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Table of Contents

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CONTENTS

Foreword i

ARTICLES

Medicaid Waivers and Consumer Protection: Evidence from the States

Tracy Douglas 101

Section 1115 and Section 1915 waivers for the Medicaid program have existed for some time and are intended to allow states to innovate and improve their Medicaid programs. As part of the Affordable Care Act, use of section 1115 waivers by states increased when implementing their versions of Medicaid expansion, allowing states to stray from program requirements for premiums and co-payments. Section 1915 waivers gave states the ability to expand the use of managed care, which outsources administration of Medicaid to private insurers. While legal scholarship has addressed some aspects of Medicaid waivers, like their legality and associated problems, it has not analyzed the evidence of how policies sanctioned by these waivers are operating in practice, and how they are affecting access to Medicaid and healthcare.

The waivers, in effect, outsource administrative processes to private companies and leave Medicaid enrollees at the mercy of a bureaucracy that they do not understand and caught up in a web designed to make them fail and impede access to healthcare. Waivers that were meant to innovate and improve Medicaid have not done so, based on the available evidence from the states. At a time when the Trump administration and the states are pulling back on the administrative state and the enforcement of regulations, an analysis of the policies accepted by Medicaid waivers shows the importance of consumer protection in healthcare and the importance of monitoring the actions of private companies to ensure that enrollees are not being wrongfully denied access. It is the Wild West in terms of oversight and regulation, with most healthcare consumers left unarmed.

The Tools at Hand: Medicaid Payment Reform for People with Complex Medical Needs

John V. Jacobi 135

Medicaid is a critically important vehicle that finances care for many of the nation's most vulnerable. Among the many reform efforts underway, this article addresses the surprisingly powerful effects of shifting Medicaid payment methods through alternative payment models (APMs) to address social services as well as medical care. In this article, Professor Jacobi explains how APMs can combat the fragmented nature of medical care. In addition, he explains that APMs can allow, or even require, the braiding together of medical and social services systems to counteract the effects of social determinants that lie at the heart of health disparities.

This article explains that states are empowered by the Medicaid statute to extend funding to encompass social services within a broader health care ambit, describes several mechanisms for the implementation of "whole person" care, and details the effects such care can have on vulnerable Medicaid beneficiaries. Finally, this article acknowledges criticism of what may be seen as Medicaid "mission creep" but responds to these criticisms by arguing that broadly construing Medicaid's mission to the poor and vulnerable is good policy for service providers and Medicaid beneficiaries.

The Shadows of Life: Medicaid's Failure of Health Care's Moral Test

Barak D. Richman, Kushal T. Kadakia, Shivani A. Shah 163

North Carolina Medicaid covers one-fifth of the state's population and makes up approximately one-third of the budget. Yet the state has experienced increasing costs and worsening health outcomes over the past decade, while socioeconomic disparities persist among communities. In this article, the authors explore the factors that influence these trends and provide a series of policy lessons to inform the state's current reform efforts following the recent approval of North Carolina's Section 1115 waiver by the Centers for Medicare and Medicaid Services. The authors used health, social, and financial data from the state Department of Health and Human Services, the Robert Wood Johnson Foundation, and the University of North Carolina to identify the highest cost counties in North Carolina. They found higher per beneficiary spending to be inversely related to population health, with many counties with the most expensive beneficiaries also reporting poor health outcomes. These trends appear to be attributed to a breakdown in access to basic health services, with high cost counties often lacking adequate numbers of health care providers and possessing limited health care services, leading patients to primarily engage the health care system in a reactive manner and predominantly in institutional care settings. To illustrate this pattern, the authors developed case studies of Tyrrell County and Graham County, which respectively are home to the state's worst health outcomes

and most expensive Medicaid beneficiaries. The authors combined stories of these counties with the larger historical trends to offer policy recommendations to help reorient North Carolina Medicaid around patient needs. The results shed light on traditionally understudied hotspots of cost and poor outcomes in North Carolina, while proposing tangible steps to support reform.

Preparing to Age in Place: The Role of Medicaid Waivers in Elder Abuse Prevention

Tara Sklar, JD, MPH, and Rachel Zuraw, JD, MBe 195

Over the last three decades, there has been a steady movement to increase access to aging in place as the preferred long-term care option across the country. Medicaid has largely led this effort through expansion of state waivers that provide Home and Community-Based Services (HCBS) as an alternative to nursing home care. HCBS include the provision of basic health services, personal care, and assistance with household tasks. At the time of this writing, seven states have explicitly tailored their waivers to support aging in place by offering HCBS solely for older adults, individuals aged sixty-five and over. However, there is growing concern about aging in place contributing to greater risk for social isolation, and with that increased exposure to elder abuse. Abuse, neglect, and unmet needs are highly visible in an institutional setting and can be largely invisible in the home without preventative measures to safeguard against maltreatment. This article examines the seven states with Medicaid HCBS waivers that target older adults, over a thirty-six-year period, starting with the first state in 1982 up to 2018. The authors conducted qualitative analysis with each waiver to explore the presence of safeguards that address risk factors associated with elder abuse. They found three broad categories in caregiver selection, quality assurance, and the complaints process where there are notable variations. Drawing on these findings, the authors outline features where Medicaid HCBS waivers have the potential to mitigate risk of elder abuse to further support successful aging in place.