are within reach of these populations.[95] These programs have success across communities while also allowing isolated adults to do some good for the community.[96]

D. Online and Digital Solutions

As an alternative to telephone interventions, online and digital solutions

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[88] MacLeod, *supra* note 8.
[89] MacLeod, *supra* note 8.
[90] MacLeod, *supra* note 8.
[91] MacLeod, *supra* note 8.
[92] MacLeod, *supra* note 8.
[93] MacLeod, *supra* note 8.
[94] MacLeod, *supra* note 13.
[95] MacLeod, *supra* note 13.
[96] MacLeod, *supra* note 8.

have been seen as another successful way to address loneliness.[97] Multiple social media groups and mobile applications have been created to aim at decreasing isolation and allowing individuals to create social connections and join networks based on common interests and hobbies.[98] One of the reasons that this has become so popular is because it creates connections across all cities, states, and countries.[99]

E. Resilience Training

Finally, social resilience classes have been developed across multiple cities that teach isolated individuals to learn different ways in which to deal with social stressors and create and sustain meaningful relationships.[100] Research regarding this training has demonstrated the positive health outcomes that have resulted from teaching individuals how to deal with social stressors that may be present in everyday life.[101]

Simply put, there are many cost-effective strategies to combat loneliness and social isolation that are well worth the investment.[102] The goal is for society to start looking at social interactions as an integral part of a person's well-being, like eating well and getting enough sleep.[103] A healthy lifestyle checklist usually includes among others, exercise, eating vegetables, and getting enough sleep, but does not usually contain criteria regarding socially connecting with others. [104]

The Centers for Medicare & Medicaid Services (CMS) have just begun expanding and implementing different types of social interventions for

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[97] N. Shapira, et al., *Promoting Older Adults' Well-Being through Internet Training and Use,* TAYLOR FRANCIS ONLINE (Dec. 13, 2005) https://www.tandfonline.com/doi/full/10.1080/13607860601086546.
[98] *Id.*
[99] *Id.*
[100] MacLeod, *supra* note 8.
[101] MacLeod, *supra* note 8.
[102] Quinn, *supra* note 29.
[103] Quinn, *supra* note 29.
[104] Quinn, *supra* note 29.

Medicare patients.[105] Medicare specifically has begun developing different programs may be able to cover non-clinical, socially-related interventions.[106] Despite this, Medicaid still lacks the necessary resources for individuals in social isolation.[107] As CMS and major private payers are beginning to realize the distinct advantages and benefits of reducing loneliness, they need to begin to increase access to social-based interventions.[108]

VIII. CONCLUSION

It is clear that loneliness has a substantial effect on the well-being and health of populations globally. These negative health effects cost the United States billions of dollars due to the hospital-related costs that arise from isolation and loneliness.[109] There are a number of cost-effective and easy-to-implement interventions that can help reduce Medicare and Medicaid costs as well as reduce the length of hospitalizations among these patients.[110]

However, there still remains a lack of awareness regarding this issue today.[111] Countries across the world have begun to realize how effective interventions can be in reducing unnecessary hospitalizations, ill health, and ultimately healthcare costs.[112] Multiple studies have also been conducted that confirm the seriousness of this epidemic.[113] Governments must begin to realize that this issue is not going away without further intervention. Most

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[105] *Identifying and Managing the Social Determinants of Health*, CARECENTRIX (Jul. 12, 2018), https://www.carecentrix.com/blog/identifying-and-managing-the-social-determinants-of-health.

[106] Rick Van Burden, *State Approaches to Financing Social Interventions through Medicaid*, MEDICAID AND CHIP PAYMENT ACCESS COMM'N (Apr. 19, 2018), https://www.macpac.gov/wp-content/uploads/2018/04/State-Approaches-to-Financing-Social-Interventions-through-Medicaid.pdf.

[107] *Identifying and Managing the Social Determinants of Health*, *supra* note 105.

[108] *Identifying and Managing the Social Determinants of Health*, *supra* note 105.

[109] *Identifying and Managing the Social Determinants of Health*, *supra* note 105.

[110] MacLeod, *supra* note 8.

[111] Bockman, *supra* note 14.

[112] Lewis, *supra* note 1.

[113] *See* Bockman, *supra* note 14; Quinn, *supra* note 29.

importantly, the Medicaid and Medicare communities encompassing older adults, the disabled, and lower-income populations, deserve the right to feel included and connected with their communities. With the help of evidence-based interventions, international studies, and increased awareness of this problem, it is possible to lower Medicaid and Medicare costs which in turn can benefit the entire country. It is entirely possible for social isolation to be a problem of the past and for these populations to once again feel the bond of community.

Decayed Dental Care in Adult Medicaid Populations

Raquel E. Boton

"For there was never yet philosopher

That could endure the toothache patiently."

— William Shakespeare, *Much Ado About Nothing*

I. Introduction

In 2014, SmileDirectClub (SmileDirect) was born.[1] SmileDirect is a teledentistry company.[2] The company allows individuals to buy an at-home impression kit and have invisible aligners sent directly to their homes.[3] While SmileDirect reduces face-to-face encounters with orthodontists, it spares customers the typical costs of orthodontic treatment, costing as low as $1,850.[4] In 2017, the American Dental Association (ADA) passed a new

[1] *The History of Teeth Straightening: From Braces to Aligners*, SmileDirectClub (Dec. 7, 2017), https://blog.smiledirectclub.com/history-of-teeth-straightening-braces-aligners.

[2] Teledentistry is the use of telehealth systems and methodologies in the practice of dentistry. Telehealth refers to the use of technology to provide virtual care without direct, in-person, face-to-face contact. D9995 and D9996 – *ADA Guide to Understanding and Documenting Teledentistry Events*, American Dental Association (July 17, 2017), http://www.ada.org/en/~/media/ADA/Publications/Files/D9995andD9996_ADAGuidetoUnderstandingandDocumentingTeledentistryEvents_v1_2017Jul17.

[3] As of 2017, SmileDirect makes up ninety-five percent of the at-home invisible aligner industry, and claims to have served over 250,000 customers. *About Us*, SmileDirectClub, https://smiledirectclub.com/about (last visited Oct. 11, 2018); *Here's How it Works*, SmileDirectClub, https://smiledirectclub.com/how_it_work (last visited Oct. 11, 2018).

[4] *Pricing*, SmileDirectClub, (https://smiledirectclub.com/pricing (last visited Oct. 11, 2018).

policy "strongly discourage[ing]" the practice of do-it-yourself orthodontics.[5] A press release from the American Association of Orthodontics stated that thirteen percent of member orthodontists have seen patients who have suffered irreparable damages because they tried do-it-yourself orthodontics.[6]

The rise of SmileDirect and do-it-yourself orthodontics illustrates a general desire for greater access to dental care among lower-income populations. However, it also demonstrates the increased health risks for populations which resort to alternative forms of dental care, such do-it-yourself orthodontics, due to financial circumstances. While orthodontic treatment primarily serves cosmetic purposes,[7] low-income populations often have trouble accessing other types of dental care due to financial circumstances. [8] An important example is preventive dental care.[9] Preventive dental care typically includes routine dental examinations, cleanings, and

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[5] The American Association of Orthodontists (AAO) also discourages the use of do-it-yourself orthodontics. The AAO issued a consumer alert cautioning consumers that these do-it-yourself orthodontic companies lack proper supervision. The alert states, "Orthodontic treatment involves the movement of biological material, which if not done correctly could lead to potentially irreversible and expensive damage such as tooth and gum loss, changed bites, and other issues." David Burger, *ADA discourages DIY orthodontics through resolution*, AMERICAN DENTAL ASSOCIATION (Nov. 10, 2017), https://www.ada.org/en/publications/ada-news/2017-archive/november/ada-discourages-diy-orthodontics-through-resolution; *Questions to Consider When Researching Direct-To-Consumer Orthodontic Companies*, AMERICAN ASSOCIATION OF ORTHODONTISTS, https://www.aaoinfo.org/_/online-orthodontic-companies/ (last visited Oct. 11, 2018).

[6] *Orthodontists Report Uptick in Number of Patients Attempting DIY Teeth Straightening*, AMERICAN ASSOCIATION OF ORTHODONTISTS (Feb. 23, 2017), https://www.aaoinfo.org/1/press-room/orthodontists-report-uptick-in-number-of-patients-attempting-diy-teeth-straightening.

[7] *Why You Should Get Orthodontic Treatment*, AMERICAN ASSOCIATION OF ORTHODONTISTS (last visited Sep. 21, 2018), https://www.aaoinfo.org/_/why-you-should-get-orthodontic-treatment.

[8] Elizabeth Hinton & Julia Paradise, *Access to Dental Care in Medicaid: Spotlight on Nonedlerly Adults*, KAISER FAMILY FOUNDATION (Mar. 17, 2016), https://www.kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults.

[9] *Id*.

fluoride treatments.[10] The lack of access to affordable preventive dental care similarly places low-income populations at increased health risks.[11] The neglect of preventive dental care in adult Medicaid populations has caused serious complications in those individuals leading to emergency room visits and hospitalizations.[12]

Do-it-yourself orthodontics and the absence of preventive dental care both illustrate how individuals with compromised dental treatment, usually due to a lack of financial resources, exhibit consequences detrimental to their health. There is an important difference between compromised orthodontic treatment and compromised preventive dental care.[13] The former involves an individual seeking out allegedly sub-standard care which increases his or her risk of harm or injury.[14] The latter increases an individual's risk of harm despite any actions taken.[15] Determinantal health outcomes due to a lack of preventive dental care are inevitable for many individuals who lack resources to access proper dental care.[16] For these reasons, this article argues the importance of expanding Medicaid to cover preventive dental care for adult Medicaid populations.[17]

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[10] *Action for Dental Health: Bringing Disease Prevention into Communities*, AMERICAN DENTAL ASSOCIATION (Dec. 2013), https://www.ada.org/~/media/ADA/Public%20Programs/Files/bringing-disease-prevention-to-communities_adh.ashx.
[11] Hinton & Paradise, *supra* note 8.
[12] *Emergency Department Visits for Preventable Dental Conditions in California*, CALIFORNIA HEALTHCARE FOUNDATION (2009), https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDUseDentalConditions.pdf.
[13] *Orthodontists Report Uptick in Number of Patients Attempting DIY Teeth Straightening*, *supra* note 6; Elizabeth Hinton & Julia Paradise, *supra* note 8.
[14] *Orthodontists Report Uptick in Number of Patients Attempting DIY Teeth Straightening*, *supra* note 6.
[15] Elizabeth Hinton & Julia Paradise, *supra* note 8.
[16] Elizabeth Hinton & Julia Paradise, *supra* note 8.
[17] Adult Medicaid populations include pregnant women with income below 138% of the poverty line, parents whose income is within the state's eligibility limit for cash assistance, most seniors and persons with disabilities who receive cash assistance, and additional populations on a state-by-state basis. *Policy Basics: Introduction to Medicaid*, CENTER ON BUDGET AND POLICY PRIORITIES (last updated Aug. 16, 2016), https://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid.

Policymakers have previously proposed and implemented legislation to increase access to dental care. Recent legislation indicates that policymakers recognize the importance of oral health for both children and adults. In 1997, the federal Children's Health Insurance Program ("CHIP") was signed into law,[18] which mandated dental benefits packages for low-income children,[19] and extended coverage beyond just children eligible for Medicaid.[20] State legislatures have also introduced legislation allowing dental therapists to provide dental care as mid-level providers.[21] These scope of practice laws generally allows dental therapists to provide dental care to both adults and children as an attempted effort to increase access to dental care.[22] The recent trend on the state level to increase the *types* of dental coverage available is most indicative of policymakers' desire to expand dental coverage to adult Medicaid populations.[23] However, in times of economic stress, states have targeted dental coverage for adult Medicaid populations to cut costs.[24] A federally funded Medicaid Expansion can help prevent against future cost-cutting setbacks.

The next section of this article provides insight into the negative effect poor oral health can have on an individual's overall health. Section III delineates the economic incentives in funding preventive dental care by contrasting those preventive costs with the high costs of both emergency dental care and treatment for diseases associated with poor oral health.

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[18] *Reports and Evaluations*, MEDICAID.GOV, https://www.medicaid.gov/chip/reports-and-evaluations/index.html (last visited Oct. 11, 2018).
[19] Hinton & Paradise, *supra* note 8.
[20] David A. Nash et al., *The dental therapist movement in the United States: A critique of current trends*, 78 J. PUB. HEALTH DENTISTRY 127, 129 (2018).
[21] *See id.* at 127. (stating that dental therapists are mid-level providers of dental care in over 50 countries who typically provide dental care to children).
[22] Nash, *supra* note 20, at 127.
[23] Justin Myers, *How Have Medicaid Dental Benefits Changed in Your State?*, PBS NEWS HOUR (Nov. 17, 2011), https://www.pbs.org/newshour/health/how-have-medicaid-dental-benefits-changed-in-your-state-1.
[24] *Id.*

Section IV analyzes the state by state variation of dental coverage under Medicaid and indicates the inefficiencies of coverage in a majority of the states. Lastly, Section V analyzes attempted solutions. It argues in favor for a federal Medicaid Expansion to include preventive dental care for adult Medicaid populations because the current lack of access to dental care burdens lower-income individuals' oral and overall health and financially burdens the Medicaid program. Additionally, previously attempted and currently adopted solutions are inadequate to improve oral health and instead, have contributed to the financial burdens on Medicaid.

II. HEALTH BURDENS OF DECAYED DENTAL CARE

Poor oral health care increases risks for chronic conditions such as diabetes and heart disease.[25] *Oral Health in America: A Report of the Surgeon General* details the links between oral health and overall health.[26] Though highlighting the connection between oral health and overall health may require additional research, dentists find the connection so compelling that it influences the ways in which dentists advocate for proper oral health.[27] For example, numerous studies associate oral infections, such as periodontal disease, with an increased risk of cardiovascular disease and adverse pregnancy outcomes.[28] Research suggests that the bacteria that causes inflammation in the gums can target the fetus through the bloodstream, potentially leading to premature labor and low-birth-weight babies.[29] In

[25] *Medicaid Adult Dental Benefits: An Overview*, CENTER FOR HEALTH CARE STRATEGIES, INC. (last updated July 2018), https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_072718.pdf.

[26] National Institute of Dental & Craniofacial Research, *Oral Health in America: A Report of the Surgeon General*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, at 97, 120, (2000) https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf.

[27] *Id.* at 120.

[28] Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26 at 120.

[29] Rajiv Saini et al., *Periodontitis: A risk for delivery of premature labor and low-birth-weight infants*, 1 J. NAT. SCI. & MED. 40, 41 (2010).

addition, evidence shows that treating periodontal disease improves metabolic control for people with type 2 diabetes.[30] Cardiovascular disease, diabetes, and premature births result in high healthcare costs which are passed on to the government, private insurers, and the individuals seeking treatment.

Dental health has also been linked to individuals' well-being and quality of life.[31] Poor oral health negatively impacts diet, nutrition, sleep, psychological status, social interaction, and education.[32] Further, oral health issues burden society by increasing lost workdays and reducing employability,[33] evidenced by the estimated 164 million hours a year that adults spend on dental visits due to oral health problems or dental visits.[34] The *Oral Health in America* report further emphasized that oral pain, both a symptom of untreated dental care and a condition in itself, is a major cause of diminished quality of life associated with reduced access to care.[35] Expanding access to preventive dental care among adult Medicaid populations can help reduce poor oral health and its associated health burdens.

III. Financial Burdens of Decayed Dental Care

In many states, Medicaid covers emergency services, but not preventive care.[36] Preventive dental services limit expenditures on non-preventive, higher cost procedures, potentially resolving the higher health costs which

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[30] Susan O. Griffin et al., *Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities*, 102 AM. J. PUB. HEALTH 411, 411 (2012).
[31] Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26, at 146.
[32] Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26, at 146.
[33] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25.
[34] Hinton & Paradise, *supra* note 8.
[35] Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26, at 147.
[36] Hinton & Paradise, *supra* note 8.

result from diseases associated with poor oral health.[37] States that reduced or eliminated adult dental benefits have seen a decrease in preventive dental service use and an increase in emergency department visits related to dental problems.[38] A recent study found $2.7 billion in dental-related hospital emergency visits in the United States over a three year period, where thirty percent of the visits were by Medicaid-enrolled adults.[39] Due to the Emergency Medical Treatment and Labor Act, hospitals that receive government payment for Medicare and operate emergency rooms must agree to examine and stabilize any person who comes into the emergency department.[40] This includes screening and stabilizing individuals entering with severely neglected dental disease, which costs significantly more than prevention or even treatment in a dental practice.[41]

According to one survey of over 10,000 participants representing Medicare beneficiaries,[42] preventive care users had lower overall dental care expenditures than users who only received non-preventive dental care.[43] Preventive dental care was classified as at least one dental visit cleaning during a year.[44] While those who used preventive dental care had more overall dental visits than those who only visited amidst oral problems, those who used preventive dental care had fewer visits for expensive non-

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[37] John F. Moeller et al., *Investing in Preventive Dental Care for the Medicare Population: A Preliminary Analysis*, 100 AM. J. PUB. HEALTH 2262, 2262 (2010).
[38] Hinton & Paradise, *supra* note 8.
[39] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25.
[40] Kristen Chang, Note, *Shining the Light on Pearly Whites: Improving Oral Care for Elders in a Post-Affordable Care Act World*, 23 ELDER L. J. 489, 511 (2016).
[41] *Id.*
[42] Medicare, like Medicaid, is a government run health-insurance program. It provides insurance to elderly adults and individuals with severe disabilities, paid for entirely by the government. *Differences between Medicare and Medicaid*, MEDICAREINTERACTIVE.ORG (last visited Nov. 29, 2018), https://www.medicareinteractive.org/get-answers/medicare-basics/medicare-coverage-overview/differences-between-medicare-and-medicaid.
[43] Moeller, et al., *supra* note 37, at 2264.
[44] Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26, 80.

preventive treatment.[45] Expensive non-preventive treatments included inlays, crowns, bridges, extractions, and root canals.[46] By expanding Medicaid to cover more preventive dental procedures, Medicaid can reduce expenditures from these more expensive, non-preventive procedures.

Furthermore, the California Healthcare Foundation estimated the cost of dental neglect in their state by looking at the costs of prevention verses "cure."[47] In 2007, the average reimbursement of a comprehensive oral exam was $60, while the average reimbursement of an emergency department visit for a preventable dental condition without hospitalization was $172, and $5,044 with hospitalization.[48] Adults ages 18 to 35 were represented the most out of all emergency department visits for preventable dental conditions in California.[49] California saw over 83,000 visits to the emergency department for preventable dental conditions in 2007, which resulted in an estimated $55 million being charged to government programs, commercial insurers, and individual payers.[50] The California Healthcare Foundation policy urges federal and state policymakers to include payment for preventive dental services in national and state coverage expansion legislation.[51] Medicaid's current gap in coverage for adult Medicaid populations is burdening Medicaid as adult populations are among the most represented in emergency department visits for preventable dental conditions.

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[45] Moeller, et al., *supra* note 37, at 2264.
[46] Moeller, et al., *supra* note 37, at 2266.
[47] *Emergency Department Visits for Preventable Dental Conditions in California*, *supra* note 12.
[48] *Emergency Department Visits for Preventable Dental Conditions in California*, *supra* note 12.
[49] *Emergency Department Visits for Preventable Dental Conditions in California*, *supra* note 12.
[50] *Emergency Department Visits for Preventable Dental Conditions in California*, *supra* note 12.
[51] *Emergency Department Visits for Preventable Dental Conditions in California*, *supra* note 12.

Expanding Medicaid to cover preventive dental care for adult Medicaid populations may encourage beneficiaries to seek treatment at a dental office, rather than the more expensive emergency room. The majority of dental emergency department visits can be redirected to a dental practice, with an estimated savings of up to $1.7 billion per year currently spent on emergency department visits nationwide.[52] These savings can help fund a Medicaid expansion that covers preventive dental care in all 50 states for adult Medicaid populations.[53]

IV. State Variety of Dental Coverage for Adult Medicaid Populations

States have substantial discretion in determining an adult's dental benefits under Medicaid because federal law does not require states to provide any dental benefits to adult beneficiaries.[54] As of July 2018, only three states provide no dental benefits at all.[55] Twelve states covered emergency-only care for pain relief purposes under defined emergency situations.[56] Sixteen states cover limited services, meaning those states cover fewer than 100 types of procedures and have a per-person expenditure cap of $1,000 or less.[57] Nineteen states cover extensive services for their adult Medicaid populations, which include more than 100 types of procedures and an expenditure cap of at least $1,000 per-person.[58] Out of the states that have adopted the Medicaid

[52] Thomas Wall et al., *Majority of Dental-Related Emergency Department Visits Lack Urgency and Can Be Diverted to Dental Offices*, American Dental Association (2014), https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx; *see also Action for Dental Health: Bringing Disease Prevention into Communities*, *supra* note 10. (showing the national average costs of common preventive services as significantly lower than the national average costs of common restorative services).
[53] *Id.*
[54] Hinton & Paradise, *supra* note 8.
[55] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25.
[56] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25
[57] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25.
[58] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25

expansion, all but one offer the same dental benefits package to both their base and expansion populations.[59]

States constantly seek ways to cut down on government spending, and frequently target dental benefits because such coverage is not required under federal Medicaid regulations.[60] However, preventive dental care can be an effective use of government funds as it may prevent reimbursement for emergency department visits.[61] Also, while dental coverage can incentivize adult Medicaid beneficiaries to seek preventive dental care, it could also encourage adult Medicaid beneficiaries to seek treatment for dental problems at a dental office, which cost less than the frequented emergency room.[62]

V. Federal Medicaid Expansion as a Better Solution

This section analyzes solutions to the lack of access to dental care for adult Medicaid populations. First, it looks at inherent issues with states' use of dental therapists as a solution. Second, it encourages a federal Medicaid Expansion to cover preventive dental care for adult Medicaid populations.

The recent movement to add dental therapists into the oral health workforce exemplifies an attempt to increase access to oral health.[63] Dental therapists are dental health professionals, somewhat analogous to nurse practitioners.[64] They have historically provided basic oral health care for children since 1921, when they were introduced in New Zealand.[65] Dental therapists in in other countries have almost exclusively treated children.[66] In the United States, they were first introduced in Alaska in 2007 to help

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[59] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25
[60] Myers, *supra* note 23.
[61] Wall, *supra* note 52.
[62] Wall, *supra* note 52.
[63] Nash, *supra* note 20, at 127.
[64] Nash, *supra* note 20, at 127.
[65] Nash, *supra* note 20, at 127.
[66] Nash, *supra* note 20, at 128.

alleviate the lack of access to dental care faced by Alaska Natives.[67] Since 2007, legislation permitting dental therapy has passed in multiple states.[68] Dental therapists in the United States involves treating adults as well as children, which causes concern among the dental profession.[69]

An article in the *Journal of Public Health Dentistry*, identified significant issues in the treatment of adults by dental therapists.[70] Specifically, adult dental care is more complex than adolescent dental care and requires dental therapists to perform tasks outside the scope of what dental therapy legislation permits.[71] Additionally, the use of dental therapists to treat adults is problematic because dental therapists receive limited training which, while adequate to treat children's less complex oral health issues, is not necessarily sufficient to treat many oral health complications in adults.[72] Thus, dental therapists as a solution is inefficient as their limited training leaves them unequipped to evaluate and manage the care of health compromised adults and ultimately requires them to refer many adult patients to dentists.[73] Dental therapists treating adults pose a higher safety concern and is less efficient than their treatment of children.[74] For these reasons, the use of dental therapists is not an effective solution to increase quality access to dental care among adult populations.

Dentists, too, are urging for a Medicaid Expansion aimed at increasing coverage for dental care. The ADA, as well as state dental societies, strongly oppose the expasive scope of practice granted to dental therapists by recent

[67] Nash, *supra* note 20, at 127;
[68] S*ee generally* MINN. STAT. ANN. § 150A.106; Nash, *supra* note 20, at 127-28.
[69] S*ee generally* MINN. STAT. ANN. § 150A.106; Nash, *supra* note 20, at 127-28.
[70] Nash, *supra* note 20, at 127.
[71] Nash, *supra* note 20, at 129.
[72] Nash, *supra* note 20, at 129.
[73] Nash, *supra* note 20, at 129.
[74] Nash, *supra* note 20, at 129.

legislation.[75] In Alaska, the ADA and the Alaska State Dental Society have filed suit against the Alaska Native Tribal Health Consortium, the state of Alaska, and eight dental therapists seeking a declaration that the defendants are violating the law by practicing dentistry without a license and requesting an injunction prohibiting their practice of dentistry.[76] The suit alleged that dental therapists' limited training does not qualify them to perform irreversible dental procedures.[77]

Dentists have instead pointed to other solutions to expand access to preventive dental care for adult Medicaid populations.[78] A main issue is that Medicaid reimbursement rates are so low that dentists will not sign up as Medicaid providers.[79] This makes it difficult for Medicaid populations to access participating dentists. Expanding Medicaid funding for dental care, including providing dentists with higher reimbursement rates, could in turn increase the number of dentists participating in the program.[80] Data shows that by the end of 2035, the number of dentists will outpace population growth.[81] Therefore, the current lack of access to dental care within adult Medicaid populations is unlikely due to a *shortage* of dental professionals. Rather than creating midlevel providers, such as dental therapists, dentists support solutions that focus on making dentists more accessible to low

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[75] Erik B. Smith, *Dental Therapists in Alaska: Addressing Unmet Needs and Reviving Competition in Dental Care*, 24 ALASKA L. REV. 105, 107 (2007).
[76] Order From Chambers, Alaska Dental Soc'y v. Alaska Native Tribal Health Consortium, 2006 WL 1794742 (2006), at 2-3; Smith, *supra* note 75, at 107.
[77] Smith, *supra* 75, at 107.
[78] Robert S. Roda, *MyView: State's failed dental therapy experiment*, AMERICAN DENTAL ASSOCIATION (Apr. 16, 2018), https://www.ada.org/en/publications/ada-news/viewpoint/my-view/2018/april/states-failed-dental-therapy-experiment.
[79] *Id.*
[80] *Id*.
[81] *ADA Responds to News Coverage of Dental Therapists*, AMERICAN DENTAL ASSOCIATION (Feb. 21, 2017), https://www.ada.org/en/press-room/news-releases/2017-archives/february/ada-responds-to-news-coverage-of-dental-therapists.

income populations, such as raising reimbursement rates to dentists and expanding coverage for beneficiaries.

A federal expansion of Medicaid to cover preventive dental care for adult Medicaid recipients could also address the other issues discussed throughout this article. Expansion would likely help lower the risk for chronic diseases and lower the chance of premature birth in adult Medicaid populations.[82] It would also alleviate the burden placed on society due to the loss of workdays and employability due to oral health problems and improve the overall well-being and quality of life.[83] An expansion of preventive dental services can also dramatically lower healthcare spending on treatment of preventable dental diseases by lowering the number of emergency department visits for such problems.[84]

A federal expansion of Medicaid to cover preventive dental care for adult Medicaid populations would ensure consistency in coverage among the states, which currently drastically varies regarding coverage.[85] A 2008 study showed that dental provider participation in Medicaid increased by at least one-third following an increase in reimbursement rates.[86] Currently, only thirty-nine percent of dentists in the United States participate in Medicaid or CHIP.[87]

VI. Conclusion

[82] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25; Saini et al., *supra* note 29, at 41.
[83] *Medicaid Adult Dental Benefits: An Overview*, *supra* note 25; Nat'l Inst. Of Dental & Craniofacial Research, *supra* note 26, at 146.
[84] Hinton & Paradise, *supra* note 8.
[85] Hinton & Paradise, *supra* note 8.
[86] Hinton & Paradise, *supra* note 8.
[87] *Dentist Participation in Medicaid or CHIP*, American Dental Association (last visited Sep. 23, 2018), https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0318_1.pdf?la=en.

As exemplified by the popularity of SmileDirect, low-income populations do not always have the means to choose the safest options when it comes to oral health care. Distinct from teeth straightening treatment, neglecting preventive dental care has higher stakes. While there are inherent problems in other avenues to improve access to dental care among low-income adult populations, such as the implementation of dental therapists,[88] policymakers should seriously consider an increase in preventive dental care coverage for adult Medicaid populations on the federal level.

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[88] Nash, *supra* note 20, at 127.

Medicaid Expansion: Providing Substance Abuse Treatment to Those Who Need It, Not Facilitating the Opioid Epidemic

Theresa M. Smith

I. INTRODUCTION

The opioid epidemic has become one of the United State's most significant health care challenges since its development in the early nineties.[1] Many have become addicted to opioids and suffer from substance use disorder (SUD). SUD occurs when the use of alcohol and/or drugs causes clinical and functional impairment and affects a person's activities at work, school, or home.[2] In 2017, approximately 72,000 Americans lost their lives due to a drug overdose with most involving opioids such as heroin, prescription pain medications and illicitly made fentanyl.[3] The opioid epidemic has substantial financial implications as well, resulting in $217.5 billion in health care costs from 2001-2017.[4] In 2010, the federal

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[1] Lindsey Liu et al., *History of the Opioid Epidemic, How Did We Get Here?*, NAT'L CAP. POISON CTR., https://www.poison.org/articles/opioid-epidemic-history-and-prescribing-patterns-182.
[2] SUBSTANCE USE DISORDERS, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, https://www.samhsa.gov/disorders/substance-use (last visited Dec 1, 2018).
[3] Nat'l Inst. on Drug Abuse, *Overdose Death Rates* (Aug. 2018), https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates [hereinafter Nat'l Inst. on Drug Abuse, *Overdose Death Rates*];
[4] Dan Mangan, *Economic cost of the opioid crisis: $1 trillion and growing faster*, CNBC, https://www.cnbc.com/2018/02/12/economic-cost-of-the-opioid-crisis-1-trillion-and-growing-faster.html (last visited Dec 1, 2018). *See also Trump Administration Makes "Crisis Next Door" a Top Priority*, THE WHITE HOUSE, https://www.whitehouse.gov/articles/trump-administration-makes-crisis-next-door-top-priority/ (last visited Dec 1, 2018).

government expanded Medicaid to help those affected with SUD under the Affordable Care Act (ACA).

The ACA significantly expanded Medicaid eligibility, increasing access to health care for many Americans.[5] With this expansion, SUD treatment was reclassified as an essential benefit, meaning all health insurance plans sold on the Health Insurance Exchange or provided by Medicaid must include services for SUD's.[6] This change has made SUD's comparable to other chronic illnesses and allows those suffering from SUD to receive physician and clinician visits, family counseling, treatment and anti-craving medications.[7] As Medicaid coverage expanded, critics of the ACA argued that this expansion is facilitating more Medicaid fraud and abuse by allowing more people access to clinicians and pharmaceuticals and ultimately increasing the supply of opioids in communities.[8] Despite these arguments, Medicaid expansion is not facilitating the opioid epidemic, but instead helping more people access to treatment.[9] Specifically, Medicaid expansion has allowed more people access to medically assisted treatment (MAT) to help combat their SUDs and more access to substance treatment facilities.[10]

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[5] *Medicaid Expansion & What It Means for You*, HEALTHCARE.GOV, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you (last visited Sept. 22, 2018); *See also* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, HENRY J. KAISER FAM. FOUND. (2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (last visited Oct 24, 2018).

[6] THE AFFORDABLE CARE ACT & ADDICTION TREATMENT: HAS OBAMACARE LIVED UP TO EXPECTATIONS?, CRC HEALTH GROUP, https://www.crchealth.com/affordable-care-act-addiction-treatment-has-obamacare-lived-up-to-expectations/ (last visited Dec 1, 2018).

[7] *Id.*

[8] *See generally* U.S. Senate Committee on Homeland Sec. and Govt'l Aff.. *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic,* SENATE.Gov, https://www.hsgac.senate.gov/imo/media/doc/2018-01-17%20Drugs%20for%20Dollars%20How%20Medicaid%20Helps%20Fuel%20the%20Opioid%20Epidemic.pdf.

[9] *See generally* Matt Broaddus et al., *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show*, CTR. ON BUDGET & POL'Y PRIORITIES (2018), https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use.

[10] *Id.* at 1.

Moreover, while critics assert that in Medicaid expansion states the opioid related overdoses are higher than non-Medicaid expansion states, this was a trend that had started prior to Medicaid expansion.[11] To cut back Medicaid expansion is not a solution to these fraud and abuse claims and would cause many people to lose access to life saving treatment. If the Government wants to address the fraud and abuse, they need to focus on strengthening Prescription Drug Monitoring Systems (PDMP's), improving Medicaid Lock-In Programs (MILP's) and reviewing physician prescribing practices rather than rolling back Medicaid expansion.

This article will review the history of the opioid epidemic, the critiques of Medicaid expansion and challenge its assertions with data collected by the Agency of Healthcare Research and Quality (AHRQ). Further, this article will demonstrate that Medicaid has created programs and procedures to prevent the types of fraud and abuse to which critics point; they just need to be strengthened and improved.

II. The History of the Opioid Crises

The opioid epidemic occurred in three waves. The first wave began when opioid-related deaths rose sharply in 1991, following a period of increased opioid prescriptions for pain management.[12] At the time, pharmaceutical companies regularly insisted that risk of addiction to prescription opioids was low.[13] Pharmaceutical companies began to heavily promote opioid prescriptions and offer vacations, dinners, and other rewards to physicians in an effort to influence physician prescription behavior.[14] As such, many

[11] Broaddus et. al., *supra* note 9.
[12] Liu et al., *supra* note 1.
[13] Lie et al., *supra* note 1.
[14] *Id*.; Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 221–227 (2009). One of the biggest perpetrators was Purdue Pharma, the creator of the extremely popular Oxycodone, more

patients were prescribed highly addictive opioids to combat their pain leading to the rise in opioid-related deaths. The second wave began in 2010, when the nation experienced a rapid uptick in heroin overdoses.[15] In response to the prescription opioid related deaths, the government began to restrict the availability of prescription opioids, which led many SUD-afflicted individuals to turn to heroin, an illegal, but more easily obtained opioid.[16] From 2002 to 2013, deaths related to heroin increased by 286 percent.[17] Approximately eighty percent of heroin users admitted to abusing prescription opioids prior to turning to heroin.[18] The final wave of the opioid epidemic was marked by a sharp rise in deaths in 2013 related to synthetically produced fentanyl.[19] By 2016, fentanyl overdoses resulted in over 20,000 annual deaths in the United States.[20] As the death toll from opioids has continued to increase at an alarming rate, the government felt the societal call to action.

In 2010, the ACA was introduced as a means to expand the pool of Medicaid-eligible individuals.[21] The Act changed Medicaid eligibility and expanded coverage to all adults under sixty-five with eligible incomes.

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commonly known as Oxycontin. In what has been described as both a commercial marketing triumph and a driving factor of a public health crisis, Purdue Pharma organized all-inclusive national pain management conferences at resorts across America, at which it promoted its product.

[15] Liu et al., *supra* note 1.

[16] Liu et al., *supra* note 1.

[17] Liu et al., *supra* note 1.

[18] Liu et al., *supra* note 1.

[19] Liu et al., *supra* note 1.

[20] Liu et al., *supra* note 1.

[21] *See Medicaid Expansion & What It Means For You*, *supra* note 5 (discussing that Medicaid eligibility was expanded to allow more individuals to qualify); *See also* Rachel Garfield et. al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* HENRY J. KAISER FAM. FOUND. (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid; *See also* 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (the portion of the Affordable Care Act that expanded Medicaid).

[22]Prior, Medicaid eligibility was based on income, household size, disability, and family status.[23] The ACA requires that all insurance plans cover SUD treatments as an Essential Health Benefit.[24] Since the Medicaid expansion, numerous beneficiaries have been utilizing these benefits to receive treatments for their SUD.

In its original form, the ACA required that all states expand Medicaid eligibility. However, when the requirement was challenged, the Supreme Court rejected the requirement and provided states the option to "opt out" of Medicaid Expansion. [25] By late 2018, thirty-seven states (including Washington D.C.) have expanded Medicaid in an effort to address their citizen's health needs, including the needs of those in recovery from SUD.[26] These states are allowing more people affected with SUD to receive medically assisted treatment, substance abuse treatment, and other benefits to help combat their addiction.

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[22] *See Medicaid Expansion & What It Means For You*, *supra* note 5 (discussing the eligibility changes of Medicaid).

[23] *See Medicaid Expansion & What It Means For You*, *supra* note 5 (illustrating that though eligibility varies by state, individuals and families with incomes below 138 percent of the Federal Poverty Level are generally eligible; this would include a family of three earning $26,347 annually or an individual earning $15, 417 annually); *See also* 42 U.S.C. 1396a(a)(10)(A)(i)(VIII); *See also* Rachel Garfield et. al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* HENRY J. KAISER FAM. FOUND. (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.

[24] Amanda J. Abraham et al., *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, 107 AM. J. OF PUB. HEALTH 31, 31–32. (2017) (discussing the SUD treatment changes under the Affordable Care Act).

[25] *See generally* National Federation of Independent Businesses v. Sebelius, 132 S. Ct. 2566 (2012) (the United States Supreme Court held that the ACA requirement for Medicaid Expansion was unconstitutional because it threatens the states with a loss of federal funding if they do not comply with the new requirements. The Court held this was unconstitutional because the Constitution did not give Congress the authority to require states to regulate).

[26] *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAM. FOUND., (July 2018), https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?activeTab=map¤tTimeframe=0&selectedDistributions=current-status-of-medicaid-expansion-decision&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

III. CRITICISM OF MEDICAID EXPANSION

Despite data suggesting that Medicaid expansion is helping more people access SUD treatment, critics suggest the expansion is fueling, rather than remedying the opioid epidemic. Wisconsin Senator Ron Johnson's office released a report entitled "Drugs for Dollars: How Medicaid Helps Fuel the Opioid Crises" outlining his concerns.[27]

Senator Johnson argued that Medicaid expansion facilitates criminal activity, ranging from Medicaid beneficiaries' selling opioids they obtained through the expanded coverage, to incidences of health care fraud involving Medicaid reimbursement.[28] Senator Johnson's report identified 298 instances of criminal cases related to the use of opioids and found that at least 80 percent of the instances were reported in states that had expanded Medicaid.[29] His report found that the number of criminal cases filed related to Medicaid fraud and abuse has increased fifty-five percent when comparing the four-year period following expansion to the four-year period preceding it.[30] Moreover, Senator Johnson's report highlights preliminary data that suggests a connection between Medicaid expansion and opioid abuse,

[27] *See generally* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic, supra* note 8 (Senator Johnson released this report to critique Medicaid expansion and argue that the expansion is actually fueling the opioid epidemic) (Jan. 17, 2018), https://www.hsgac.senate.gov/imo/media/doc/2018-01-17%20Drugs%20for%20Dollars%20How%20Medicaid%20Helps%20Fuel%20the%20Opioid%20Epidemic.pdf.

[28] U.S. Senate. Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic, supra* note 8, at 3.

[29] *See* Letter from Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Aff., to Daniel R. Levinson, Inspector Gen. U.S. Dep't of Health & Hum. Servs. (July 27, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.) *See generally* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic, supra* note 8 (Chairman Johnson obtained internal data compiled by HHS showing drug overdose death rates in expansion versus non-expansion states between 2013 and 2015).

[30] *See* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 8 at 7.

specifically that drug overdose deaths are rising nearly twice as fast in expansion states as non-expansion states.[31] Senator Johnson's report also states that opioid related hospital stays paid for by Medicaid massively spiked after Medicaid expansion as well, suggesting that more opioid users are being admitted to the hospital, and that Medicaid is not helping people recover from SUD.[32] These increases, he argues, are leading to more Medicaid spending, particularly in expansion states.[33] However Senator Johnson's claims are incorrect.

IV. Medicaid Expansion is Helping with the Opioid Epidemic

Medicaid expansion is helping to fight the opioid epidemic by allowing more people access to treatments and medications to help combat SUD.[34] AHRQ's Healthcare Cost and Utilization Project found that hospitalizations among opioid users who were uninsured decreased seventy-nine percent in expansion states: from 13.9 percent in 2013 (prior to Medicaid expansion) to 2.9 percent in 2015. The data suggests that more people with SUD now have insurance coverage, and are utilizing that coverage to pay for hospitalizations and treatment.[35] In non-expansion states, hospitalizations among uninsured

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[31] *See* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 8 at 7. (Chairman Johnson obtained internal data compiled by HHS showing drug overdose death rates in expansion versus non-expansion states between 2013 and 2015).
[32] *See* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 8 at 7 (*citing* Healthcare Cost & Utilization Project, Opioid-Related Hospital Use, AGENCY FOR HEALTHCARE RES. AND QUALITY WEBSITE, https://www.hcupus.ahrq.gov/faststats/OpioidUseServlet?location1=US&characteristic1=06&setting1=IP&location2=&characteristic2=06&setting2=IP&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide (last modified Dec. 13, 2017)).
[33] *See* U.S. Senate Committee on Homeland Sec. and Govt'l Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 8 at 8.
[34] *See generally* Matt Broaddus et al., *supra* note 9 (In his article, Matt Broaddus discusses the data collected by the Agency of Healthcare Research and Quality and how it highlights that Medicaid Expansion is helping with the opioid crises).
[35] *Matt Broaddus et al., supra note 9.*

individuals decreased only a mere 0.9 percent during the same period, from 17.3 percent in 2013 to 16.4 percent in 2015, suggesting that many individuals remain without health insurance in those states.[36] Contrary to Senator Johnson's assertions Medicaid expansion has allowed more people to access medication-assisted treatment (MAT) by making those treatments more affordable.[37] Specifically, Medicaid has made Buprenorphine, a prescription to help combat opioid addiction, and Naloxone, a drug utilized to reverse the effects of an opioid overdose, more affordable for Medicaid beneficiaries.[38] As such, Medicaid spending on drugs to combat SUD and to save lives of those overdosing from SUD doubled between 2011 and 2016, suggesting that more Medicaid beneficiaries suffering from SUD are utilizing these treatments to combat their disorder.[39]

Moreover, the use of SUD treatment services between 2011 and 2015 rose nationally at 18.9 percent, suggesting that more Medicaid beneficiaries are utilizing these services.[40] Despite Senator Johnson's claim that there are more opioid related hospitalizations in expansion states, this study suggests that the increase of hospitalizations began in 2011, well before Medicaid expansion in 2013.[41] After, opioid related hospitalizations rose similarly between expansion states and non-expansion states, disputing Senator Johnson's argument that hospitalizations are spiking in expansion states relative to non-expansion states.[42] Specifically, the data shows that in Medicaid expansion states opioid related hospitalizations are up by twelve

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[36] *Matt Broaddus et al., supra note 9.*
[37] *Matt Broaddus et al., supra note 9.*
[38] Matt Broaddus et al., *supra* note 9.
[39] Matt Braoddus et. al., supra note 9.
[40] Hefei Wen, et al., *Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care Among Low-Income Adults with Behavioral Health Conditions,* Health Servs. Res., December 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693853/).
[41] Matt Broaddus et al., *supra* note 9.
[42] Matt Broaddus et al., *supra* note 9.

percent, compared with ten percent in non-expansion states.[43] Again, this data suggests that Medicaid expansion is, contrary to Senator Johnson's claims, helping to combat the opioid epidemic.[44]

V. THE FEDERAL GOVERNMENT NEEDS TO STRENGTHEN MECHANISMS TO COMBAT FRAUD

Rather than cutting back on Medicaid eligibility, as Senator Johnson and other expansion critics would suggest, the federal government should seek to improve the policies and procedures designed to combat fraud and abuse inherent to the opioid epidemic instead of removing the life saving treatment that Medicaid expansion is providing. One of the primary mechanisms through which the CMS has sought to reduce Medicaid fraud and abuse is PDMPs.[45] The agency has worked with forty-nine out of fifty states to implement PDMP that track scheduled prescriptions dispensed from pharmacies.[46] PDMPs require routine reporting of all data related to specific prescriptions.[47] This data includes medication data for the past year, dates when medications were dispensed, and information on patients, prescribers, pharmacies, and doses.[48] States use this data to identify trends in controlled substance use and distribution both within and across state lines.[49] Law enforcement uses the data to identify fraudulent or overprescribing practices and other illegal activity.[50]

However, this is not to say that PDMP as they currently operate do not

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[43] Matt Broaddus et al.,*supra* note 9.
[44] Matt Broaddus et al s*upra* note 9.
[45] Erin P. Finley et al., *Evaluating the Impact of Prescription Drug Monitoring Program Implementation: A Scoping Review*, 17 BMC HEALTH SERVS. RES., 420, 1, 1-8 (2017).
[46] *Id.* at 1.
[47] *Id.* at 1.
[48] *Id*. at 1.
[49] *Id*. at 1-2.
[50] *Id.* at 2.

have flaws that cannot be improved.[51] Because PDMPs are established at the state level, there is significant variation in how they operate between states [52] Some states require providers to use PDMPs when writing a prescription for opioids, whereas other states make reporting optional.[53] Differences between states also affect the situations in which physicians are required to consult PDMP records before prescribing opioids to a particular patient.[54] Some states, including Delaware, North Dakota and Utah require providers to run patient background checks via the PDMP when they deem it reasonable based on their own subjective "judgment of [a patient's] inappropriate use."[55] Other states, such as Oklahoma, require prescribers to consult the PDMP only when "prescribing, administering, or dispensing Methadone."[56] Because of this lack of consistency, very little research has been done on the impacts of PDMP effectiveness as an opioid risk management tool.[57]

The lack of consistency creates an opportunity for CMS or HHS to establish a standardized PDMP model. The federal government would be able to utilize standardized PDMPs to better combat Medicaid fraud and abuse as it relates to opioids. In fact, local law enforcement agencies are already utilizing PDMPs to identify fraudulent and illegal prescribing activity, and federal authorities can follow suit[58] In this federal standardized model, we could make sure all providers are enrolled and each provider must utilize PDMPs prior to prescribing and reporting their prescribing practices to make these PDMPs more useful tools to combat fraud and abuse related to

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[51] *Id*. at 6.
[52] *Id*. at 6.
[53] *Id*. at 6.
[54] *Id.* at 2.
[55] *Id.* at 2.
[56] *Id*. at 2. (Methadone is a prescription treatment utilized to help SUD-afflicted individuals to overcome addiction).
[57] *Id*. at 2.
[58] *Id.* at 1.

opioids. PDMPs can pose a solution to Senator Johnson's critiques of Medicaid Expansion without removing access to care for those afflicted with SUD.

Another model system that is being utilized to combat Medicaid fraud are MILPs). Commonly referred to as "Lock-In" programs, MILPs are programs that restrict Medicaid enrollees who are deemed to be at-risk for opioid abuse to use only one pharmacy or medical office for prescriptions.[59] States use MILPs to track Medicaid enrollees who have utilized Medicaid services at a frequency or quantity that is not medically necessary.[60] MILPs generally use billing and payment records to identify individuals who have a suspicious pattern of opioid prescription.[61] Once identified, those individuals are restricted from using Medicaid benefits to pay for additional prescriptions unless a designated physician or pharmacist writes those prescriptions.[62] The purpose of MILPs are to prevent commonly known "doctor shopping" whereby Medicaid enrollees go to multiple doctors to get multiple prescriptions for opioids.[63]

As with PDMPs, the use of MILPs brings challenges. Specifically, in MILPs people who may not be misusing opioids are getting caught in MILPs. MILPs only analyze payment records and not clinical information, they tend to target individuals overbroadly, and "lock in" some individuals who use opioids for real medical necessity. Another concern with the use of MILPs is

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[59] Asheley Skinner et. al., *Reducing Opioid Misuse: Evaluation of a Medicaid Controlled Substance Lock-In Program,* 17 J. PAIN 1151, 1150-1155 (Aug. 2016).
[60] *Tracking Opioid and Substance Use Disorders in Medicare Medicaid, and Human Services Programs*, Before Comm. On Finance, (2018) (Testimony from Brett P. Giroir & Kimberly Brandt) https://www.hhs.gov/about/agencies/asl/testimony/2018-04/tracking-opioid-and-substance-use-disorders-medicare-medicaid-hhs-programs.html.
[61]Alex K. Gertner, *Lock In Programs May Be Doing More Harm than Good and Congress is Considering Expanding Them*, HEALTH AFFS. BLOG (July 10, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180629.14455/full/.
[62] *Id.*
[63] *Id.*

that if a person is seeing multiple doctors in the course of treatment, MILPs may falsely recognize the activity as "doctor shopping."[64] Moreover, MILPs can pose a threat to individuals' ability to access medically assisted treatment (MAT) as a means of treating addiction. Buprenorphine, a primary medication used to treat opioid addiction, is itself an opioid.[65] Because Buprenorphine is an opioid, providers have found some patients locked in by MILPs for attempting to receive MAT treatment.[66] To better utilize MILPs as a means to fight Medicaid fraud and abuse, the federal government should create a standardized system that utilizes both payment and clinical records to appropriately target with a higher degree of accuracy. Again, MILPs can provide another tool to combat the fraud and abuse Senator Johnson discusses without removing the critical access to care for those now covered under Medicaid Expansion.

Despite MILPs posing as a potential way to combat fraud and abuse, by identifying those with SUD, do nothing to connect these individuals to care.[67] While there's an argument to be made for MILPs: that cutting off the supply of prescription opioids will thereby reduce their misuse, in failing to connect patients to care, Congress is missing out on an important step of ending the opioid epidemic. Similarly, like PDMPs, MILPs may decrease deaths from prescription opioids, but may result in an increase in heroin and fentanyl deaths as history repeats itself and people turn to the illicit street drugs to fulfill their addictions when their prescription opioids are removed.[68] When people who suffer from SUDs are cut off from prescription opioids, not connecting them with appropriate care and treatment can result in more people turning to illicit heroin and fentanyl, which has higher overdose

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[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*

rates.[69] In order to begin to address and combat the opioid epidemic, Congress must connect these people to care, not just cut off their prescription opioid supply.

Finally, a potential alternative to help combat not only the opioid epidemic but also Medicaid fraud and abuse is looking for alternatives besides prescribing opioids to manage pain. Numerous agencies across the United States have been tasked with seeking answers to the opioid epidemic and many have suggested looking for alternative ways to manage pain without the use of opioids.[70] If an increasing number of doctors can utilize alternative pain management instead of prescribing opioids, then ideally fewer people would be using opioids and by theory, less people would become addicted to them. Moreover, if doctors are not prescribing opioids as easily, this could curb some of the fraud that Senator Johnson highlights in his report. Perhaps if Congress imposed a federal alternative pain management program for physicians to utilize, this could prevent unnecessary prescriptions for opioids and thereby begin to combat the rate of new opioid addictions. Again, this is just another suggestion on how the federal government can address the Medicaid fraud and abuse claims Senator Johnson reports, but do so without removing people's access to SUD treatment under Medicaid Expansion.

VI. CONCLUSION

Medicaid expansion has allowed more people access to much needed SUD treatment. While Senator Johnson and other critics fear that Medicaid abuse is contributing to the opioid epidemic, research and data suggests that is not

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[69] *Id.*

[70] Katie Duensing, *AHRQ, NIH, HHS, CMS, & Congress: Looking to Integrative Pain Care to Reduce Opioid Use,* ACAD. INTEGRATIVE PAIN MGMT. (June 19, 2018), https://www.integrativepainmanagement.org/blogpost/1677160/303966/AHRQ-NIH-HHS-CMS--Congress-Looking-to-Integrative-Pain-Care-to-Reduce-Opioid-Use.

the case. In an effort to curb any Medicaid fraud, the federal government should make standard procedures across each state for prescription drug monitoring programs, Lock-In programs, and alternative pain management instead of repealing Medicaid Expansion. The government should also establish better procedures for directing individuals afflicted by SUD to appropriate care. Finally, the government should continue to focus on finding alternative ways to manage patient's pain that do not include prescribing opioids. Instead of denying life saving treatment to those affected by SUD by repealing the new eligibility requirements of Medicaid under the ACA, the above-referenced programs should be improved and strengthened. Strengthening and improving these programs may provide the compromise necessary to address Senator Johnson's concerns while also protecting the access to care of those newly eligible for Medicaid under Medicaid Expansion.

Poverty's poison: contaminated drinking water, its effect on impoverished youth and Medicaid's role

Xochitl Rodriguez

INTRODUCTION

Environmental racism is structural violence promulgated by the exploitation of those without resources by those in economic and political power.[1] The United States' legacy of racism and discrimination promotes inequalities by ensuring that minority and economically destitute populations remain stereotyped and locked in poverty.[2] These stereotypes help to negate the value of their lives, and result in the placement of environmental hazards in their neighborhoods.[3] Environmental hazards include: lead, manganese, tar sands, asbestos, and more.[4]

Lead in particular has received national attention due to the Flint Water Crisis.[5] Although average lead levels may not be cause for great alarm, poor minority populations were found to have lead poisoning at six times the average.[6] As a result, states have begun testing their drinking water for lead

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[1] Robert D. Bullard, *Race and Environmental Justice in the United States*, 18 YALE J. INT'L L. 319, 321 (1993).
[2] *Id*., at 322.
[3] *Id*.
[4] *Id.*, at 321.
[5] Siddhartha Roy, *Hazardous Waste-Levels of Lead found in a Flint Household's Water*, FLINT WATER STUDY (Aug. 24, 2015), http://flintwaterstudy.org/2015/08/hazardous-waste-levels-of-lead-found-in-a-flint-households-water/.
[6] Erin Schumaker & Alissa Scheller, *Lead Poisoning Is Still A Public Health Crisis For African-Americans*, HUFFPOST, (Dec. 6, 2017),

and discovered that lead poisoning is an epidemic they hadn't acknowledged.[7] Yet, current laws ignore the magnitude of the situation because they focus on reactive measures such as lead testing after a child has already been poisoned.[8] In order to solve this toxic situation, federal and state laws need to be more proactive in their approach. Medicaid plays a critical role since many impoverished minorities depend on this government program for their healthcare.

This article aims to describe the adverse effects of lead, the steps cities are taking to ameliorate the situation, how those steps can be expanded upon to address and solve the lead crisis, and how Medicaid coverage can be enhanced to help impoverished children affected by this public health crisis. The exact enhancements being proposed include Medicaid's adoption of mandatory universal lead screening requirements and the implementation of Health Service Initiatives whereby lead testing kits, lead filters, and lead-free water can be provided to affected communities.

I. Adverse Effects of Lead and the Corporate Greed that Fueled This Public Health Crisis

Lead is a neurotoxin with no safe level of exposure.[9] The World Health Organization (WHO) notes that lead accumulates in all areas of the body, because lead is absorbed through a process similar to the absorption of

https://www.huffingtonpost.com/2015/07/13/black-children-at-risk-for-lead-poisoning-_n_7672920.html.

[7] Arthur Delaney, *Lots of Cities Have the Same Lead Pipes That Poisoned Flint and There's No Plan to Dig Them Up*, HuffPost (Jan. 28, 2016), https://www.huffingtonpost.com/entry/lead-pipes-everywhere_us_56a8e916e4b0f71799288f54.

[8] Joshua Schneyer & M.B. Pell, *Millions of American Children Missing Early Lead Tests, Reuters Finds*, Reuters (June. 9, 2016), https://www.reuters.com/investigates/special-report/lead-poisoning-testing-gaps/.

[9] *Lead Poisoning and Health,* World Health Org. (Aug. 23, 2018), http://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health [hereinafter WHO].

vitamins.[10] Children are particularly vulnerable because they absorb four to five times as much lead as adults.[11] Moreover, impoverished children such as those on Medicaid tend to be malnourished, which causes their bodies to adsorb greater amounts of lead in comparison to other children.[12] This is particularly important because a child's brain and nervous system is still developing and lead exposure can inhibit development, potentially causing psychiatric and psychological disorders, mental retardation, and toxicity to the organs.[13]

There is no recognized or recommended medical treatment for low levels of lead other than nutritional counseling.[14] However, once lead levels surpass 45 micrograms per deciliter, the only recommend therapy,[15] has many adverse side effects that can cause severe damage to the cardiovascular, neurological, renal, and hepatic functions of the patient.[16] Additionally, the adverse effects of lead poisoning cannot be reversed and presents lifelong challenges.[17]

However, lead poisoning is completely avoidable so long as governments locate the source of the poisoning and take measures to protect affected areas and populations from exposure.[18] Lead pipes were recognized throughout the

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[10] Eliza McCarthy, *Heavy Metal: How Dangerous is Lead?*, SLATE (May 19, 2004), http://www.slate.com/articles/health_and_science/medical_examiner/2004/05/heavy_metal.html.
[11] WHO, *supra* note 9.
[12] WHO, *supra* note 9.
[13] WHO, *supra* note 9; McCarthy, *supra* note 10.
[14] *Recommended Actions Based on Blood Lead Level*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 26, 2018), https://www.cdc.gov/nceh/lead/acclpp/actions_blls.html.
[15] *Lead Levels in Children*, CTRS. FOR DISEASE CONTROL & PREVENTION (2018), https://www.cdc.gov/nceh/lead/acclpp/lead_levels_in_children_fact_sheet.pdf (explaining that chelation therapy is the only recommended therapy and is a procedure by which a solution is introduced into the body which binds to the lead and effectively flushes it from the system).
[16] Lila Abassi, *Chelation Therapy – Fad Treatment with Real Risks*, AM. COUNCIL ON SCI. AND HEALTH (Aug. 8, 2017), https://www.acsh.org/news/2017/08/08/chelation-therapy-fad-treatment-real-risks-11667.
[17] WHO, *supra* note 9.
[18] Abassi, *supra* note 16.

nation as a source of poisoning by the late 1800s,[19] when it was already known that the consumption of lead-tainted water was responsible for up to 60 percent of an infant's lead exposure.[20] By the 1920s, many cities began to recognize lead poisoning as a public health emergency, and began to prohibit or restrict the use of lead pipes.[21] Lead manufacturing companies, represented by the Lead Industries Association, recognized lead as a health hazard but did not want to jeopardize their market and profitability.[22] Consequently, the Association worked to promote the sale of lead pipes through a prolonged and effective campaign in which they presented self-published books and articles about the engineering advantages of lead over other available materials and lobbied government agencies to preserve lead as the preferred material for water service projects.[23]

Installation of lead pipes was finally prohibited nationally in 1986.[24] However very few cities formed initiatives to replace their lead pipes, leaving citizens burdened by the cost.[25] As a result, impoverished citizens with inadequate funds, the majority of which are minorities on Medicaid, are the most at-risk of having elevated blood lead levels.[26] This is because, although government agencies are aware of the danger of lead pipes, very few measures have been taken to protect minority populations from exposure.

II. FEDERAL AND STATE LAWS AIMED AT AMELIORATING THE SITUATION

The Safe Drinking Water Act (SDWA), which authorizes the Environmental Protection Agency (EPA) to set and enforce national drinking water standards, was amended in 1986, and finally prohibited the installation

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[19] Richard Rabin, *The Lead Industry and Lead Water Pipes "A Modest Campaign",* 98 AM. J. OF PUB. HEALTH 1584, 1584 (Sept. 2008).
[20] *Id*.
[21] *Id.*
[22] *Id.*, at 1585.
[23] *Id.*, at 1587.
[24] Id. at 1590.
[25] Id. at 1590.
[26] Schumaker & Scheller, *supra* note 6.

of lead water pipes nationwide.[27] The amendments recognized source water protection, established funds for water system improvements, and recognized the importance of an informed public.[28] However, the amendments failed to establish a protocol for removing previously installed lead pipes and failed to clearly define the EPA's responsibility.[29] That failure lead to ambiguities that enabled political and racial inequalities to define the law and undermine the welfare of the impoverished, thereby resulting in the problem we have today.

The Lead and Copper Rule (LCR) is an additional federal regulation that supplements the SDWA.[30] The LCR is meant to protect the public from high levels of lead and copper by regulating chemical anti-corrosion additions within the water supply.[31] However, these chemicals do not protect against slight increases in lead, which children are most susceptible to.[32] Therefore this is simply a temporary solution which in no way protects the most vulnerable populations.

Medicaid, the vital program through which impoverished Americans should be able to access preventative services and medical care to combat the lead crisis, has guidelines to help detect increases of lead in water.[33] All children enrolled in Medicaid are required to receive lead test screenings at 12 and 24 months, the cost of which is covered.[34] Medicaid provides

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[27]Rabin, *supra* note 19, at 1590.
[28] *Understanding the Safe Drinking Water Act*, ENVTL. PROTECTION AGENCY (June 2004), https://www.epa.gov/sites/production/files/2015-04/documents/epa816f04030.pdf [hereinafter EPA *Understanding the Safe Drinking Water Act*].
[29] *Id*. at 2.
[30] *Drinking Water Requirements for State and Public Water Systems: Lead and Copper Rule,* ENVTL. PROTECTION AGENCY (Mar. 15, 2017), https://www.epa.gov/dwreginfo/lead-and-copper-rule#rule-summary.
[31] *Id*.
[32] *Id*.
[33] CTRS. FOR MEDICARE & MEDICAID SVCS., CMCS Informational Bulletin: Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children's Health Insurance Program (Nov. 30, 2016) [hereinafter CMS].
[34] *Id*. at 2.

coverage for medically necessary services to ameliorate defects resulting from lead poisoning, which are identified through screening services.[35] If high lead levels are detected, an environmental assessment is required in order to identify the source of exposure, the cost of which is reimbursed by Medicaid.[36] However, there is concern that blood tests to detect lead are not being coded correctly in order to be included in the Medicaid screening data, resulting in inaccurate data which does not properly alert the state and federal governments when lead levels surpass action levels.[37]

States have an affirmative obligation to ensure that providers are informed of reporting requirements and that Medicaid-eligible children and their families are aware of available services, however there are still gaps in testing.[38] To address these gaps, Medicaid has expanded its program, to align with CDC recommended regulations, and allow states to request approval to implement targeted lead screening programs.[39] A major drawback of this program is that it is not mandatory, and to date, only one state has applied.[40] Other existing state laws are typically inconsistent in their screening requirements, which results in the lack of a national testing protocol and inconsistencies in data.[41] As a result, only 41 percent of Medicaid enrolled toddlers have been tested as recommended by Medicaid.[42]

III. How These Steps Can be Expanded to Effectively Address the Lead Crisis in Various Cities

Recently, Flint, Michigan received national attention when toxic levels of

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[35] *Id.*
[36] *Id.*, at 3.
[37] *Id.,* at 2.
[38] *Id.*
[39] *Id.*, at 3.
[40] Jennifer Dickman, *Children at Risk: Gaps in State Lead Screening Policies*, SAFER CHEMICALS HEALTHY FAMILIES (Jan. 2017) saferchemicals.org_children-at-risk-report.pdf.
[41] *Id*. (explaining that very few states require universal screening and a significant number of children do not get lead testing as a result).
[42] Schneyer & Pell, *supra* note 8.

lead were detected in its drinking water due to city officials' failure to apply anti-corrosion chemicals when changing the city's water source to the polluted Flint River.[43] Water sample results from the Department of Environmental Quality (DEQ) monitoring period exceeded the acceptable lead level, yet DEQ acted in bad faith and waited until a second round of sampling was conducted six months later to determine whether the results had improved instead of ameliorating the problem.[44] Even then, DEQ's sampling methods were tainted with bad practices such as selectively testing homes that were unlikely to have high levels of lead, asking residents to pre-flush their taps, invalidating high lead water samples, and failing to conduct follow-up tests on homes with high levels of lead.[45] The EPA did not begin to take notice until Professor Marc Edward's team from Virginia Tech, performed a study which revealed that lead levels ranged from 200 parts per billion (ppb) to 13,000 ppb, surpassing the level at which water is considered hazardous waste.[46] However, the EPA did not take steps to ameliorate the problem until months after the study's results were released.[47] Instead of acting immediately on behalf of the citizens health, the EPA failed to intervene and allowed the MDEQ to publicly express skepticism about the high levels of lead, and delay a response to the crisis.[48]

This is not a unique situation, as reports reveal that 18 million impoverished Americans live in communities where water systems are in

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[43] Roy, *supra* note 5.
[44] Letter from Doug A. Ringler, Auditor General, Office of the Auditor General, to Jim Ananich, Senate Minority Leader (Dec. 23, 2015) (on file with the Office of the Auditor General) [hereinafter Letter from Doug A. Ringler to Jim Ananich].
[45] Sara Ganim, *5,300 U.S. Water Systems are in Violation of Lead Rules*, CNN (June 29, 2016), https://www.cnn.com/2016/06/28/us/epa-lead-in-u-s-water-systems/index.html.
[46] Christopher Ingraham, *This is How Toxic Flint's Water Really I*s, WASHINGTON POST (Jan. 15, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/01/15/this-is-how-toxic-flints-water-really-is/?utm_term=.9f8dc9b4d28c (explaining that water with lead levels of 5,000 ppb is typically categorized hazardous waste).
[47] CNN Library, *Flint Water Crisis Fast Facts*, CNN (Apr. 8, 2018), https://www.cnn.com/2016/03/04/us/flint-water-crisis-fast-facts/index.html.
[48] *Id*.

violation of the laws concerning lead levels.[49] These impoverished communities are mostly made up of minorities and located in states throughout the country, including Illinois, Missouri, Texas, Oregon, Rhode Island, Massachusetts, and more.[50] These communities have only begun to garner attention due to class action lawsuits implicating the bad practices continually being used by the EPA and the state's water utility systems.[51]

Chicago, Illinois, seems to be in the early stages of a public health crisis similar to that in Flint, Michigan.[52] The same bad practices that were discovered in Flint are being practiced in Chicago.[53] Chicago's Department of Water Management only conducts water screenings on 50 homes once every three years, the minimum required by federal law.[54] Given that the homes they are testing are unlikely to have high levels of lead because they are located in middle and upper-class neighborhoods, these reports are unreliable and simply false reassurances to the citizens of Chicago that their water is safe. In fact, when the Chicago Tribune investigated the issue in 2016, they found elevated lead levels in 70 percent of the 2,797 homes sampled across the city.[55]

City of Chicago officials are aware of this problem as was revealed by a

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[49] Ganim, *supra* note 45.

[50] Emily A. Benfer, *Contaminated Childhood: The Chronic Lead Poisoning of Low-Income Children and Communities of Color in the United States*, HEALTH AFFAIRS (August 8, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170808.061398/full/; Ganim, *supra* note 42.

[51] Ganim, *supra* note 45 (presenting graphs showing that community water systems exceed action levels of lead, some of which have led to lawsuits).

[52] Katie Pohlman, These *33 Cities Cheated on Lead Contamination Tests, Similar to Flint, Michigan*, ECOWATCH (June 2, 2016), https://www.ecowatch.com/these-33-cities-cheated-on-lead-contamination-tests-similar-to-flint-m-1891160461.html.

[53] Michael Hawthorne & Jennifer Smith Richards, *Chicago Often Tests Water for Lead in Homes Where Risk is Low,* THE CHICAGO TRIBUNE (Feb. 23, 2016), http://www.chicagotribune.com/news/watchdog/ct-chicago-lead-pipes-water-testing-met-20160226-story.html; Katie Pohlman, *supra* note 52.

[54] *Hawthorne & Richards, supra* note *53*.

[55] Alex Lubben, *Chicago Drinking Water is Full of Lead, Report Says*, VICE NEWS (Apr. 13, 2018), https://news.vice.com/en_us/article/ne9kwx/lead-found-in-70-percent-of-chicago-homes-chicago-tribune-reports.

2017 lawsuit which implicated the Office of the Mayor and the Department of Public Health. The lawsuit filed by the non-profit organization Better Government Association (BGA), accused city officials of hiding emails about high levels of lead in Chicago Public Schools (CPS).[56] Federal and state law does not require testing for lead in school water pipes.[57] However after the Flint water crisis, the CEO of CPS announced lead testing would begin in schools with buildings built before 1986.[58] The complaint filed by the BGA specifies that in 2016, it was discovered that over 100 CPS schools in predominantly minority neighborhoods showed high levels of lead in their drinking water, often more than 300 ppb and as high as 1,100 ppb.[59] Further, the data reveals that children ages five and younger, who live in predominantly African-American neighborhoods, continue to be harmed as their blood lead levels are six times the city average.[60]

In response to the elevated levels of lead found in the unveiled CPS water tests, the Illinois General Assembly approved SB550, the Preventing Lead in Drinking Water Bill.[61] The bill specifies several measures to identify lead in water including testing at schools and daycare centers, parental notification, notification in areas near construction, and an inventory of lead pipes.[62] However, the bill leaves the cost of testing and notification to the schools, which may cost hundreds of thousands of dollars.[63] The bill requires parental

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[56] Lisa Klein, *Chicago Accused of Hiding Emails About Lead*, COURTHOUSE NEWS SERVICE (Apr. 12, 2017), https://www.courthousenews.com/chicago-accused-hiding-emails-lead-issue/.
[57] Dickman, *supra* note 40.
[58] Lauren Fitzpatrick, *75 CPS Schools Now Have Tested Positive for Lead* (Sept. 9, 2018), https://chicago.suntimes.com/education/75-cps-schools-now-have-tested-positive-for-lead/.
[59] *Id.*
[60] THE INT'L COMMITTEE OF THE FOURTH INT'L, *Chicago Schools and Water Infrastructure Plagued by Lead Contamination*, WORLD SOCIALIST WEB SITE (Mar. 16, 2017), https://www.wsws.org/en/articles/2017/03/16/chic-m16.html [hereinafter ICFI].
[61] *Lead in Drinking Water,* ILLINOIS ENVTL. COUNCIL (2018), https://ilenviro.org/lead-in-drinking-water/ [hereinafter IEC].
[62] Lead in Drinking Water Notification and Inventories, 415 ILCS 5/17.11.
[63] ICFI, *supra* note 60.

notification if elevated lead levels are detected, however there are no provisions that require remedial action to be taken if contamination is discovered.[64] The law also recommends that schools use property tax dollars levied for school safety to cover testing and remediation costs.[65] The General Assembly ignores the fact that schools with the most elevated lead levels are in impoverished communities, and they do not have excessive amounts of property tax dollars at their disposal.[66]

The City of Chicago has begun to replace some lead water main pipes, however this has drawn sharp critiques as some claim this is making the problem worse.[67] This is because the City only chooses to replace the lead water mains and not the lead service pipes which transport water to resident's homes.[68] A 2013 EPA report notes that disruption from replacement of only lead water mains causes lead from the service pipe to leach unsafe levels into the water supply because the handling of the pipe disrupts the protective coating of anti-corrosion chemicals.[69] Unlike other cities, which are willing to cover the costs to ensure that their residents can drink lead-free water, Chicago has not .[70] Instead, Chicago city officials believe it to be the responsibility of the homeowner to replace the lead pipes leading to their homes.[71] This has created an even greater economic and racial divide, as most low-income minority households cannot afford this repair which comes with a $20,000 price tag.[72] Compounding the issue, the city of Chicago is no longer addressing lead in its letters and handouts notifying residents when

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[64] ICFI, *supra* note 60.
[65] ICFI, *supra* note 60.
[66] Fitzpatrick, *supra* note 58.
[67] Michael Hawthorne, *Judge says Chicago's Lead Pipes Cause Contamination but Throws Out Class-Action Lawsuit*, CHICAGO TRIBUNE (Apr. 13, 2018), http://www.chicagotribune.com/news/local/breaking/ct-met-chicago-lead-pipes-lawsuit-20180413-story.html.
[68] *Id*.
[69] *Id.*
[70] Lubben, *supra* note 55.
[71] Pohlman, *supra* note 52.
[72] Pohlman*, supra* note 52.

their water mains will be replaced.[73] Additionally, Chicago has cut funding to anti-lead programs by 50%, and has begun citing insufficient funds for their failure to inspect properties, fix lead hazards, and aid impoverished families.[74]

Nevertheless, the people of Flint, Michigan and Chicago, Illinois could have benefited from a stronger Medicaid program, one which could provide them with lead testing kits, lead filters and bottled water. This would have provided an early warning to parents who could have obtained water through the Medicaid program instead of through the public water systems. In this way their children would not have to face the defects and lifelong stigma that stems from lead exposure.[75] This is because children who have been exposed to lead exhibit lower intelligence and academic performance.[76] This affects their ability to learn and makes them more likely to drop out of school and become incarcerated in their future, thus condemning them to poverty for another generation.[77]

A. How Laws and Medicaid Coverage Can be Enhanced to Help Impoverished Children

As demonstrated, the state and federal legislatures have yet to take definitive steps to protect their citizens from lead-tainted water. The SDWA prohibited the installation of new lead pipes without establishing a protocol for removing existing lead pipes.[78] The LCR provided a temporary solution for the existence of lead pipes with anti-corrosion chemicals.[79] However, the

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[73] Hawthorne & Richards, *supra* note 53.
[74] ICFI, *supra* note 60.
[75] Schneyer & Pell, *supra* note 8.
[76] Schneyer & Pell, *supra* note 8.
[77] Schneyer & Pell, *supra* note 8.
[78] EPA *Understanding the Safe Drinking Water Act*, *supra* note 28.
[79] *Use of Lead Free Pipes, Fittings, Fixtures, Solder and Flux for Drinking Water,* ENVTL PROTECTION AGENCY (July 11, 2017), https://www.epa.gov/dwstandardsregulations/use-

SDWA failed to implement a prohibition of the bad practices the EPA continues to follow.[80] These minor attempts to address the lead crisis fail to recognize that anti-corrosion chemicals are only a temporary solution which does not protect against increases in lead when the pipe is shaken or the water is slightly more acidic.[81] The critique against replacing lead pipes is that the replacement of water mains leads to handling of lead service pipes which disrupts anti-corrosion chemicals and increases levels of lead in the drinking water.[82] However this would not be an issue if water management companies simply replaced the service pipes at the same time as they replaced the water mains, a solution which was declared viable by countering legal assessments dealing with a lead water crisis in Washington D.C.[83]

Meanwhile, Medicaid remains the most vital program through which impoverished minorities can access preventative services and medical care to deal with the effects of lead in their water supply. The most crucial step Medicaid can take at the moment is to provide all residents in affected areas with lead water test kits and lead filters in order to properly test and screen

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lead-free-pipes-fittings-fixtures-solder-and-flux-drinking-water [hereinafter EPA *Use of Lead Free Pipes*].

[80] National Primary Drinking Water Regulations, 40 C.F.R. § 141; National Primary Drinking Water Regulations Implementation, 40 C.F.R. § 142; Pohlman, *supra* note 52.

[81] Hawthorne, *supra* note 67.

[82] Hawthorne, *supra* note 67.

[83] The legal assessment completed by D.C.'s water company concluded that public funds could not be used to proactively replace service lines on private property because this would add an asset to the homeowner, not a benefit to the public. However, countering legal assessments revealed that this was not a reasonable conclusion.

When the EPA first promulgated the SDWA, the law was interpreted as granting public water systems (pws) authority to replace any portion of the line the pws controls. Since pws retain authority to be able to safeguard the quality, integrity, and safety of drinking water, the EPA concluded that requiring the pws to replace service lines was consistent with the SDWA's primary purpose of protecting public health. Whether or not the service lines are considered the property of the homeowner or of the pws does not affect the fact that the EPA originally made the pws responsible for replacing service lines to promote public safety. This is because a municipality cannot give away its rights in the public way. Therefore, under the original interpretation of the SDWA it would not be possible to interpret fixing the service lines as adding an asset to the homeowner, nor would replacing the service lines pose the constitutional problem of eminent domain concerning private property.

Memorandum from EarthJustice to Environmental Protection Agency, 3 (EPA) (Nov. 11, 2014)

the toxin out of their water supply.[84] In neighborhoods where construction is ongoing and could result in elevated levels of lead, bottled water should also be routinely handed out to residents.[85] Medicaid should also adopt mandatory universal lead screening requirements for all states instead of allowing state lead screening policies to differ.[86] Medicaid should make the testing easily accessible and affordable, or possibly free through the development of Health Services Initiatives, and by sending health professionals to schools and community centers in impoverished neighborhoods to perform on site lead screening. Medicaid should also require mandatory universal reporting of results within a specified time frame.[87] In this way, Medicaid could help ensure that children who are missed because of gaps in state lead screening policies have access to testing, appropriate treatment, water filters, and bottled water if necessary, until their lead water pipes are replaced and it can be ensured that elevated levels of lead do not remain.

IV. Conclusion

Although lead exposure impacts are irreversible, Medicaid can still benefit those who have been harmed by lead-tainted water, as well as prevent the recurrence of such poisoning. This can only be accomplished through the immediate adoption of mandatory universal lead screening requirements which can ensure that all at-risk children are tested routinely. Medicaid can also help by implementing new programs, such as Health Service Initiatives which can better inform impoverished minorities of the dangers of lead and provide them with lead testing kits, lead filters and bottled water, to prevent

[84] Fran Spielman, Vallas, Green Warn Chicago Faces Flint-Style Drinking Water Crisis, CHICAGO SUN TIMES (July 26, 2018), https://chicago.suntimes.com/news/vallas-green-chicago-drinking-water-flint-crisis-lead-pipes/.
[85] *Id.* (explaining that handing out water to Flint residents helped them and might help Chicago residents faced with a similar problem).
[86] CMS, *supra* note 33, at 3.
[87] CMS, *supra* note 33, at 4 – 5.

children from being exposed to lead tainted water. In this way, situations such as those found in Flint, Michigan and Chicago, Illinois can be prevented. As a result, minority populations can be aided in their attempt to overcome this environmental hazard and the resulting stigma and defects that burden the population and the Medicaid program can be overcome.