

Medicare, Medicaid, and Medical Marijuana: Why
Hospitals Should Not be High on Patient
Certification

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I. INTRODUCTION

When Illinois passed the Compassionate Use of Medical Cannabis Pilot Program Act (the Act), it sparked a burning debate as to how medical marijuana would affect hospitals.¹ Unfortunately, few resources exist to guide hospitals about the legal implications of introducing cannabis clinically. As medical marijuana businesses prepare to open in the spring of 2015, qualified patients have already begun to submit their applications for registration cards.² With patients now actively seeking physician certification of their debilitating conditions, hospitals must prepare for the imminent questions raised by a Schedule I controlled substance's legalization at the state level. This note will provide an overview as to how medical marijuana may affect Illinois hospitals in the context of reimbursement primarily through the Medicare and Medicaid programs. With careful planning and substantial discussion with medical staff, there is no reason for the Act to cause "Reef-

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1. See generally Compassionate Use of Medical Cannabis Pilot Program Act, 410 ILL. COMP. STAT. 130/ (creating the Illinois' Medical Cannabis Pilot program and allowing physicians to recommend the therapeutic use of medical marijuana to patients).

2. *Medical Marijuana ID Card Applications Top 2,000*, ASSOCIATED PRESS (Sept. 5, 2014), available at <http://chicago.cbslocal.com/2014/09/05/medical-marijuana-id-card-applications-top-2000/> (a qualified patient, as defined in the statute, is an individual who has been diagnosed by a physician as having a debilitating medical condition. Debilitating medical conditions have thus far been defined to include cancer, glaucoma, HIV, Hepatitis C, seizure disorders, and numerous other conditions as listed in § 130/10).

er Madness”³ in the management of clinical medicine.

The next part of this note begins by providing background information on the introduction of cannabis as a medical substance. Part III discusses the implementation of the Illinois Compassionate Use Act and accompanying regulations. Part IV addresses the potential effects of state legalization of medical marijuana, patient certification, and the effects on Medicare and Medicaid reimbursement. Part V examines potential federal political changes acting as a harbinger to a uniform policy on medical cannabis.

II. WHAT IS MEDICINAL MARIJUANA?

The medical application of cannabis may be broken into two primary components. The first is tetrahydrocannabinol, or THC.⁴ THC is the psychoactive component of cannabis, and has been shown to help increase appetite and reduce nausea.⁵ THC has been used in particular with cancer patients and patients suffering from the human immunodeficiency virus (HIV).⁶ Synthetic THC has been utilized in the drug Marinol for several years, an FDA-approved treatment that is covered under some insurance plans.⁷ THC has also been shown to be somewhat efficacious in reducing anxiety and as a means of improving sleep quality.⁸

3. “Reefer Madness,” originally released as “Tell Your Children” was a 1936 propaganda film revolving around the story of teenagers who become addicted to marijuana and involved in several illegal activities. REEFER MADNESS (George A. Hirliman Productions 1936).

4. NAT’L CANCER INST., *Cannabis and Cannaboids: Laboratory/Animal/Preclinical Studies*, <http://www.cancer.gov/cancertopics/pdq/cam/cannabis/healthprofessional/page4> (last modified Nov. 6, 2014).

5. Leland Kim, *UCSF Study Finds Medical Marijuana Could Help Patients Reduce Pain with Opiates*, UNIV. OF CAL. S.F. (Dec. 6, 2011), <http://www.ucsf.edu/news/2011/12/11077/ucsf-study-finds-medical-marijuana-could-help-patients-reduce-pain-opiates>.

6. NAT’L CANCER INST., *supra* note 4.

7. U.S. DEP’T OF JUSTICE, *RX Cannabis*, http://www.justice.gov/dea/divisions/sea/in_focus/marinol-cessmet.pdf (last visited Oct. 6, 2014) (explaining the pharmacology, dosage, and trials supporting the safety and effectiveness of Marinol. Marinol is used to stimulate appetite for AIDS patients suffering from anorexia resulting from the effects of the virus, as well as an antiemetic for chemotherapy-induced emesis).

8. Mark A. Ware et al., *Smoked Cannabis for Chronic Neuropathic Pain: A Randomized Controlled Trial*, 182 CANADIAN MED ASS’N J. 694, 700 (2010), available at

Cannabidiol (CBD), the second primary component of cannabis, is currently the most salient component of the medical application of cannabis. CBD is used as an oil extract from cannabis, and can be obtained to minimize or eliminate psychoactive effects.⁹ CBD oil has been shown to be particularly effective in reducing seizures.¹⁰ Studies going as far back as 1977 have shown CBD as an effective anticonvulsant with an ability to bind to receptors that inhibit electrical activity comparably to drugs clinically effective in treating and preventing major convulsions.¹¹ More recent studies have shown that CBD alone is not sufficient to negate the necessity of anti-seizure medications, but it has proven to supplement their efficacy substantially.¹² The majority of evidence supporting the efficacy of the substance does remain anecdotal, but new studies across the country may substantiate the various claims regarding the substance.¹³

In terms of clinical concerns, it is important to note that cannabis cannot be administered to a lethal overdose because cannabinoid receptors are not

<http://www.cmaj.ca/content/182/14/E694.abstract> (study involving adults with post-traumatic or postsurgical neuropathic pain and efficacy of varying strengths of cannabis in reducing various symptoms).

9. Jack Giddingson, *Cannabidiol: The Side of Marijuana You Don't Know*, CHICAGO NOW (Nov. 20, 2013, 7:11 PM) <http://www.chicagonow.com/chicago-medical-marijuana/2013/11/cannabidiol-the-side-of-marijuana-you-dont-know/>.

10. See Nicholas A. Jones et al., *Cannabidiol Displays Antiepileptiform and Antiseizure Properties In Vitro and In Vivo*, 332 J. OF PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS 569, 576 (2010) (demonstrating efficacy in general seizure disorders).

11. Paul Consroe & Andrea Wolkin, *Cannabidiol—Antiepileptic Drug Comparisons and Interactions in Experimentally Induced Seizures in Rats*, 201 J. PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS 26, 26 (1977).

12. Kim, *supra* note 5.

13. See Sue Hughes, *FDA Approves Cannabis Extract Study in Pediatric Epilepsy*, MEDSCAPE (Dec. 12, 2013), available at <http://www.medscape.com/viewarticle/817701> (indicating that the FDA approved studies to begin on a form of medicinal marijuana for the treatment of epilepsy in children); see also Press Release, Earth Science Tech Announces Positive Preliminary Test Results on the Effects of Its Hemp Oil Enriched With CBD-Cannabidiol on Animal Breast Cancer Cells and on Normal Cells (Oct. 9, 2014), available at <http://www.financialnewsmedia.com/profiles/etst.html> (indicating that a sponsored research agreement between Earth Science Tech, Inc. and the University of Central Oklahoma showed that the effects of Hemp Oil enriched with CBD can inhibit the proliferation of cancer cells more than that of normal cells).

located in brainstem areas affecting breathing.¹⁴ Medical concerns associated with the chronic use of cannabis include tachycardia, hypotension, conjunctival injection, bronchodilation, and decreased gastrointestinal motility.¹⁵ Additionally, cannabis may be addictive, but its addictive potential is substantially lower than other substances of abuse.¹⁶ Smoking cannabis comes with the same general cancer-related concerns and other pulmonary health risks incurred through the smoking of any other substance.¹⁷ Overall, medical cannabis may potentially be viewed as a less dangerous substitute for opiates.¹⁸

III. THE ILLINOIS COMPASSIONATE USE ACT

While there are a number of concerns relating to implications for hospitals confronting medical marijuana, the Act ultimately may render these concerns much ado about nothing. To begin, the Act reiterates the provisions of the Smoke Free Illinois Act.¹⁹ Essentially, medical marijuana may not be smoked in or near a hospital.²⁰ This aspect of the law was confirmed

14. NAT'L CANCER INST., *Cannabis and Cannaboids: Adverse Effects*, <http://www.cancer.gov/cancertopics/pdq/cam/cannabis/healthprofessional/page6> (last updated May 13, 2014).

15. *Id.*

16. *Id.*; see also Phillip M. Boffey, *What Science Says About Marijuana*, N.Y. TIMES (July 30, 2014), <http://www.nytimes.com/2014/07/31/opinion/what-science-says-about-marijuana.html> (discussing a 1999 study conducted by the Institute of Medicine on dependency rates of various substances. For a point of comparison, forty-six percent of the population was found to have ever used marijuana, with nine percent becoming dependent on it. Comparatively, seventy-six percent of the population had used tobacco, with thirty-two percent becoming dependent. Anti-anxiety medications had been used by thirteen percent of the population, with a nine percent rate of dependency).

17. NAT'L CANCER INST., *supra* note 14.

18. Philippe Lucas, *Cannabis as an Adjunct to or Substitute for Opiates in the Treatment of Chronic Pain*, 44 J. PSYCHOACTIVE DRUGS, 125, 131 (2012) ("Therefore cannabis has the potential to both relieve suffering for those suffering from chronic pain, and to reduce morbidity and mortality often associated the use and abuse of pharmaceutical opiates"); see Marcus A. Bachhuber, *Penn Study Shows 25 Percent Fewer Opioid-Related Deaths in States Allowing Medical Marijuana*, PENN MED. (Aug. 26, 2014), available at http://www.uphs.upenn.edu/news/News_Releases/2014/08/bachhuber/.

19. 410 ILL. COMP. STAT. 130/30 (2014); see Smoke Free Illinois Act 410 ILL. COMP. STAT. 82/1 (2008).

20. 410 ILL. COMP. STAT. 130/30 (2014).

in a memo issued by the Illinois Hospital Association (IHA).²¹ The IHA also noted that the law is silent on consumables, and that it will ultimately be up to hospitals as to how they wish to handle the substance in this form.²²

The Act additionally places strict requirements on which providers may certify patients for medical marijuana registry cards.²³ Only a doctor of medicine (MD) or a doctor of osteopathic medicine (DO), licensed under the Illinois Medical Practice Act of 1987, with a controlled substance license, may complete a written certification.²⁴ A certification may only be made in person, as the Act specifically forbids making a physical examination for purposes of certification through telemedicine.²⁵ A certifying physician must also possess an established bona-fide physician-patient relationship with the qualified patient.²⁶ A physician is further required to maintain a record-keeping system for all patients the physician certifies, which must be accessible by the Illinois Department of Public Health and Department of Financial and Professional Regulation.²⁷ These records are protected and privileged, and do not place the physician or hospital under additional risk of liability.²⁸ As a result, hospitals should not be concerned about patients receiving certification without a full review of their medical record by a physician treating their condition.²⁹

21. *IHA Summary: New Legislation on Medical use of Marijuana*, ILL. HOSP. ASS'N., (Aug. 5, 2013), <http://www.ihatoday.org/uploadDocs/1/pa980122summary.pdf>.

22. *Id.* at 5. (the Act describes consumables as cannabis infused products).

23. *See* ILL. ADMIN. CODE TIT. 77, § 946.300 (2014).

24. 410 ILL. COMP. STAT. 130/5.

25. *Id.* at 130/35.

26. *Id.* at 130/55; *see* Robert McCoppin, *Patients Face 'Hoop-Jumping' to Gain Medical Marijuana*, CHI. TRIB. (Aug. 16, 2014), <http://www.chicagotribune.com/lifestyles/health/ct-medical-marijuana-patient-applications-met-20140816-story.html> (“Patients and doctors do not need a prior relationship, as long as the doctor reviews the patient’s records.”); *see also* *Medical Marijuana ID Card Applications Top 2,000*, *supra* note 2 (providing the definition for a qualified patient).

27. 410 ILL. COMP. STAT. 130/35.

28. *Id.*

29. *See* Paul Merrion, *Illinois Takes Aim at State’s First Medical Marijuana Clinic*, CRAIN’S CHICAGO BUS. (Dec. 16, 2013), <http://www.chicagobusiness.com/article/20131216/NEWS02/131219823/illinois-takes-aim-at-states-first-medical-marijuana-clinic> (Illinois in-

The Illinois Legislature recently amended the Act to create a provision for children with seizure disorders.³⁰ While the provision does not go into effect until January 2015, the amendment allows the issuance of registry identification cards to qualifying patients under the age of eighteen who suffer from epilepsy or other seizure disorders.³¹ The law specifically provides the Department of Public Health with the authority to expand the qualifying debilitating conditions for individuals under eighteen to become qualified patients, but only with consent from a parent or legal guardian.³² Minors receiving certification will be restricted to the use of consumables.³³

IV. HOW MEDICAL MARIJUANA AFFECTS HOSPITALS & INSURANCE REIMBURSEMENT ELIGIBILITY

The structure of the Act effectively designates physicians as the “gatekeepers” to access to medical marijuana.³⁴ As a result, hospital staff physicians may be placed in a position where a patient suffers from a designated debilitating medical condition and wishes to be certified. A physician certification may take place in a range of settings, but it is most likely to occur on a primary care basis, or for general treatment of the particular condition.³⁵ If a Medicare or Medicaid patient seeking certification schedules an

investigated a clinic that opened in August of 2013 and charged a physician for certifying patients for medical cannabis without conducting physical examinations or establishing a legitimate physician-patient relationship. The Illinois Department of Financial and Professional Regulation issued a warning to doctors to be cautious about setting up medical cannabis clinics shortly after the investigation. This is indicative that hospitals will not see an increase of inpatient admissions who received certification at random); *Cf.* Steve Lopez, *A Visit to The Medical Marijuana Doctor*, L.A. TIMES, (Oct. 28, 2009), <http://articles.latimes.com/2009/oct/28/local/me-lopez28> (California has what are referred to as Marijuana “shops”; clinics which operate solely certify patients for medical marijuana registration cards).

30. 410 ILL. COMP. Stat. 130/60(b) (2013), *amended by* IL Pub. A. No. 098-0775 (2014).

31. *Id.*

32. *Id.*

33. *Id.*

34. *See id.* at 130/1 (certification must be completed by a physician, hence designating them as the gatekeeper to accessing a registration card and medical marijuana).

35. *See* McCoppin, *supra* note 26 (stating those seeking certification need to make appointments with physicians, and if that patient is new to the physician, then that physician

appointment to discuss certification, the physician may be placed in a difficult legal situation. Given that any billing for services under Medicare or Medicaid includes a provision of certifying compliance with all federal and state law, certifying a patient for medical marijuana may be a violation of federal law.³⁶ Thus, billing for any service related to patient certification may be considered a violation of federal law.³⁷ Billing for certification through a hospital could jeopardize both the individual physician and the hospital's ability to participate in Medicare and Medicaid.³⁸ Furthermore, the hospital would be submitting a bill for a service that may be considered illegal, which involves a process to obtain a substance the government claims has no medical value.³⁹ Seeking reimbursement for such a service may trigger False Claims Act liability.⁴⁰ However, based on physician-

must be treating the patient's disease).

36. Condition of Participation: Compliance with Federal, State and Local Laws and Regulations, 42 C.F.R. § 485.608 (2011).

37. *Id.*; see ILL. HEALTH FACILITIES & SERVS. REVIEW BD., STATE HOSP. DATA SUMMARY, 2013, <http://www.hfsrb.illinois.gov/pdf/2013%20Hospital%20State%20Summary.pdf> (for inpatient services in Illinois hospitals in 2013, Medicare and Medicaid accounted for 56.5% of payer mix. The impact of losing Medicare and Medicaid eligibility would be a death penalty); Lindsey Dunn & Scott Becker, *50 Things to Know About the Hospital Industry*, BECKER'S HOSP. REVIEW (July 23, 2013), <http://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry> (stating that on average, Medicare constitutes an average of 40.9% of the payer mix of a hospital, and Medicaid constitutes an average of 17.2% of payer mix).

38. Condition of Participation: Compliance with Federal, State and Local Laws and Regulations, *supra* note 36.

39. See generally DRUG ENFORCEMENT AGENCY, THE DEA POSITION ON MARIJUANA I (Apr. 2013), available at http://www.justice.gov/dea/docs/marijuana_position_2011.pdf (the DEA states marijuana "has a high potential for abuse, has no accepted medicinal value in treatment in the United States, and evidence that there is a general lack of accepted safety for its use even under medical supervision." Billing the government for a service that includes certifying patients for medical marijuana would be in contradiction with the DEA position. Assisting qualified patients in obtaining a Schedule I substance through certification may be equated to providing a service or consultation for the purpose of obtaining a drug with no federally recognized medical value. However, the DEA specifically stated it will prosecute only those who manufacture, distribute, or possess any illegal drugs. While this may not benefit billing concerns, it may alleviate some criminal liability for certification.)

40. See generally False Claims Act, 31 U.S.C. §3729 (a hospital may be found liable under the False Claims Act for knowingly submitting a false claim to the government for payment. The penalty for doing so is a civil fine between \$5,000 and \$10,000, plus triple the amount the government paid for the claim or claims.) A False Claims Act claim may proceed under two theories, the most likely being false certification. A false certification claim is based on certifying the compliance with certain laws as a prerequisite for billing. See U.S. *ex*

patient confidentiality, a general visit that involves certification may not be construed as a visit solely for certification, and may still be billable without falsely certifying compliance with all federal laws.⁴¹

Should a hospital choose not to bill for the certification process, the act of certification may not create liability.⁴² While the courts have not substantially addressed the legal implications of certification and billing insurance, federal courts in California have found processes similar to certification as protected under the First Amendment.⁴³ The Act specifically states the physician is ultimately certifying that a patient has a qualifying condition to be eligible for a registry card, which is likely protected under the First Amendment.⁴⁴ However, obtaining certification is the only means for a pa-

rel. Absher v. Momence Meadows Nursing Ctr., Inc., 764 F.3d 699, 711 (7th Cir. 2014). A hospital certifying compliance with all federal laws and then billing Medicare for a service that includes certifying a patient for the use of a Schedule I substance may trigger liability under this theory. *See id.* The alternate worthless services theory may also be alleged. The Seventh Circuit has not yet recognized the worthless services theory under the False Claims Act. *See id.* at 710. However, in other circuits the worthless services theory proceeded with the claim that if a provider or facility billed the government for a service that is so deficient that it is essentially the equivalent of no performance at all, the provision and billing of that service violates the False Claims Act. *Mikes v. Strauss*, 274 F.3d 687, 703 (2d. Cir. 2001). Thus, a hospital could be sued under the False Claims Act for billing Medicare or Medicaid for the certification consultation provided by a staff physician, or potentially for providing a service the government deems to be without any value.

41. *See* 410 ILL. COMP. STAT. 130/130(k).

42. *See generally id.* at 130/10; *see generally* ILL. DEP'T OF PUB. HEALTH, PHYSICIAN WRITTEN CERTIFICATION FORM, *available at* <http://www2.illinois.gov/gov/mcpp/Documents/Physician%20Certification%20Form%20080814.pdf>. Note, the statute and regulations refer to the process as “certification,” not prescription. The certification process itself, as demonstrated by the certification form, only certifies that the patient has one of a listed number of medical conditions, has a bona-fide patient relationship, and that the physician conducted an in person physical examination, reviewed the patient’s medical history, and explained the risks and benefits of the medical use of cannabis. The final statement the physician must certify is that in the physician’s professional opinion, the qualifying patient is likely to receive a therapeutic or palliative benefit from using medical cannabis for treatment of the debilitating medical condition or symptoms of that debilitating medical condition.

43. *See Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (California case setting the precedent on First Amendment protection of discussions of the benefits and potential concerns of medical marijuana); *see also Denney v. Drug Enforcement Admin.*, 508 F. Supp.2d 815, 832 (E.D. Cal. 2007).

44. 410 ILL. COMP. STAT. 130/5 (describing the certification process as one in which the doctor states the patient has a qualifying condition to obtain a registry card, and verifies the bona-fide physician-patient relationship. The Act also uses the phrase “cannabis and prescription medications” in section 15, indicating the intention of the state to maintain the two concepts separate from each other).

tient to obtain medical marijuana, which bears a striking resemblance to a prescription.⁴⁵ A clear answer on this issue is unlikely to arise until medical cannabis is available and litigation begins.

The interaction between the Drug Enforcement Agency (DEA) certification and insurance is perhaps the greatest liability faced by hospitals with physicians certifying patients.⁴⁶ Physicians under the Act must have a valid DEA license to certify patients.⁴⁷ However, the requirements to receive a DEA license include that all drugs listed in Schedule I may not be prescribed, administered, or dispensed for medical use.⁴⁸ Thus, if certification is construed as the equivalent to prescribing medical marijuana, the DEA may have grounds to revoke the controlled substance license of any practitioner certifying patients under the Act.⁴⁹ Consequently, physicians certifying patients at a hospital could jeopardize the DEA license of both the physicians and hospitals. Without a valid DEA license, neither a hospital as an individual entity nor its physicians may participate in Medicare or Medicaid.⁵⁰

Even if a hospital determines that it will not permit staff physicians to certify patients for medical marijuana, or allow for certification on hospital or hospital-owned premises, hospitals are faced with patients bringing their

45. See generally *id.* at 130/55.

46. See DRUG ENFORCEMENT AGENCY, OFFICE OF DIVERSION CONTROL, PRACTITIONER'S MANUAL §2 (2006), available at <http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section2.htm>; see also Kay Lazar & Shelley Murphy, *DEA Targets Doctors Linked to Medical Marijuana*, BOSTON GLOBE (June 6, 2014), <http://www.bostonglobe.com/metro/2014/06/05/drug-enforcement-administration-targets-doctors-associated-with-medical-marijuana-dispensaries-physicians-say/PHsP0zRlaxXwnDazsohIOL/story.html> (describing physicians given an ultimatum in Massachusetts regarding their relationships with dispensaries. While the DEA has not replicated any similar type of action regarding physicians known to be certifying patients, the DEA is retaining its power to revoke DEA licenses for those involved with the distribution of medical marijuana).

47. 410 ILL. COMP. STAT. § 130/10.

48. DRUG ENFORCEMENT AGENCY, *supra* note 46.

49. *Id.*

50. Matthew Potter, *New Medicare Part D Rule Affects PA Prescribers*, AM. ACAD. OF PHYSICIAN ASSISTANTS (June 3, 2014), <http://www.aapa.org/twocolumn.aspx?id=2684>.

own medical cannabis into inpatient settings.⁵¹ Qualifying patients are not restricted from bringing cannabis into medical facilities, which may complicate inpatient admissions.⁵² Through triage, a nurse may indicate on the medical record that the patient is consuming cannabis without generating any legal liability.⁵³ However, if the patient is admitted into inpatient care, practitioners should avoid administering the drug directly because such administration is a clear violation of federal law and will likely complicate billing.⁵⁴ Practically, however, patients consuming medical marijuana in the hospital cannot have their use simply omitted from the record.⁵⁵ Hospitals must be wary of patients bringing the substance into the hospital and monitor other drug administration closely. Complications from ignoring medical marijuana may result in reduced quality of care, which may in turn affect insurance payments from Medicare and Medicaid, as well as private insurers.⁵⁶

The notion of hospitals operating dispensaries comes in clear conflict with Medicare and Medicaid certification.⁵⁷ Possessing and maintaining a

51. See ILL. COMP. STAT. § 130/30 (patients are not forbidden from bringing medical marijuana in to a hospital, just from smoking it in the hospital. As a result, patients with debilitating conditions may bring consumable products in during an inpatient stay).

52. 410 ILL. COMP. STAT. 130/30(a)(3)(F).

53. See David Karp et al., *Medical Record Documentation for Patient Safety and Physician Defensibility: A Handbook for Physicians and Medical Office Staff*, MED. INS. EXCH. OF CALIFORNIA 6 (Jan. 2008), available at <http://www.miec.com/Portals/0/pubs/MedicalRec.pdf> (recording a patient is using medical cannabis is not a legal issue, as it is no different than ordinary triage circumstances where a nurse may inquire and record if the patient uses alcohol, smokes or uses any substance of abuse).

54. Marcoux et al., *Medical Marijuana and Related Legal Aspects*, 38 PHARMACY & THERAPEUTICS 612, 618 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875249/>.

55. See Karp, *supra* note 53.

56. Marcoux *supra* note 54. Failing to note a patient is using medical marijuana, like the failure to note the patient is using any drug, may provide medical complications from interactions with other substances. Currently, a total of 549 drugs have documented interactions with cannabis, seven of which have highly clinically significant interactions. *Cannabis Drug Interactions*, <http://www.drugs.com/drug-interactions/cannabis.html> (last updated Nov. 16, 2014).

57. See Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations, *supra* note 36 (certifying compliance with federal law while possessing and trafficking a controlled substance).

large amount of a controlled substance is a clear violation of federal law and a hospital pharmacy dispensing marijuana would be in violation of its DEA license.⁵⁸ However, this risk may not be enough to stop hospitals from examining the prospect of a hospital-operated dispensary. For example, Swedish Covenant Hospital recently expressed interest in operating a dispensary, given its secure pharmacy and physician population interested in patient certification.⁵⁹ Swedish Covenant Hospital's ambitions were quelled by the City's zoning restrictions.⁶⁰ Hospitals in Chicago cannot operate a dispensary if near a school, in a residential area, or a facility with a day-care center on site.⁶¹ Regardless, operating a dispensary within a hospital presents incredible risk to losing Medicare and Medicaid participation, and likely opens a door to litigation and criminal charges for the hospital, physicians, nurses, and pharmacists.⁶² Unless a hospital wishes to take the risk of future operating uncertainty and near-certain litigation, any interaction between hospital pharmacies and marijuana should be avoided.

As a final consideration, hospitals should keep in mind that medical marijuana is not reimbursed through private insurance.⁶³ So long as the substance remains on Schedule I, insurance companies are prohibited from reimbursing for the purchase of an illegal substance with "no medical value."⁶⁴ Without insurance reimbursement, very few patients may be able

58. See DRUG ENFORCEMENT AGENCY, *supra* note 46.

59. Becky Schlinkerman, *Hospital Sales of Medical Marijuana Fraught with Questions*, CHICAGO SUN TIMES (July 21, 2014), available at <http://politics.suntimes.com/article/chicago/hospital-sales-medical-marijuana-fraught-questions/mon-07212014-158am>.

60. Ted Cox, *Medical Marijuana Zoning Set by City Council Committee* DNAINFO CHICAGO. (July 29, 2014, 6:54 PM), <http://www.dnainfo.com/chicago/20140729/downtown/medical-marijuana-zoning-set-by-council-committee>.

61. *Id.*

62. Schlinkerman, *supra* note 59; DRUG ENFORCEMENT AGENCY *supra* note 39.

63. Eamon Murphy, *Why Won't Health Insurance Cover Medical Marijuana?*, STREET (Apr. 14, 2014), <http://www.thestreet.com/story/12676155/1/why-wont-health-insurance-cover-medical-marijuana.html>.

64. Michelle Andrews, *When Your State Says Yes to Medical Marijuana, but Your Insurer Says No*, NAT'L PUB. RADIO (Nov. 20, 2012, 9:38 AM), <http://www.npr.org/blogs/health/2012/11/20/165554172/when-your-state-says-yes-to-medical-marijuana-but-your-insurer-says-no>.

to afford medical marijuana in Illinois.⁶⁵ As a result, hospitals may ultimately be risking Medicare and Medicaid participation in exchange for certifying patients to use a drug they will not be able to afford in sufficient quantities.⁶⁶

V. LOOKING FORWARD

While medical cannabis' clinical usage remains confined to smoking in private residences or through consumables, pharmaceutical companies have begun to enter into the medical marijuana market.⁶⁷ For example, GW Pharmaceuticals (GW) has developed two drugs, Sativex and Epidolex.⁶⁸ These two drugs have received fast track designation by the Food and Drug Administration (FDA) and are in Phase III trials.⁶⁹ Should GW gain ap-

65. Robert McCoppin, *Medical Marijuana May Cost Patients Top Dollar*, CHI. TRIB. (Sept. 1, 2014), available at <http://www.chicagotribune.com/news/ct-medical-marijuana-cost-met-20140901-story.html#page=1>.

66. *Id.* (discussing how health insurance does not cover medical marijuana and a credit card cannot be used to purchase it. Purchasers must have the cash to afford prices ranging as high as \$500 an ounce, and may range even higher in Illinois. For a patient who may need an ounce a month, this could lead to a conservative estimate of \$6,000 a year in cash for access to the substance before taxes. Given that many suffering from the conditions covered by the Act may be unable to work or work sufficient hours to obtain sufficient cash in addition to medical expenses, access to the substance will be costly for many who need it most).

67. Bruce Kennedy, *3 Pharma Companies Investing in Cannabis-Related Treatments*, BENZINGA (Aug. 28, 2014, 10:42 AM), <http://finance.yahoo.com/news/3-pharma-companies-investing-cannabis-144217923.html> (there is developing interest in the pharmaceutical application of cannabis, marking a significant change from the previous pharmaceutical manufacturer stance); *But see* Pamela Engel, *America's Drug Companies are Bankrolling the Crusade Against Legal Weed*, BUSINESS INSIDER (Jul. 11, 2014, 10:27 AM), <http://www.businessinsider.com/police-unions-and-pharmaceutical-companies-fund-anti-marijuana-fight-2014-7> (indicating there is still substantial incentive for pharmaceuticals to not only avoid medical cannabis but to try to further prevent its legalization).

68. *GW Pharmaceuticals Announces that Sativex Receives Fast Track Designation from FDA in Cancer Pain*, GW PHARM., (Apr. 28, 2014), <http://www.gwpharm.com/GW%20Pharmaceuticals%20Announces%20that%20Sativex%20Receives%20Fast%20Track%20Designation%20from%20FDA%20in%20Cancer%20Pain.aspx> [hereinafter *Sativex*]; *GW Pharmaceuticals Announces Epidolex Receives Fast Track Designation from FDA for the Treatment of Dravet Syndrome*, GW PHARM., (June 6, 2014), <http://www.gwpharm.com/GW%20Pharmaceuticals%20Announces%20Epidiolex%20Receives%20Fast%20Track%20Designation%20from%20FDA%20for%20the%20Treatment%20of%20Dravet%20Syndrome.aspx> [hereinafter *Epidolex*].

69. *Sativex*, *supra* note 69; *Epidolex*, *supra* note 69; see NAT'L INST. OF HEALTH, FAQ QUESTION: WHAT ARE CLINICAL TRIAL PHASES?, <http://www.nlm.nih.gov/services/ctphases.html> (last updated Apr. 18, 2008) (explaining Phase III trials are clinical trials where a drug is given to a large sample to confirm the drug is both safe and effective to

approval from the FDA for either drug, the DEA would be required to reconsider marijuana's scheduling as a Schedule I substance.⁷⁰ If marijuana were removed from Schedule I, physicians could not only certify, but also prescribe the substance.⁷¹ Whether the drug would be reimbursable under Part D of Medicare may be up to the discretion of the federal government, and private insurance may hesitate as well.⁷² However, with the possibility of a pharmaceutical company demonstrating some forms of medical marijuana to be safe and effective, insurance reimbursement for certain medical marijuana-based treatments may be considered in the near future⁷³

Hospitals willing to take on the risk presented by certifying patients or maintaining a dispensary must remember that the risk calculation is entirely politically dependent.⁷⁴ In 2013, the Department of Justice (DOJ) issued a memorandum that it would not challenge state laws legalizing medical marijuana.⁷⁵ Additionally, the House of Representatives recently voted to defund the DOJ, including the DEA, for any activity with the purpose of interfering with medical marijuana operations legalized by States.⁷⁶ However,

meet the FDAs approval requirements for new drug applications).

70. See Schedules of Controlled Substances, 21 U.S.C.A. § 812(b)(1) (West 2014).

71. See *id.*

72. Michelle Andrews, *Advocates of Medical Marijuana Face Another Hurdle: Insurance Coverage*, KAISER HEALTH NEWS (Nov. 19, 2012), <http://kaiserhealthnews.org/news/112012-michelle-andrews-on-medical-marijuana/> (stating insurance companies “want to see stronger scientific evidence that marijuana is as safe and effective as other drugs to treat pain or nausea.”).

73. See *id.*

74. Sean Sullivan & Scott Clement, *Public Support for Medical Marijuana is Reaching New Highs. Why do Republican 2016 Hopefuls find the Idea a Buzzkill?*, THE WASHINGTON POST (Aug. 15, 2014), <http://www.washingtonpost.com/blogs/post-politics/wp/2014/08/15/public-support-for-medical-marijuana-is-reaching-new-highs-why-do-republicans-2016-hopefuls-find-the-idea-a-buzzkill/> (discussing while public opinion in favor of legalizing marijuana medicinally remains around eighty percent, Republican candidates are very mixed on their support in any change in position. Many of these leaders come from states who have legalized the substance medically or have legislation in motion to legalize, raising questions as to whether their opinion will shift depending on how their state votes).

75. Kevin Johnson & Raju Chbeium, *Justice Dept. Won't Challenge State Marijuana Laws*, USA TODAY (Aug. 29, 2013), <http://www.usatoday.com/story/news/nation/2013/08/29/justice-medical-marijuana-laws/2727605/>.

76. John Ingold, *Impact of U.S. House Vote on Medical Marijuana Enforcement Unclear*, DENVER POST (May 31, 2014), http://www.denverpost.com/marijuana/ci_

with Attorney General Eric Holder resigning from office and the 2016 elections looming, medical marijuana may soon be brought to the national stage for a political verdict.⁷⁷ Given the anecdotal evidence of success, as well as the continuing trend towards state legalization for medical purposes, it is unlikely the medical legalization push does not reach Congress' doorstep in the next five years.

VI. CONCLUSION

Medical marijuana may have substantial benefits for patients, but the risks it presents for hospitals negate some of the positive outlook for medical marijuana. Clinical administration of medical marijuana puts a hospital's Medicare and Medicaid status at risk. Without the ability to participate in Medicare and Medicaid, a hospital would be unable to continue to exist. The risk of jeopardizing Medicare and Medicaid participation remains high given the DEA position on marijuana, and hospitals must remain wary of this risk. Until the Seventh Circuit addresses whether certification is the equivalent to prescribing, it is in a hospital's best interest to implement clear policies on how it wishes for staff and community physicians to approach requests from patients.

Furthermore, it is imperative that Illinois hospitals communicate with all clinical staff on how to approach issues stemming from patients seeking certification. Most importantly, the hospital must determine how it intends to have nurses and other clinical staff handle patients bringing in their own medical marijuana to the inpatient setting. Until the federal government reconciles the current conflict in law resulting from the growing number of

25869675/impact-u-s-house-vote-medical-marijuana-enforcement.

77. Johnson, *supra* note 75; see also Conor Friedersdorf, *The Other Big Election 2014 Losers: Marijuana Prohibitionists*, ATLANTIC MONTHLY (Nov. 5, 2014 6:26 AM), <http://www.theatlantic.com/politics/archive/2014/11/the-biggest-election-2014-winner-marijuana/382393/> (discussing 2014 midterm election outcomes for several states with marijuana on the ballot. Oregon, Alaska, and Washington, D.C. all voted to legalize marijuana. A Florida constitutional amendment legalizing medicinal marijuana failed, but achieved fifty-eight of the sixty percent of the vote needed for the amendment to pass).

states legalizing medical marijuana, hospitals are best suited to proceed with caution and avoid the introduction of marijuana into clinical practice.