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## NOTES

### INDIANA MEDICAID: HOPE AMID A CRISIS

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*There's all sorts of trauma from drama that children see,  
type [] that normally would call for therapy.  
But you know just how it go in our community,  
Keep [it] inside it don't matter how hard it be.<sup>1</sup>*

#### I. INTRODUCTION: THE CRISIS

The rise in substance misuse in the United States has been neither quiet nor subtle. In 2017, the U.S. Department of Health and Human Services (HHS) declared a public health emergency in response to the named “Opioid Crisis” and overdose epidemic, with an estimated 130 deaths per day or more from opioid-related drug overdoses.<sup>2</sup> The substance misuse crisis has led both traditional and nontraditional healthcare stakeholders to take action. For example, in October 2018, the United States witnessed President Trump sign the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act into law.<sup>3</sup> This was just months after three hip-hop/rap albums were released speaking out on substance misuse and mental health,<sup>4</sup> including one artist who dedicated their entire album to the consequences of youth either around or involved in substance abuse.<sup>5</sup> Around this same time, in June of 2018, Timothy Hill, the Acting Director for the Center for Medicaid

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1. J. COLE, *Friends, on KOD* (Interscope Records, Roc Nation, and Dreamville Records 2018).

2. *What is the U.S. Opioid Epidemic?*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/index.html> [<https://perma.cc/H2DB-Y45U>].

3. MaryBeth Musumeci & Jennifer Tolbert, *Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act*, KAISER FAM. FOUND. (Oct. 5, 2018), <https://www.kff.org/medicaid/issue-brief/federal-legislation-to-address-the-opioid-crisis-medicaid-provisions-in-the-support-act/> [<https://perma.cc/S62R-9DGE>].

4. *See generally* J. COLE, *KOD* (Interscope Records, Roc Nation, and Dreamville Records 2018); KID CUDI & KANYE WEST, *KIDS SEE GHOSTS* (GOOD & Def Jam 2018); KANYE WEST, *YE* (GOOD & Def Jam 2018).

5. J. COLE, *supra* note 4.

and Children’s Health Insurance Program (CHIP) Services, stressed that Neonatal Abstinence Syndrome (NAS), a withdrawal syndrome suffered by infants exposed to opioids during pregnancy,<sup>6</sup> is a “significant and rapidly growing public health concern . . . directly related to the opioid crisis facing this country.”<sup>7</sup> To put it in perspective, the U.S. saw a more than a five-fold increase of babies born with NAS the U.S. from 2000 to 2012.<sup>8</sup>

What led musicians and other leaders to push the spotlight onto the children involved in this “wicked problem”<sup>9</sup>—the substance abuse crisis? Perhaps it is a growing recognition of the future health risks for children born with NAS. For example, a ground-breaking study looked at the impact traumatic childhood experiences have on future health outcomes across an individual’s lifespan.<sup>10</sup> Each defined experience is now known as an adverse childhood experience (“ACE”),<sup>11</sup> and unfortunately, babies born with NAS have already been exposed to at least one ACE, and some have likely been exposed to more than one ACE based on the data available related to pregnant mothers who use opioids.<sup>12</sup> ACES

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6. Jean Y. Ko et al., *Morbidity and Mortality Weekly Report: Incidence of Neonatal Abstinence Syndrome—28 States, 1999-2013*, 65 MORBIDITY & MORTALITY WKLY. REP. (MMWR) 799, 799 (2016), [https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s\\_cid=mm6531a2\\_w](https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s_cid=mm6531a2_w) [<https://perma.cc/UF4K-XDYV>].

7. Timothy B. Hill, *CMCS Informational Bulletin Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants*, U.S. DEP’T HEALTH & HUM. SERVS. (June 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf> [<https://perma.cc/BR46-RFZ9>].

8. *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, NAT’L INST. ON DRUG ABUSE (Jan. 2019), <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome> [<https://perma.cc/3YZY-CG8Y>].

9. See Jonathan C. Lee, *The Opioid Crisis is a Wicked Problem*, 27 AM. J. ON ADDICTIONS 51, 51 (2017) (describing the opioid overdose epidemic as an “endemic complex system[] with components that interact in complicated, poorly understood and unpredictable ways” and as “impossible to establish a single locus . . .”).

10. See generally V. J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, 14 AM. J. PREVENTATIVE MED. 245 (1998).

11. *Id.* at 245, 250 (defining ACE categories to include psychological abuse, physical abuse, sexual abuse, substance abuse in the household, mental illness in the household, mother treated violently in the household, and criminal behavior in the household).

12. *Preventing Adverse Childhood Experiences*, CTRS. FOR DISEASE CONTROL & PREVENTION, [https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildabuseandneglect%2Facestudy%2Faboutace.html](https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildabuseandneglect%2Facestudy%2Faboutace.html) [<https://perma.cc/4A7G-278Z>] (One definition of an ACE is household substance abuse. Accordingly, every child born with NAS already has a score of one just from being born because of the mother exposing to substances in utero). See Sylvia Paull, *ACES Histories for Mothers Recovering From Substance Abuse*, ACES TOO HIGH (Dec. 27, 2015), <https://acesoohigh.com/2015/12/27/aces-histories-for-mothers-recovering-from-substance-abuse>

have been found to have an impact on neurodevelopment and link individuals to the leading causes of death in the U.S., such as obesity, smoking, alcohol abuse, and substance abuse.<sup>13</sup> Additionally, there is an increased risk for adverse health outcomes as the number of ACEs increases.<sup>14</sup> Substance abuse in the household, a circumstance children born with NAS unfortunately often find themselves in, is defined as an ACE.<sup>15</sup>

This note seeks to demonstrate that the only way of solving this “wicked”<sup>16</sup> problem is to end the cycle of substance abuse by public health policy interventions. This note will further offer attainable solutions at the policy level, specifically through Indiana’s Medicaid program. The Medicaid program is an excellent point of intervention because NAS newborns are more likely to be enrolled in Medicaid programs versus private insurance.<sup>17</sup> This note seeks to explain why the Indiana Medicaid program is not currently optimized to equip infants born with NAS with the best chance for positive health outcomes and rather is providing a barrier in efforts to end the familial cycle of substance misuse in the United States.<sup>18</sup>

## II. BACKGROUND

### *A. The Crisis’ Impact on Indiana*

Compared to other states, Indiana is disproportionately affected by the current national opioid crisis and has shown no sign of slowing. In 2017, there was a national ten percent increase in overdoses caused by opioids while Indiana saw an eighteen percent increase,<sup>19</sup> seeing its highest ever number of drug overdose

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[<https://perma.cc/2VCG-CQ6X>] (describing how a small residential program in Tennessee for new mothers and their infants recovering from substance abuse conducted a survey and found these mothers had an ACE score average of about 6); Mohamed E. Abdel-Latif et al, *Profile of Infants Born to Drug-Using Mothers: A State-Wide Audit*, 49 J. PEDIATRICS & CHILD HEALTH, E80 (2012) (explaining many of the infants born with NAS have parents with a mental illness, a characteristic considered to be an ACE).

13. See Felitti et al., *supra* note 10, at 254.

14. See *id.*

15. See *id.* at 248.

16. See Lee, *supra* note 9, at 51.

17. Khaleel S. Hussaini & Luigi F. Garcia Saavedra, *Neonatal Abstinence Syndrome (NAS) in Southwestern Border States: Examining Trends, Population Correlates, and Implications for Policy*, 22 MATERNAL & CHILD HEALTH J. 1352, 1355 (2018).

18. See *About the CDC-Kaiser ACE Study*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html> [<https://perma.cc/4A7G-278Z>] (under ACE definitions, defining one ACE as having a household member with a substance use disorder. Under major findings, ACEs increase the risk for adverse health outcomes including substance abuse).

19. F. B. Ahmad et al., *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION (2018), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

deaths in one year.<sup>20</sup> Approximately one in twelve Indiana residents (almost half a million people) meet the criteria for having a Substance Use Disorder (SUD)<sup>21</sup> with nearly four thousand Indiana residents having died from opioids within the last decade.<sup>22</sup>

Unsurprisingly, trends in NAS have correlated to the rise in SUD.<sup>23</sup> In the US, the “incidence of NAS has sharply increased from 1.19 per 1000 births in 2000, to 5.63 per 1000 births in 2012.”<sup>24</sup> While data tracking NAS trends has historically been somewhat inconsistent in Indiana,<sup>25</sup> the Indiana State Department of Health began an initiative to collect data on NAS in 2016, expanding the range of hospitals since.<sup>26</sup> Subsequent to this initiative, data collected from 2016 to 2017 showed about sixteen percent of newborns tested at participating hospitals were exposed to opioids during their mother’s pregnancy.<sup>27</sup>

Additionally, data on national trends and corresponding Medicaid spending provides further insight into how NAS is burdening Indiana. National data demonstrates rural infants are disproportionately affected nearly seven-fold as compared to urban infants,<sup>28</sup> and Indiana notably has a higher rural population percentage than the national average.<sup>29</sup>

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[<https://perma.cc/PBH6-ZFE7>].

20. Lincoln Wright, *Indiana Overdose Deaths in 2017 Reach Record High*, SOUTH BEND TRIB. (Aug. 24, 2018), [https://www.southbendtribune.com/news/publicsafety/indiana-overdose-deaths-in-reach-record-high/article\\_68edd5ef-f168-5d10-b34f-5c4b5b7f8e13.html](https://www.southbendtribune.com/news/publicsafety/indiana-overdose-deaths-in-reach-record-high/article_68edd5ef-f168-5d10-b34f-5c4b5b7f8e13.html) [<https://perma.cc/CF6G-BXT5>]

21. HAROLD KOOREMAN & MARION GREENE, TREATMENT & RECOVERY FOR SUBSTANCE USE DISORDERS IN INDIANA (Lyndy Kouns ed., 2016), <https://fsph.iupui.edu/doc/research-centers/Treatment%20and%20Recovery%202016.pdf> [<https://perma.cc/3B4T-ZDXA>].

22. Bob Segall, *So Many Bodies: Indiana Coroners Trying to Keep Up with Opioid Epidemic*, WTHR (Nov. 15, 2017, 7:14 PM), <https://www.wthr.com/so-many-bodies-indiana-corners-trying-to-keep-up-with-opioid-epidemic> [<https://perma.cc/6GT5-TD3E>].

23. See Comm. on Obstetric Practice, *ACOG Committee Opinion Number 711: Opioid Use and Opioid Use Disorder in Pregnancy*, AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, AM. SOC. OF ADDICTION MED. 2 (Aug. 2017), <http://acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice-/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy?IsMobileSet=falseS> [<https://perma.cc/87BV-ZB4L>].

24. Lauren A. Sanlorenzo et al., *Neonatal Abstinence Syndrome: An Update*, 30 CURRENT OPINION PEDIATRICS 182, 184 (2018).

25. See Maureen Groppe, *Data Show High Rate of Opiate-Affected Newborns*, INDY STAR (Aug. 13, 2016, 3:02 PM), [www.indystar.com/story/news/2016/08/13/data-show-high-rate-opiate-affected-newborns/88561134](http://www.indystar.com/story/news/2016/08/13/data-show-high-rate-opiate-affected-newborns/88561134) [<https://perma.cc/A97Q-ZRAM>] (describing Indiana’s new initiative to improve data collection methods on NAS).

26. Associated Press, *Indiana Agency Collects Data on Neonatal Abstinence Syndrome*, WASH. TIMES, (Dec. 23, 2017), <https://www.washingtontimes.com/news/2017/dec/23/indiana-agency-collects-data-on-neonatal-abstinenc/> [<https://perma.cc/X2UV-GEUV>].

27. *Id.*

28. Sanlorenzo et al., *supra* note 24, at 2.

29. See BRIGITTE S. WALDORF, WHAT IS RURAL AND WHAT IS URBAN IN INDIANA? (2007),

Nationally, eighty percent of the \$1.5 billion spent on caring for infants with NAS was paid for by Medicaid.<sup>30</sup> Indiana Medicaid has spent \$23.7 million to treat 1,616 infants born with NAS since October 1, 2015.<sup>31</sup> These figures not only provide insight on how Indiana infants are significantly affected but they also provide insight on how Medicaid can potentially aid as a tool; a tool to both improve this population's health outcomes and work toward ending the current substance misuse crisis.

The subsequent sections of this note will proceed by discussing the health problems associated with this population of infants born with NAS, followed by the structure of Indiana's Medicaid program and a discussion of why it is not currently optimized to provide this population with the best chance for a healthy future.

### *B. Neonatal Abstinence Syndrome and Its Health Implications*

Short-term effects of NAS put infants at an increased risk for serious health complications, even death, if not properly treated.<sup>32</sup> Opioid-exposed infants born and those subsequently diagnosed with NAS are at an increased risk for premature birth and low birth weight, including the complications that go along with those conditions.<sup>33</sup> Additionally, these infants are more likely to suffer from respiratory distress, problems feeding, seizures, jaundice, irritability, tremors, hyperthermia as well as the complications associated with those conditions.<sup>34</sup> Infants born with NAS also demonstrate unusual social and behavioral characteristics, often contributing to the difficulty in treating their condition.<sup>35</sup>

Additionally, infants born with NAS are at an increased risk for a variety of adverse long-term health problems as they develop through childhood into adulthood. Regarding the cognitive health risks, NAS puts infants at an increased risk for future developmental delays including social, emotional, intellectual,<sup>36</sup>

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<https://pcrd.purdue.edu/files/media/What-is-Rural-and-What-is-Urban-in-Indiana.pdf> [<https://perma.cc/39WG-XAA8>].

30. S.W. Patrick et al., *Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009-2012*, 35 J. PERINATOLOGY 650, Table 1 (2015).

31. Giles Bruce, *Babies Are Being Born Addicted to Opioids in Indiana at Alarming Rates. Help Isn't Always Available.*, THE TIMES (Sept. 17, 2017), [https://www.nwitimes.com/news/special-section/opioids-in-nwi/babies-are-being-born-addicted-to-opioids-in-indiana-at/article\\_baa97c4c-d4f8-5f2c-b4d4-5c1fe44534e2.html](https://www.nwitimes.com/news/special-section/opioids-in-nwi/babies-are-being-born-addicted-to-opioids-in-indiana-at/article_baa97c4c-d4f8-5f2c-b4d4-5c1fe44534e2.html) [<https://perma.cc/64UK-NT6P>].

32. See Stephen W. Patrick et al., *Prescription Opioid Epidemic and Infant Outcomes*, 135 PEDIATRICS 842, 847 (May 2015).

33. See *id.* at 844.

34. *Id.* Megan W. Stover & Jonathan M. Davis, *Opioids in Pregnancy and Neonatal Abstinence Syndrome*, 39 SEMINARS PERINATOLOGY 561, 562 (2015).

35. See Mohamed E. Abdel-Latif, *supra* note 12, at E84.

36. See Stephanie L. Merhar et al., *Retrospective Review of Neurodevelopmental Outcomes in Infants Treated for Neonatal Abstinence Syndrome*, 38 J. PERINATOLOGY 587 (2018).

and behavioral delays.<sup>37</sup> The increased risk of physical outcomes include comorbidities and suboptimal outcomes such as visual<sup>38</sup> and motor abnormalities, torticollis and plagiocephaly, and exposure to the hepatitis C virus.<sup>39</sup> Further, consistent with what we know regarding ACEs<sup>40</sup> and future health risks associated with NAS, children with parents who have a substance abuse disorder are at an increased risk of developing a substance use disorder themselves, thereby risking a replication of the same cycle with themselves and their own future children.<sup>41</sup>

### *C. Indiana Medicaid Program and Waiver System*

As previously mentioned, data on Indiana's Medicaid spending offers insight as to why Medicaid has the potential to be one of the best, most attainable policy interventions in the growing NAS and substance abuse crisis. Indiana Medicaid has spent \$23.7 million to treat 1,616 infants born with NAS since October 1, 2015.<sup>42</sup> As discussed previously, data show children born with NAS will likely rely on Medicaid for their healthcare needs.<sup>43</sup> Unfortunately, data based on ACEs and NAS indicates Indiana Medicaid is not currently optimized to provide children born with NAS with the healthcare they will likely need in order to have the best chance for a healthy future.

Previously discussed, babies born with NAS are at an increased risk of developing a variety of adverse health outcomes in the future, affecting both physical and mental health.<sup>44</sup> Indiana has three Medicaid options for children.<sup>45</sup> As of 2018,<sup>46</sup> each Medicaid program now offers both substance abuse treatment

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37. Eric S. Hall et al., *Developmental Disorders and Medical Complications Among Infants with Subclinical Intrauterine Opioid Exposures*, 22 POPULATION HEALTH MGMT. 19, 22 (2018).

38. Merhar, *supra* note 36, at 591.

39. Hall, *supra* note 37, at 19.

40. See *About the CDC-Kaiser ACE Study*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html> (under ACEs definitions, defining one ACE as having a household member with a substance use disorder); see also *About the CDC-Kaiser ACE Study*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html> (under major findings, ACEs increase the risk for adverse health outcomes including substance abuse).

41. Anthony Nagle & Gill Watson, *Parental Substance Misuse: An Islington Perspective*, 17 CHILD ABUSE REV. 444, 445 (2008); Kathleen R. Merikangas et al., *Psychopathology Among Offspring of Parents with Substance Abuse and/or Anxiety Disorders: A High-risk Study*, 39 J. CHILD PSYCHOL. & PSYCHIATRY 711, 712 (1998).

42. Bruce, *supra* note 31.

43. Patrick et al., *supra* note 32, at 652.

44. See generally Nagle & Watson, *supra* note 41; Merikangas et al., *supra*, note 41; Merhar, et al., *supra* note 36.

45. Ind. Medicaid for Members., *Children*, IN.GOV (2019), <https://www.in.gov/medicaid/members/218.htm> [<https://perma.cc/NT7G-RT87>].

46. See Letter from Eric J. Holcomb, Governor of Ind., to Norris Cochran, Sec'y of the Dep't.

and mental health treatment to all Indiana Medicaid members whereas, in the past, only certain plans offered certain services.<sup>47</sup> These types of services are those that individuals born with NAS are at an increased chance of needing some time in the future.<sup>48</sup> This attempt to improve access to mental health and substance abuse services was a major improvement through the HIP 2.0 program,<sup>49</sup> however, Indiana will have to make additional changes in order to maximize the potential benefits of expanding access to treatment.

Indiana notoriously, and consistently falls behind in national healthcare rankings. A 2016 report ranked Indiana 45 out of 51 (including all 50 states and the District of Columbia) on the state's mental healthcare status, the lower ranking indicating a higher prevalence of a qualifying mental illness and a low rate of access to care.<sup>50</sup> The 2017 U.S. News & World Report ranked Indiana 40 out of 50 overall for general state healthcare rankings, taking into consideration access, quality, and public health services.<sup>51</sup> It might seem that the newly amended Indiana Medicaid program will solve the issues surrounding lack of mental health and substance abuse treatment accessibility, however, there are deeper issues and it is unclear whether Indiana is willing to fix them.

Healthcare accessibility goes beyond what services a healthcare plan will cover. There has to be a workforce behind those services. Currently, there is a severe shortage of mental health and addiction specialists,<sup>52</sup> services individuals

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of Health and Human Servs., (Jan. 31, 2017), [https://www.in.gov/fssa/hip/files/HIP\\_2\\_0\\_Letter.pdf](https://www.in.gov/fssa/hip/files/HIP_2_0_Letter.pdf) [<https://perma.cc/DQ5F-69AH>].

47. Ind. Medicaid for Members, *What is Covered by Indiana Medicaid?*, IN.GOV, <https://www.in.gov/medicaid/members/297.htm> [<https://perma.cc/9ZXU-SZGM>]. Sarah Fentem, *State Will Now Cover More Addiction Treatment for Hoosiers on Medicaid*, SIDE EFFECTS PUBLIC MEDIA, WFYI INDIANAPOLIS (Feb. 11, 2018), <http://www.sideeffectspublicmedia.org/post/state-will-now-cover-more-addiction-treatment-hoosiers-medicare> [<https://perma.cc/KA2D-7QET>].

48. See generally Nagle & Watson, *supra* note 41; Merikangas et. al., *supra* note 41; Merhar et al., *supra* note 36.

49. See Maureen Groppe, *Who Will Benefit From Indiana's HIP 2.0?*, INDYSTAR (Jan. 27, 2015, 11:59 AM), <https://www.indystar.com/story/news/2015/01/27/will-benefit-expansion-indianas-medicare-alternative/22403479/> [<https://perma.cc/S5C5-8JPF>] (explaining Indiana's experimental program in expanding Medicaid).

50. *Reports Highlight Mental Health Treatment Concerns in Indiana*, OPTIONS BEHAV. HEALTH SYS., <https://www.optionsbehavioralhealthsystem.com/about/indiana-community-resources/indianas-mental-health-crisis/> [<https://perma.cc/H8LZ-6FS5>]. See also *Ranking the States*, MENTAL HEALTH AMERICA, <http://www.mentalhealthamerica.net/issues/ranking-states> [<https://perma.cc/8E9N-D8M9>].

51. *Health Care Rankings. Measuring How Well States Are Meeting Citizens' Health Care Needs*, U.S. NEWS & WORLD REP., <https://www.usnews.com/news/best-states/rankings/health-care> [<https://perma.cc/LA2Q-LY8Q>].

52. Christine Vestal, *How Severe is the Shortage of Substance Abuse Specialists?*, PEW CHARITABLE TRUSTS (Apr. 1, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists> [<https://perma.cc/B6G7-7DQG>].

born with NAS are at an increased risk of needing.<sup>53</sup> Nationally, behavioral health specialists trained to work with individuals with substance use disorders, including psychiatrists, psychologists, and counselors have an availability on average of 32 behavioral health specialists per 1,000 people affected by a mental health and/or substance use disorder; in Indiana, that number is just under 20 specialists per 1,000 affected.<sup>54</sup>

The main reasons attributed to this shortage are the stigma associated with the SUD population and poor pay.<sup>55</sup> Physicians, psychologists, and counselors in the behavioral health field have considerably smaller salaries compared to their counterparts in other specialties that require the same amount of education and training.<sup>56</sup> This lower salary is a result of notoriously low reimbursement rates from state governments for mental health and substance abuse treatment services.<sup>57</sup>

Medicaid, including CHIP, covers about 74 million people (about 24%) of the U.S. population.<sup>58</sup> States participating in Medicaid provide eligible individuals coverage for medical services and the federal government matches the state's Medicaid payments to the program based on the current federal medical assistance percentage ("FMAP").<sup>59</sup> The FMAP for a state will always be in a range of 50% - 83% federal matching per state dollar spent,<sup>60</sup> and "takes into account the average per capita income for each [s]tate relative to the national average."<sup>61</sup> Indiana's current FMAP, for example, is 65.83%;<sup>62</sup> this means that the federal government will contribute 65.84% of the cost for a covered medical service for an individual, and Indiana will contribute 34.16% of the cost for that service. Indiana's Medicaid program covers certain services for individuals with incomes 133% below the federal poverty line, as well as pregnant women and

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53. See Nagle & Watson, *supra* note 41, at 444-453. See generally Merikangas et al., *supra*, note 41; Merhar et al., *supra* note 36; Hall et al., *supra* note 37, at 22.

54. Vestal, *supra* note 52.

55. *Id.* See also Natalie Jacewicz, *Teaching Future Doctors About Addiction*, KAISER HEALTH NEWS (Aug. 2, 2016), <https://khn.org/news/teaching-future-doctors-about-addiction/> [<https://perma.cc/N385-5LJL>]. See also David Levine, *What's the Answer to the Shortage Of Mental Health Care Providers?*, U.S. NEWS & WORLD REP. (May 25, 2018), <https://health.usnews.com/health-care/patient-advice/articles/2018-05-25/whats-the-answer-to-the-shortage-of-mental-health-care-providers> [<https://perma.cc/J7FH-2RRG>].

56. Vestal, *supra* note 52.

57. *Id.*

58. NICOLE HUBERFELD, ELIZABETH WEEKS LEONARD, & KEVIN OUTTERSON, *THE LAW OF AMERICAN HEALTH CARE*, 89 (2nd ed. 2018).

59. *Id.* at 91-92 (explaining 42 U.S.C. § 1396(b)).

60. *Id.* at 92 (with excerpt of 42 U.S.C. § 1396d(b)).

61. *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/2HHP-8JQ7>].

62. *Id.*



children even further below this threshold.<sup>63</sup>

Indiana Medicaid has eight waivers which allow for reimbursement for services not traditionally covered under Medicaid, opening the door for some practitioners to receive reimbursements for things like outpatient psychosocial addiction treatment,<sup>64</sup> addiction treatment, group therapy, and other mental health services which are otherwise not covered under the general Medicaid program.<sup>65</sup> The issues with these waivers are that each waiver offers distinct services, individuals may only be enrolled in one waiver program at a time,<sup>66</sup> and existing monetary spending caps on some of the waivers.<sup>67</sup>

Individuals born with NAS are at risk for needing treatment under two different Indiana Medicaid Waiver programs based on current research on future health outcomes of this population. The first waiver, under the Indiana Family and Social Services Administration (FSSA)'s Division of Aging, is the Aged & Disabled (A&D) Waiver.<sup>68</sup> Its purpose is to provide home- and community-based services to individuals who otherwise would require a nursing facility level of care.<sup>69</sup> The second waiver, under the Division of Disability and Rehabilitative Services (DDRS) of the FSSA, is the Family Supports (FS) Waiver.<sup>70</sup> This waiver provides "services to participants in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual disabilities or related conditions."<sup>71</sup> Notably, this waiver does not provide reimbursement for behavioral therapy and does not provide reimbursement for mental health or addiction treatment.<sup>72</sup> The Community Integration and Habilitation (CIH) Waiver under DDRS is similar to the FS Waiver but serves a population that meets additional criteria relating to their diagnosis of developmental disability or intellectual disability, generally with more substantial functional limitations.<sup>73</sup> Again, however, this waiver does not provide

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63. *Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html> [<https://perma.cc/D2WS-NJ5U>].

64. *See* Procedure Code 4306F (PT TLK PSYCH & RX OPD ADDIC), Outpatient Fee Schedule, [http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee\\_home.asp#OutpatientFeeSchedule](http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp#OutpatientFeeSchedule) [<https://perma.cc/F8V7-7PSX>] (these spreadsheets are updated over time).

65. *See id.*

66. *Maertz v. Minott*, No. 1:13-cv-00957-JMS-MJD, 2015 U.S. Dist. LEXIS 74084, R \*3, 10 (S.D. Ind. June 9, 2015).

67. *Steimel v. Wernert*, 823 F.3d 902, 907 (7th Cir. 2016).

68. *See* Family & Soc. Serv. Admin., *Indiana Home and Community-Based Services Waiver*, IN.GOV, <https://www.in.gov/fssa/da/3476.htm> [<https://perma.cc/5HLF-6DXQ>].

69. *Steimel*, 823 F.3d at 907.

70. Family & Soc. Serv. Admin., *Bureau of Developmental Disabilities Services*, IN.GOV, <https://www.in.gov/fssa/ddrs/2639.htm> [<https://perma.cc/WU45-THXW>].

71. *Id.*

72. *See generally* Family & Soc. Serv. Admin., *Medicaid HCBS Programs*, IN.GOV, <https://www.in.gov/fssa/ompp/2549.htm> [<https://perma.cc/JYZ2-5HRK>].

73. *Steimel*, 823 F.3d at 907; Family & Soc. Serv. Admin., *supra* note 69.

reimbursement for behavioral therapy nor does it provide reimbursement for mental health or addiction treatment.

There are other Indiana Medicaid waivers relatively unrelated to the needs of individuals born with NAS, however, they are still worth mentioning to add context and to paint a picture of a state like Indiana's Medicaid system. A waiver that ended new enrollees in 2017 is the PRTF Transition Waiver.<sup>74</sup> Individuals still on this waiver are provided behavioral health community-based care and are considered high-need children, including those that have transitioned from a psychiatric residential treatment facility to a community setting.<sup>75</sup> Relatively unrelated to this topic, there is also a Traumatic Brain Injury Waiver through FSSA's Division of Aging.<sup>76</sup>

Potentially related to the future needs of individuals born with NAS, the Adult Mental Health Habilitation ("AMHH") Waiver provides community-based services for adults with "serious mental illness or co-occurring mental illness and addiction disorders."<sup>77</sup> To be eligible for the AMHH Waiver, an applicant must have an eligible primary mental health diagnosis which includes schizophrenic disorder, major depressive disorder, bipolar disorder, delusional disorder, or psychotic disorder.<sup>78</sup>

The Behavioral and Primary Healthcare Coordination (BPHC) Waiver provides assistance in coordinating healthcare services to manage the mental health and/or addiction and physical healthcare needs.<sup>79</sup> To be eligible for this waiver, an individual must have a primary mental health diagnosis.<sup>80</sup>

The last waiver is the Child Mental Health Wraparound (CMHW) Waiver.<sup>81</sup> This waiver provides services to youth "with serious emotional disturbances with intensive, home and community based wraparound services."<sup>82</sup> There are some exclusions regarding eligibility, however, including having a primary substance use disorder, a pervasive developmental disorder, a primary attention deficit hyperactivity disorder, an intellectual disability or disabilities, or a dual diagnosis of serious emotional disturbance and intellectual disabilities.<sup>83</sup>

As hinted at above, there are several roadblocks or obstacles with Indiana's

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74. See Family & Soc. Serv. Admin., *Psychiatric Treatment Residential Facility (PRTF) Transition waiver*, IN.GOV, <https://www.in.gov/fssa/dmha/6643.htm> [<https://perma.cc/BGD4-UR5U>].

75. *Id.*

76. Family & Soc. Serv. Admin., *supra* note 72.

77. Family & Soc. Serv. Admin., *Adult Mental Health Habilitation Services*, IN.GOV, <https://www.in.gov/fssa/dmha/2876.htm> [<https://perma.cc/BC4Q-8HMU>].

78. 405 IND. ADMIN. CODE § 5-21.8-4 (2020).

79. Family & Soc. Serv. Admin., *Behavioral and Primary Care Coordination*, IN.GOV, <https://www.in.gov/fssa/dmha/2883.htm> [<https://perma.cc/D2PU-F77B>].

80. 405 IND. ADMIN. CODE § 5-21.6-4 (2020).

81. Family & Soc. Serv. Admin., *supra*, note 72.

82. Family & Soc. Serv. Admin., *Child Mental Health and Wraparound Services*, IN.GOV, <https://www.in.gov/fssa/dmha/2766.htm> [<https://perma.cc/9NHM-BEW8>].

83. 405 IND. ADMIN. CODE § 5-21.7-5 (2020).

waiver program. Waiver participants may also use services provided through Indiana's traditional Medicaid,<sup>84</sup> but again, the services required for those suffering from a mental health or substance misuse disorder generally not covered, inpatient or outpatient, under Indiana's general Medicaid plan.<sup>85</sup> Additionally, some waivers have spending caps. For example, the A&D and CIH waivers have no cap on services, while the FS Waiver has a cap on services at \$17,300 per year,<sup>86</sup> potentially limiting the treatment individuals on those waiver programs need.

Further obstacles lie in the primary diagnosis restrictions regarding eligibility for each waiver program. A child prenatally exposed to opioids is given a primary diagnosis of developmental disability.<sup>87</sup> An individual's primary diagnosis generally does not change throughout the life course.<sup>88</sup> If a child is later diagnosed with some other diagnoses, this becomes the secondary, tertiary (and so on) diagnosis; the primary diagnosis stays the same regardless of whether the secondary or tertiary diagnosis affects their daily lives more.<sup>89</sup> Again, qualification for participation in a waiver program is dependent on an individual's primary diagnosis.<sup>90</sup> For example, eligibility for the BPHC waiver requires the applicant to have a primary mental health diagnosis; such as schizophrenic disorder, major depressive disorder, bipolar disorder, delusional disorder, or psychotic disorder.<sup>91</sup> The problem lies in a child born and treated for NAS

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84. *Steimel*, 823 F.3d at 907.

85. See *IHCP Fee Schedule*, IND. HEALTH COVERAGE PROGRAMS [http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee\\_home.asp#OutpatientFeeSchedule](http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp#OutpatientFeeSchedule) [<https://perma.cc/F9TB-DXZG>] (these spreadsheets are updated over time); Family & Soc. Serv. Admin., *supra*, note 72.

86. Family & Soc. Serv. Admin., *Bureau of Developmental Disabilities Services*, IN.GOV, <https://www.in.gov/fssa/ddrs/2639.htm> [<https://perma.cc/R74H-DMZF>]

87. IND. STATE DEP'T OF HEALTH, ANNUAL LEGISLATIVE REPORT OF THE INDIANA BIRTH DEFECTS AND PROBLEMS REGISTRY 2018 3 (2018), [https://www.in.gov/isdh/files/OPA\\_Approved\\_2018%20Annual%20Legislative%20Report%20for%20IBDPR.pdf](https://www.in.gov/isdh/files/OPA_Approved_2018%20Annual%20Legislative%20Report%20for%20IBDPR.pdf) [<https://perma.cc/GEF4-MG53>]. See generally, IND. FAM. & SOC. SERV. ADMIN., MEDICAID HOME AND COMMUNITY BASED SERVICES RATE METHODOLOGY PROJECTS 3 (2019), [https://www.in.gov/fssa/files/FSSA\\_HCBS\\_Kickoff\\_Webinar\\_March\\_18\\_19.pdf](https://www.in.gov/fssa/files/FSSA_HCBS_Kickoff_Webinar_March_18_19.pdf) [<https://perma.cc/SC6C-UJDJ>] (there is no authority that expressly answers the question as to why individuals born with NAS are given a primary diagnosis at birth of a developmental disorder. However, it can be deduced that because the Division of Disabilities and Rehabilitative Services receives significantly more funding compared to the Division of Mental Health and Addiction, physicians are more inclined to provide a diagnosis that will allow them to be reimbursed from the division where they not only can be reimbursed, but can also receive a larger sum of reimbursement).

88. See Javier Meseguer, *Outcome Variation in the Social Security Disability Insurance Program: The Role of Primary Diagnoses*, 73 SOC. SECURITY BULL. 39, 50 (2013) (in the context of the Social Security Administration).

89. See *id.*

90. See 405 I.A.C. § 5-21.8-4 (2020); see also 405 IND. ADMIN. CODE § 5-21.7-5 (2020).

91. See 405 I.A.C. § 5-21.8-4.

retaining a primary diagnosis of a developmental disability.<sup>92</sup>

Generally, the FS Waiver is the basic entry point to receive services for children with a developmental disability,<sup>93</sup> and a child born with NAS that was given a primary diagnosis of developmental disability will likely never, under current policies, be able to receive services under a waiver other than the FS Waiver—even if they need services covered under another waiver, such as mental health or addiction treatment services—because they retain their primary diagnosis of a developmental disability, disqualifying them from receiving services under the mental health and addiction waivers.

One obscurity in this issue is the reluctance of physicians to change an individual's primary diagnosis. An interesting note is that eligibility for the waivers is determined by someone from Indiana's Family and Social Services Administration ("FSSA") and not by the individual's primary care physician.<sup>94</sup> To use the AMHH waiver as an example, an applicant for services under this waiver would have their case reviewed by a Division of Mental Health and Addiction State Evaluation Team from the FSSA.<sup>95</sup> This team from the FSSA would look through the applicant's medical records and determine whether or not they meet the eligibility criteria for services under the waiver program.<sup>96</sup> Again, this waiver, which provides mental health and addiction treatment services, has primary diagnosis requirements.<sup>97</sup>

Hypothetically, let us assume an individual applying for intensive mental health or substance use disorder treatments under this waiver was an individual born with NAS. Without a change in primary diagnosis from developmental disability to one of the qualifying mental health conditions, this hypothetical individual likely would be ineligible for this waiver's services. The expanded mental health services available under the Affordable Care Act has led to a heightened "crack down" on healthcare fraud and abuse prevention from the Office of Inspector General.<sup>98</sup> It can reasonably be assumed this heightened focus might be preventing physicians from changing a primary diagnosis for fear of being accused of fraudulent billing practices. This offers some insight into the reluctance for a physician to change an individual's primary diagnosis, and

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92. *See supra* text accompanying note 88.

93. Marci Wheeler, *Indiana's Medicaid Waiver Programs: Home and Community-Based Services for Adults and Children*, IND. RESOURCE CTR. FOR AUTISM (2018), <https://www.iidc.indiana.edu/pages/medicaid-waiver-programs-home-and-community-based-services-for-adults-and-children> [<https://perma.cc/D2P9-TGXU>].

94. DIV. OF MENTAL HEALTH & ADDICTION, ADULT MENTAL HEALTH HABILITATION SERVICES 37 (2019), <https://www.in.gov/medicaid/files/dmha%20amhh.pdf> [<https://perma.cc/HRJ7-DP2J>].

95. *Id.*

96. *Id.* at 37-38.

97. *Id.* at 17.

98. *See Spotlight On . . . Fighting Fraud at Community Mental Health Centers*, U.S. DEP'T HEALTH & HUMAN SERVS., <https://oig.hhs.gov/newsroom/spotlight/2013/cmhc.asp> [<https://perma.cc/48N9-SFM5>].

another is lack of reimbursement in the primary care setting for services relating to mental health.<sup>99</sup> One additional theory offered is a detrimental psychological effect caused by a change in primary diagnosis on the individual patient.<sup>100</sup>

In sum, one waiver program does not include reimbursement for all the services these individuals will likely need, based on the research on future health risks of babies born with NAS. Services these individuals may need fall under two waivers,<sup>101</sup> one of which is the FS Waiver, which would cover services for behavioral and language/speech therapy, occupational therapy, in addition to therapy for developmental or cognitive delays.<sup>102</sup> As previously mentioned, individuals born with NAS are at an increased risk of developing some sort of future substance misuse disorder,<sup>103</sup> including an opioid use disorder.

Because traditional Indiana Medicaid does not reimburse for all types of substance abuse treatment,<sup>104</sup> an individual relying on Medicaid would need to seek one of the waivers for the treatment for more intensive treatment options such as inpatient services. The waiver under which substance abuse treatment, and possibly mental health services, would be a different waiver which is available through the Division of Mental Health and Addiction as previously mentioned. For children under 19 years of age, that would be the Child Mental Health Wraparound Program;<sup>105</sup> for individuals 19-34 years of age, that would be the Behavioral and Primary Healthcare Coordination program;<sup>106</sup> and for individuals 35 years of age or older, that would be the Adult Mental Health Habilitation Services program.<sup>107</sup> Because individuals may not be on more than one waiver at a time, this cohort of individuals born with NAS risk not having access to those treatments they may require based on their future health risks. Currently, if we use the created hypothetical and an individual is diagnosed with a behavioral or cognitive disability, and later a mental health or substance abuse disorder, that individual would have to pick which of the issues they want to treat

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99. DANNA MAUCH ET AL., REIMBURSEMENT OF MENTAL HEALTH SERVICES IN PRIMARY CARE SETTINGS 32 (2008), [https://www.integration.samhsa.gov/Reimbursement\\_of\\_Mental\\_Health\\_Services\\_in\\_Primary\\_Care\\_Settings.pdf](https://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf) [<https://perma.cc/WBV6-49J6>].

100. See Jules Montague, *What Happens When Doctors Change Your Diagnosis?*, THE GUARDIAN (June 11, 2018), <https://www.theguardian.com/lifeandstyle/2018/jun/11/what-happens-when-doctors-change-your-diagnosis> [<https://perma.cc/8MGA-GDYJ>].

101. See generally Wheeler, *supra* note 93. See Hall et al., *supra* note 37, at 20.

102. See Family & Soc. Serv. Admin., *supra*, note 70.

103. See generally, Anthony Nagle & Gill Watson, *supra* note 41; Merikangas et al., *supra*, note 41.

104. See *IHCP Fee Schedules*, IND. MEDICAID, (2017), [http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee\\_home.asp#OutpatientFeeSchedule](http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp#OutpatientFeeSchedule), [<https://perma.cc/4E8P-QKT8>] (these spreadsheets are updated over time); see also Family & Soc. Serv. Admin., *supra*, note 72.

105. See Family & Soc. Serv. Admin., *Indiana Youth System of Care*, IN.GOV, <https://www.in.gov/fssa/dmha/2732.htm> [<https://perma.cc/S4TD-UEXL>].

106. Family & Soc. Serv. Admin., *Behavioral and Primary Healthcare Coordination*, IN.GOV, <https://www.in.gov/fssa/dmha/2883.htm> [<https://perma.cc/9QDK-S8EC>].

107. Family & Soc. Serv. Admin., *supra* note 77.

and leave the others untreated.

### III. INDIANA MEDICAID AS AN INTERVENTION TO END THE OPIOID USE CRISIS

This new cohort of individuals, as a result of the current substance abuse crisis (specifically, the opioid crisis), has needs that will not fit into the traditional, current Medicaid program, especially in Indiana. The following discussion contains policy recommendations based on the health needs of these individuals and what is most attainable and feasible in Indiana. With the growing recognition that this opioid crisis is a public health issue rather than a criminal justice problem,<sup>108</sup> the policy recommendations set forth will be analyzed using Nancy Kass' six-step ethics framework for public health interventions<sup>109</sup> to consider any ethical implications within each proposal. Research demonstrates a need to nurture and provide for this resilient group of individuals, arising out of the current opioid crisis.

#### *A. Policy*

Previously mentioned, the Family Supports Waiver is the basic entry point to receive services for children with a developmental disability.<sup>110</sup> Currently, this waiver has a cap on services at \$17,300 per year.<sup>111</sup> A first policy recommendation is for the Indiana General Assembly to create a regulatory ability for this allowance to go toward services reimbursed under any waiver, regardless of the issue of primary and secondary diagnoses. This would solve the issue of an individual on the FS Waiver not being able to access mental health and addiction treatment services. Because the total cap on services would remain the same, Indiana would not need to spend any additional dollars on these individuals.

A second policy recommendation would be to create a new Medicaid waiver

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108. See U.S. DEP'T OF HEALTH & HUMAN SERV., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 1-2 (2016), <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf> [<https://perma.cc/EX3U-2VZR>]. Press Release, American Academy of Family Physicians, American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, American Psychiatric Association, Joint Principles on Opioid Crisis Call for Comprehensive, Public Health Approach to Addiction Treatment (June 11, 2018), <https://www.aafp.org/media-center/releases-statements/all/2018/joint-principles-on-opioid-crisis.html> [<https://perma.cc/2X37-UUBK>]. See generally Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANNUAL REV. OF PUB. HEALTH, 559 (2015). See *America's Drug Overdose Epidemic: Data to Action*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/features/confronting-opioids/index.html> [<https://perma.cc/BB7Y-WLSV>].

109. See generally Nancy E. Kass, *An Ethics Framework for Public Health*, 91 AM. J. PUB. HEALTH 1776 (2001).

110. Wheeler, *supra* note 93.

111. Family & Soc. Serv. Admin., *supra* note 86.

or program entirely, specially tailored to this cohort of individuals born with NAS. Under Section 1915(c) of the Social Security Act, a state can create a waiver for Home and Community Based Services (similar to those already created by Indiana) to allow beneficiaries with long-term services and support to receive Medicaid-reimbursed care outside of an institutional setting.<sup>112</sup> The idea is to tailor a waiver specifically to the needs of these individuals and demonstrate, based on current research, that these individuals have an increased risk to develop long-term health issues including cognitive, mental health, and substance abuse problems.<sup>113</sup>

Similarly, states can also create a program that offers acute-care services and long-term services by defining and establishing a separate eligibility group.<sup>114</sup> Indiana has already done both, as mentioned, with the FS Waiver, the Aged & Disabled Waiver, the Community Integration and Habilitation Waiver, including some other 1915(i) programs tailored to mental health and substance abuse treatment.<sup>115</sup> But again, there is currently no regulatory ability for an individual to utilize services from more than one program. This restricts an individual with the ability to treat only one or two of their health conditions, leaving a potentially life-threatening issue, such as a substance use disorder or mental health issue, untreated.

Ethically, individuals should not have to pick what medical problems get treated and which ones go untreated, especially when those issues are life threatening or altering and may contribute to the growing substance abuse crisis. Ideally, a new Medicaid waiver or program would be created for and tailored to this cohort to allow access to mental health and addiction treatment services, in conjunction with other developmental disability services they may require throughout childhood, to adolescence, and throughout their life.

A third recommendation would be to restructure regulations and policies regarding primary and secondary diagnosis eligibility requirements for the Medicaid waivers. Stated earlier, an individual's primary diagnosis determines which Medicaid waiver program for which they are eligible or ineligible.<sup>116</sup> Essentially, the first major diagnosis an individual is given becomes their primary diagnosis for life and is rarely, if ever, changed.<sup>117</sup> Again, a child prenatally

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112. HUBERFELD, WEEKS, & OUTTERSON, *supra* note 58, at 92. *See also National Overview of 1915(c) HCBS Waivers*, CTRS. FOR MEDICARE & MEDICAID SERV., <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/national-overview-1915-c-waivers.html> [<https://perma.cc/HAE6-V5CE>].

113. *See generally* Nagle & Watson, *supra* note 41, at 444-53; Merikangas et al., *supra* note 41. *See also* Merhar et al., *supra* note 36. *See also* Hall et al., *supra* note 37.

114. *Home & Community-Based Services 1915(i)*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-i/index.html> [<https://perma.cc/7NU2-Z78H>].

115. Family & Soc. Serv. Admin., *supra*, note 72.

116. *See, e.g.*, 405 I. A. C. § 5-21.6-4. *See also* I. A. C. § 5-21.8-4 (2018). *See also* 405 I. A. C. § 5-21.7-5.

117. *See* Meseguer, *supra* note 88.

exposed to opioids is given a primary diagnosis of developmental disability<sup>118</sup> and this primary diagnosis generally does not change.<sup>119</sup> If this same individual is later diagnosed with some other diagnoses, such as a mental health or substance use disorder, this becomes the secondary, tertiary (and so on) diagnosis; the primary diagnosis stays the same regardless of whether the secondary or tertiary diagnosis affects their daily lives more.<sup>120</sup> The intention with this recommendation of restructuring the policies surrounding primary, secondary, and so on, diagnoses is to allow for more flexibility in changing an individual's primary diagnosis. Ideally, a provider would have more discretion to switch the primary diagnosis to what is affecting the individual most significantly.

Accordingly, an individual born with NAS given a primary diagnosis of a developmental disorder, hypothetically utilizing Indiana Medicaid in addition to the FS Waiver for their medical needs, may be eligible for one of the mental health or addiction treatment waivers by their provider changing their primary diagnosis to one of the qualifying disorders, if such disorder arises in the future. Put another way, if a mental health or addiction problem is affecting an individual's life more significantly than their developmental disability, this allows for a provider involved in the patient's care to change the primary diagnosis to the mental health or addiction problem thereby allowing the individual to access services under one of the DMHA waivers.

A fourth recommendation relates to the current mental healthcare provider shortage. Broadly speaking, better access to behavioral health, mental health, and addiction treatment are needed, whether that is through more providers specializing in that field or training more primary care providers to have the ability to integrate that type of treatment in the primary care setting. The previous Surgeon General, Dr. Vivek Murthy, in his report identified both these concerns by stressing the need to integrate these types of treatment into the primary healthcare setting, a need to restructure how this type of treatment is billed allowing for reimbursement in the primary care setting,<sup>121</sup> and creating a widespread workforce prepared to handle mental health, behavioral health, and substance use disorder.<sup>122</sup> While mild substance use disorders may be treated in the primary care setting, more serious conditions likely require specialty residential or intensive outpatient treatment with some sort of long-term management.<sup>123</sup>

This returns to the issue of the shortage of workforce trained to handle mental health, behavioral health, and substance use disorders.<sup>124</sup> A fifth recommendation

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118. *See supra* text accompanying note 88.

119. *See Meseguer, supra* note 88, at 50.

120. *Id.* (in the context of the Social Security Administration).

121. *See* U.S. DEP'T OF HEALTH & HUMAN SERV., *supra* note 108, at 1-20.

122. *See id.* at 7-10 – 7-11 (recommending professional schools and continuing education programs incorporate curricula surrounding the most up to date information regarding substance use disorder and science regarding prevention, treatment, and recovery).

123. *Id.* at 6-3.

124. *See id.* at 6-31; *see also* Vestal, *supra* note 52.



is for Indiana to find innovative ways to increase this workforce through financial incentives and education. The University of Wisconsin and the Medical College of Wisconsin added psychiatric training positions to their post medical school options, and just by this addition, the number of psychiatry residents throughout the nation grew by 5.3%.<sup>125</sup> The Surgeon General's Report goes even further by suggesting that states implement financial incentives for medical students and other professional students to go into this area by utilizing the Health Resources & Services Administration (HRSA) awards to provide grants, scholarships, and loan repayments programs.<sup>126</sup> Creating a more expansive workforce is important for Indiana's substance and opioid use crisis, especially when it comes to rural communities, and the best way to do this is for Indiana to use grants or other financial resources available to create opportunities for professionals and professional students to seek training opportunities in these underserved specialties, behavioral, mental, and addiction health.

### *B. Ethical and Public Health Considerations*

Several of the policy recommendations discussed above would include either new or a reallocation of resources directed toward improving health outcomes of individuals born with NAS. Dr. Nancy Kass, an expert in public health ethics,<sup>127</sup> set forth a six-step framework (hereinafter referred to as the "Kass six-step framework") designed to help public health professionals and leaders consider ethical implications of proposed policy interventions<sup>128</sup> as I have done above. Moral dilemmas can arise out of resource allocation; therefore, it is important to consider the populations affected before implementing the policies. While "no principle ought to have moral superiority over any other," public health leaders have "affirmative obligations to *improve* the public's health and, arguably, to reduce certain social inequities."<sup>129</sup>

The first step of the Kass six-step framework asks what are the public health goals of the proposed program?<sup>130</sup> The goal of the intervention should be started in terms of, or as a piece of, a larger aim toward, reduction of morbidity and mortality.<sup>131</sup> Because existing data demonstrates a variety of health needs throughout the life course that have a likelihood of contributing to the cycle of substance misuse,<sup>132</sup> policy interventions were chosen to focus on the whole

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125. See Levine, *supra* note 55.

126. See U.S. DEP'T OF HEALTH & HUMAN SERV., *supra* note 108, at 6-33, 7-4; see also *FY18 HRSA Opioids Fundings*, HEALTH RESOURCES & SERVS. ADMIN., <https://www.hrsa.gov/opioids/hrsa-fy18-awards.html> [<https://perma.cc/5JEL-U58H>].

127. See Nancy E. Kass, *ScD*, JOHNS HOPKINS BERMAN INST. BIOETHICS, <https://bioethics.jhu.edu/people/profile/nancy-kass/> [<https://perma.cc/AFZ8-WFB5>].

128. See generally Kass, *supra* note 109.

129. *Id.* at 1777.

130. *Id.*

131. *Id.* at 1778.

132. See generally Nagle & Watson, *supra* note 41, at 444-453; Merikangas et al., *supra* note

person, and policies designed to reduce morbidity (future adverse health outcomes) among individuals born with NAS rather than mortality with the hope of implementing policies that will strengthen primary, secondary, and tertiary prevention<sup>133</sup> in substance use disorders. Kass describes the importance of keeping the goal of public health interventions in terms of reducing morbidity or mortality because improving health should be at the forefront of public health interventions, and other goals such as increasing employment, increasing workplace productivity, and strengthening communities will follow as incidental or intermediary outcomes.<sup>134</sup>

The second step of the Kass six-step framework asks how effective is the program in achieving its stated goal?<sup>135</sup> Only proven initiatives are ethically justified.<sup>136</sup> To justify the chosen intervention(s), policymakers must consider the data available to support the assumption the policy will, in fact, achieve its goal in reducing morbidity or mortality.<sup>137</sup> The recommended policies were chosen based on little to no requirements for Indiana to increase spending.

However, some of the proposals outlined above might cause a reallocation of sources, such as investing in incentives for healthcare professionals to enter the mental health or substance use disorder treatment workforce or reducing the cap of services on one waiver in order to create a new waiver or program specifically tailored to the needs of NAS. If Indiana does not want to increase spending on Medicaid, this would call for a reduction in spending in one of the current programs in order to meet the goals of one of the outlined proposals. Kass emphasizes, “in terms of cost, constraints on liberty, or targeting particular already vulnerable segments of the population—the stronger the evidence must be to demonstrate that the program will achieve its goals.”<sup>138</sup>

Establishing this cohort of individuals born with NAS are a vulnerable population and that they are at risk for several adverse long-term health outcomes, it is still important to remember the moral dilemma of no one population having no moral superiority over another.<sup>139</sup> Nevertheless, public health leaders have an affirmative duty to improve vulnerable populations’ health and reduce existing inequalities,<sup>140</sup> and there is a strong, positive correlation between access to healthcare and improved health outcomes.<sup>141</sup>

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41; *see also* Merhar et al., *supra* note 36; *see also* Hall et al., *supra* note 37.

133. *See* CTR. FOR DISEASE CONTROL & PREVENTION, PREVENTION 1, [https://www.cdc.gov/pictureofamerica/pdfs/picture\\_of\\_america\\_prevention.pdf](https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf) [<https://perma.cc/3ER2-ZM87>] (describing primary, secondary, and tertiary prevention).

134. Kass, *supra* note 109, at 1778.

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.* at 1779.

139. *Id.* at 1777.

140. *Id.*

141. *See* Kevin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 J. AM. MED. ASS’N 2579, 2579 (May 17, 2000).

Kass states even with good data, a policy or program is not alone justified.<sup>142</sup> The third step of the Kass six-step framework asks what are the known or potential burdens of the program?<sup>143</sup> There are three broad categories to consider: (1) risks to privacy and confidentiality; (2) risks to liberty, dignity, opportunity and/or self-determination, specifically, in terms of too much of a paternalistic ideology; and (3) risk to justice if an intervention is targeted at a certain group.<sup>144</sup>

As hinted at earlier, one of the potential burdens would be a reduction in Medicaid spending on one group in order to fund a new program or waiver for this cohort of individuals born with NAS. Additionally, privacy and confidentiality could become a concern with opening up more access to types of healthcare treatment due to the fact individuals would have more providers involved in their care, unless efforts are made to incorporate screening and treatment for mild forms of substance use disorder into the primary care setting. Conversely, burdens concerning paternalism are likely minimal in the policy recommendations, as individuals would not be mandated into mental health or addiction treatment in addition to any other type of behavioral treatment.

The next step is to consider whether burdens can be minimized, and whether there are alternative approaches.<sup>145</sup> The first policy recommendation (to allow individuals to access treatment on any waiver in which they retain an eligible diagnosis for) is the least burdensome on the individuals and on the government spending, as the cap would remain the same and other individuals on different waivers would not have any funding taken away from their program, like the proposal for the entirely new waiver or program would require. However, another state has created a similar program as the waiver program proposed for individuals born with NAS. Wisconsin received a grant to integrate services for “medically complex children enrolled” such as those needing behavioral or other mental health treatment in their state Medicaid program.<sup>146</sup> An early evaluation of this program showed promise, by healthcare costs decreasing and the children were more likely to attend primary care, schedules, therapies, and mental healthcare through this focused and integrated program.<sup>147</sup>

The fifth inquiry in the Kass six-step framework asks is the program implemented fairly?<sup>148</sup> Fairness in this context does not mean that programs or resources must be allocated equally to all communities, but rather, the allocation should be equitable based on distributive justice.<sup>149</sup> Kass emphasizes distributions of programs, in this case, resources must be justified by data and social

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142. Kass, *supra* note 109, at 1779.

143. *Id.*

144. *Id.*

145. *Id.* at 1780.

146. HANNAH KATCH, STATES ARE USING FLEXIBILITY TO CREATE SUCCESSFUL, INNOVATIVE MEDICAID PROGRAMS 1, 2, 6 (2016), <https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs> [<https://perma.cc/5HAN-9YSU>].

147. *Id.* at 6.

148. Kass, *supra* note 109, at 1780.

149. *Id.* at 1780-81.

consequences must be considered by any unequally allocated resources.<sup>150</sup> In this circumstance, where Indiana is preparing to take care of a cohort of individuals born of NAS, policymakers must be aware all opioid-exposed infants are at increased risk for long-term medical problems<sup>151</sup> and socioeconomic status is a “powerful predictor of health.”<sup>152</sup> Because these individuals born with NAS are most likely to rely on Medicaid,<sup>153</sup> an indicator of lower socioeconomic status, even without exposure to opioids during birth, they are already at risk for premature death and other health disparities.<sup>154</sup>

Adding in the data demonstrating additional health risks this population faces, they are arguably currently one of the most vulnerable populations in Indiana and therefore equity justifies the unequal allocation of resources to them. As already discussed, justification exists as to why targeting this population through public health prevention measures can help end the substance abuse cycle,<sup>155</sup> and that access to treatment improves health outcomes.<sup>156</sup>

The last step of the six-step Kass framework asks how can the benefits and burdens of the program be fairly balanced?<sup>157</sup> This is meant to be a procedural inquiry and includes a democratic process where society can engage in open discussion, voicing views from all socioeconomic classes.<sup>158</sup> While it is meant to demonstrate the benefits society gains through a public health approach, stakeholders must understand others included in the discussion might have different priorities.<sup>159</sup> The most obvious and significant burden of the proposed policy interventions are cost and where to pull funds from. However, investments in public health show a strong correlation with a healthy economy<sup>160</sup> and support investments to support this population born with NAS. The opioid crisis in Indiana has been costly on the state’s economy.

The opioid crisis has cost Indiana approximately \$43.3 billion in loss based on gross state product, resources spent individuals with substance use disorder, and resources spent on opioid-related deaths.<sup>161</sup> This figure is consistent with the

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150. *Id.* at 1781.

151. Hall et al., *supra* note 37, at 1.

152. Kass, *supra* note 109, at 1781.

153. S.W. Patrick et al., *supra* note 30, at 656. *See* Hussaini & Saavedra, *supra* note 17, at 1352.

154. *See* Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, HEALTH AFFS., 60 (2002).

155. *See* Nagle & Watson, *supra* note 41, at 444-53; Merikangas et al., *supra* note 41; *see also* Merhar et al., *supra* note 36; *see also* Hall et al., *supra* note 37.

156. Fiscella et al., *supra* note 141, at 2597.

157. Kass, *supra* note 109, at 1781.

158. *Id.*

159. *Id.*

160. *See* Michael Blanding, *Public Health and the U.S. Economy*, HARV. T.H. CHAN SCH. PUB. HEALTH (2012), <https://www.hsph.harvard.edu/news/magazine/public-health-economy-election/> [<https://perma.cc/2BJG-7CYT>].

161. Ryan M. Brewer & Kayla M. Freeman, *Cumulative Economic Damages From 15 Years*

theory of a strong public health framework to create a healthy, productive workforce that generates a healthy state economy.<sup>162</sup> Taking into consideration the stakeholders “at the table” in this discussion, this type of benefit may be important in considering whether or not to implement one of the recommended policies.

In sum, after utilizing the Kass six-step framework, the policy recommendations laid out above are ethical public health interventions. The policy interventions are likely to achieve the goal of improving healthcare access to a vulnerable population with the goal of reducing morbidity. The potential burdens are recognized and minimized, and the expected benefits justify the potential burdens. Based on this Kass six-step framework, the policy interventions would be ethical.

#### IV. CONCLUSION

Appropriately identified as a “wicked” problem,<sup>163</sup> this current opioid crisis has unfortunately exposed the fatal flaws of the fragmented, piecemeal U.S. healthcare system. Additionally, our system has an unfortunate history of being reactive instead of proactive<sup>164</sup> and public health has consistently been disregarded despite the recognition of its importance.<sup>165</sup> One example, especially relevant in Indiana, are the naloxone laws. Prior to recognition, there was a crisis, naloxone, which is a lifesaving opioid overdose reversing drug, remained available only by prescription through a pharmacy and was not changed until 2016.<sup>166</sup> An unfortunate reality of this change meant that thousands of Hoosiers

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*of Opioid Misuse Throughout Indiana*, IND. BUS. REV., <https://www.ibrc.indiana.edu/ibr/2018/spring/article1.html> [<https://perma.cc/7TLN-LMTN>].

162. See Blanding, *supra* note 160.

163. See Lee, *supra* note 9 (describing the opioid overdose epidemic as an “endemic complex system[] with components that interact in complicated, poorly understood and unpredictable ways” and as “impossible to establish a single locus . . .”).

164. See Susan Milligan, *Why is Health Care So Complicated?*, U.S. NEWS & WORLD REP. (June 30, 2018), <https://www.usnews.com/news/the-report/articles/2017-06-30/why-cant-congress-figure-out-health-care-reform/> [<https://perma.cc/VBS3-PS73>] (quoting John McDonough from Harvard’s T.H. Chan School of Public Health, “[i]t’s a basic principle of behavioral economics that people are much more risk-averse than they are risk-takers.”).

165. See *generally* OFFICE OF INSPECTOR GEN., PUBLIC HEALTH AND MANAGED CARE: OPPORTUNITIES FOR COLLABORATION (1999), <https://oig.hhs.gov/oei/reports/oei-01-98-00170.pdf> [<https://perma.cc/6FMM-RZGV>]. See Jeffrey Levi, *Ensuring Timely Access to Care for People With HIV Infection: A Public Health Imperative*, 92 AM. J. PUB. HEALTH 339, 339-340 (2002) (describing the lessons the HIV epidemic taught us including necessary early public health interventions and consistent healthcare delivery for all regardless of socioeconomic status).

166. See Shari Rudavsky, *The Surgeon General Wants More of us to Carry Naloxone. Here’s Where to Get it Free*, INDY STAR (May 5, 2018), <https://www.indystar.com/story/news/2018/05/05/indiana-health-officials-give-free-naloxone-prevent-overdose-deaths/582337002/> [<https://perma.cc/SW6E-YUT2>].

had to die before this new law was passed.

The federal government has shown signs it believes the opioid crisis is over. While the federal government provided a large lump sum of money to address the opioid crisis initially through the SUPPORT Act,<sup>167</sup> and called for an additional \$7 billion in the budget for 2019, the Trump Administration dropped its request to only \$3 billion.<sup>168</sup> Additionally, several experts argue that this crisis is not simply one that has come and gone, but rather exposes the inadequate infrastructure for those suffering from addictions in the United States which is not something that can be solved with one lump sum of money and no additional, long-term policy change from the federal government.<sup>169</sup> This is significant, as the addictions crisis seems to be morphing from opioids to other illicit drugs such as cocaine and meth.<sup>170</sup>

The previous discussion suggests that states can no longer rely on the federal government to step in and provide any additional funding or legislative change. The previous discussion also suggests that the United States is no longer in solely an opioid crisis, rather an addiction crisis generally. The infrastructure of addiction treatment needs to be improved by states, like Indiana, and part of that infrastructure should be, and can be, more accessible healthcare especially to those that are at high risk for perpetuating addiction crisis.

Social determinants of health continue to be a driver in health inequities. Socioeconomic status most often determines what type of healthcare an individual will receive, for example, private or employer-based insurance, or government-funded insurance like Medicaid. While socioeconomic status is considered to be a social determinant of health, another determinant of health is called a structural determinant of health, and those “include architectural, economic, or political frameworks that create barriers to remediating social

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167. Musumeci & Tolbert, *supra* note 3; German Lopez, *Trump Just Signed a Bipartisan Bill to Confront the Opioid Epidemic*, VOX (Oct. 24, 2018), <https://www.vox.com/policy-and-politics/2018/9/28/17913938/trump-opioid-epidemic-congress-support-act-bill-law> <https://www.vox.com/policy-and-politics/2018/9/28/17913938/trump-opioid-epidemic-congress-support-act-bill-law> [https://perma.cc/25Q8-NSXT].

168. Lopez, *supra* note 167; German Lopez, *Trump’s Budget Proposal Does Nothing for the Opioid Epidemic*, VOX (Mar. 11, 2019), <https://www.vox.com/policy-and-politics/2019/3/11/18260152/trump-budget-opioid-epidemic-2019> (the author noting Trump’s budget proposal called for \$8.6 billion to build parts of the United States-Mexico border, which he argued would prevent illicit drugs entering the United States).

169. *Id.* (highlighting the inconsistencies across addiction treatment facilities and how only few offer the “gold standard” of care).

170. Martha Bebinger, *Fentanyl-Linked Deaths: The U.S. Opioid Epidemic’s Third Wave Begins*, NPR (Mar. 21, 2019), <https://www.npr.org/sections/health-shots/2019/03/21/704557684/fentanyl-linked-deaths-the-u-s-opioid-epidemics-third-wave-begins> [https://perma.cc/2UF5-D6PJ]; Dan Vergano, *The Opioid Crisis is Becoming a Meth and Cocaine Crisis*, BUZZFEED NEWS (Jan. 16, 2019), <https://www.buzzfeednews.com/article/danvergano/cocaine-meth-overdose-wave> [https://perma.cc/7L4N-LGUV].

determinants or perpetuate social determinants such as health inequities.”<sup>171</sup>

Arguing the U.S. healthcare system itself is a structural determinant of health<sup>172</sup> is not so egregious as Indiana’s Medicaid system is being exposed by the inherent inequality resulting from the vulnerable population of individuals born with NAS unable to receive the full spectrum of care they require. Without some sort of policy action, the current healthcare system, both nationally and in Indiana, will continue to perpetuate the opioid crisis. Indiana has the opportunity to be a leader and create a healthcare delivery system that meets the needs of the population of individuals born amid the opioid crisis and be better prepared for future crises.

This discussion has shown that under current policies, individuals born with NAS are unlikely to receive the full spectrum of care they may require across their lifespan.<sup>173</sup> Further, neglecting to provide the treatment these individuals need may only perpetuate addiction in the United States. This discussion has offered attainable solutions at the policy level that reflect larger themes of inadequacy in the United States healthcare system. These broader policy arguments are outside the scope of this note discussion. However, through this example of NAS in the opioid crisis, the areas where the healthcare system is weak have been exposed. Taking a “half glass full” perspective, this can provide an opportunity. Again, Indiana has the opportunity to be a national leader by creating a healthcare delivery system that meets the needs of a vulnerable population and reflecting a healthcare policy that considers the determinants of health.

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171. Nicolas P. Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*, 11 NE. UNIV. L. REV. 315, 325 (2019).

172. *Id.* at 318 (arguing the U.S. healthcare system itself is a structural determinant of health and should take some responsibility in driving the current opioid crisis).

173. *See generally* Nagle & Watson, *supra* note 41, at 444-53; Merikangas et al., *supra* note 41; *see also* Merhar et al., *supra* note 36; *see also* Hall et al., *supra* note 37.