NATIONAL SAFETY COUNCIL

Position/Policy Statement

Medicaid Support for Mental Health and Substance Use Disorder (SUD)

Policy/Position:

The National Safety Council (NSC) believes that Medicaid is a critical tool to reduce overdose deaths, help individuals receive treatment and recover from opioid use disorder (OUD) and other substance use disorders (SUDs) and mitigate impacts of mental illnesses and increase treatment. Currently, nearly 17% of Medicaid beneficiaries have an SUD.[1] As of January 2020, an additional 4.4 million people across the United States and 1.5 million people living with a mental illness or SUD would be eligible for healthcare coverage – including access to behavioral health services (including treatment for SUDs) – if all states expanded Medicaid programs.[2]

NSC supports states adopting Medicaid expansion and opposes cuts to the Medicaid program. Evidence demonstrates that Medicaid expansion states have seen improvements in access to medications and services for the treatment of mental health conditions and SUD following expansion. Many national and multi-state studies showed greater improvements in expansion compared to non-expansion states.[3,4,5] Studies have shown that Medicaid expansion is associated with increases in overall prescriptions for Medicaid-covered prescriptions, including medications to treat OUD and opioid overdose.[6] Medicaid is one of the largest sources of federal funding of health care services for individuals with OUD, including medications for addiction treatment (MAT).[7] Many of these individuals also have increased financial strains due to medication costs and other treatment. Access to Medicaid should be available to people based on income level only, without additional restrictions and regardless of other individual circumstances. Certain mechanisms, such as 1115 waivers[8], are of particular interest here when expanding access to treatment for OUD.

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[1] https://www.kff.org/report-section/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals-issue-brief/#endnote_link_223575-4
[2] https://www.kff.org/medicaid/fact-sheet/uninsured-adults-in-states-that-did-not-expand-who-would-become-eligible-for-medicaid-under-expansion
[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476
[4] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/
[5] https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304338
[6] http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf
[7] https://www.gao.gov/assets/710/704043.pdf
[8] 1115 waivers are designed to give states flexibility in how they operate their programs, including specific flexibilities to help states address the opioid crisis

Background

Mental Health and SUD

Nearly one in five adults in the U.S. lives with a mental illness. These illnesses vary in degree of severity from mild, moderate and severe. Mental illness is categorized under two categories: Any Mental Illness (AMI) and Serious Mental Illness (SMI).[9]

In 2018, an estimated 47.6 million adults live with AMI, which represents 19.1% of all U.S. adults. AMI is higher among women than men and people reporting more two or more races. It is also highest among people ages 18-25.[10][11] There were approximately 11.4 million adults in the U.S. with SMI. SMI is also found in more women than men, among people reporting two or more races, and highest among people ages 18-25.[12,13] As of 2018, the rate of unemployment is higher among U.S. adults who have mental illness compared to those who do not.[14] Historically, people with serious mental illness are underemployed.[15,16,17]

According to the Substance Abuse Mental Health Services Administration (SAMHSA) in 2018, nearly one in five people aged 12 or older used an illicit drug in the past year. In the same year, about 20.3 million people aged 12 or older had an SUD related to alcohol or illicit drugs in the past year. Approximately 14.8 million had alcohol use disorder and 8.1 million people had illicit drug use disorder. Marijuana use disorder is the most common (4.4 million people), followed by opioid use disorder (2.0 million people).[18]

Medicaid Expansion

The Patient Protection and Affordable Care Act[19] sought to expand Medicaid coverage to most low-income adults making less than 138% of the federal poverty level (FPL). In 2012, the U.S. Supreme Court ruled that states could opt out of the law's Medicaid expansion, leaving the decision to each state's governor and legislature.[20] As of April 27, 2020, 36 states and Washington, DC have adopted Medicaid expansion fully or have an alternative plan while 14 states have not expanded Medicaid.[21]

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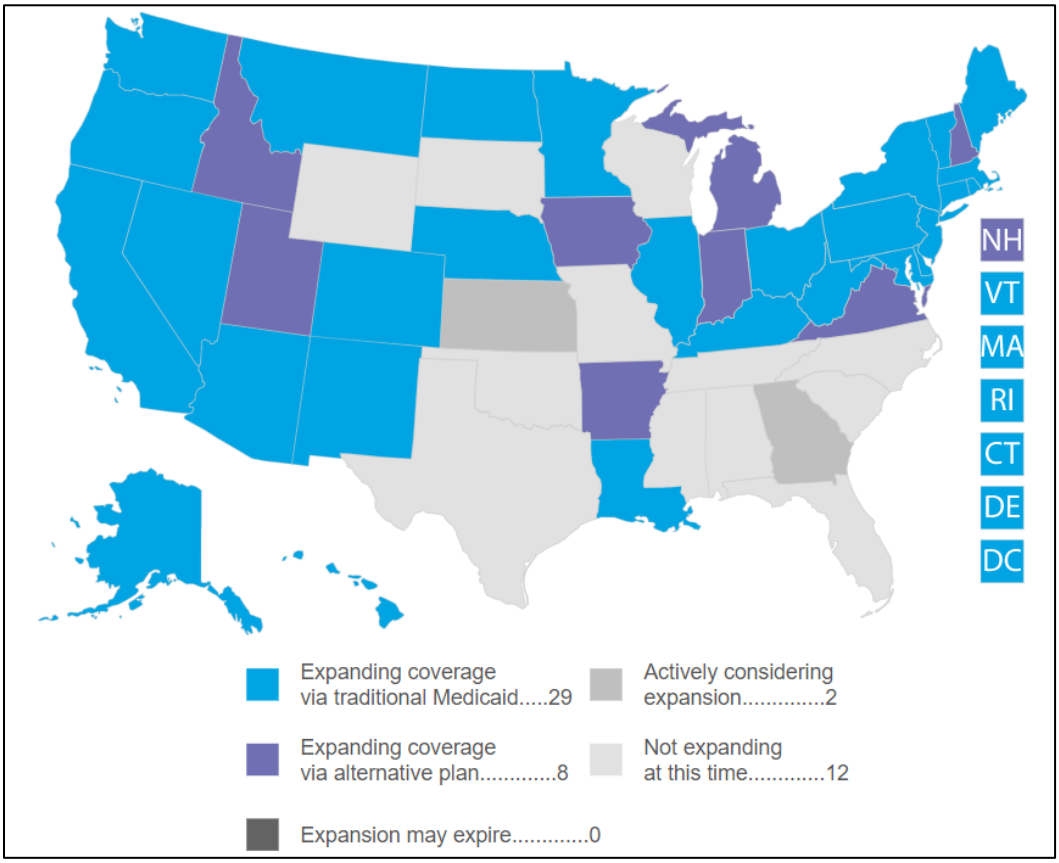
[9] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#:~:text=Mental%20illnesses%20are%20common%20in,(46.6%20million%20in%202017).
[10] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
[11] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#:~:text=Mental%20illnesses%20are%20common%20in,(46.6%20million%20in%202017).
[12] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
[13] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#:~:text=Mental%20illnesses%20are%20common%20in,(46.6%20million%20in%202017).
[14] https://www.nami.org/mhstats
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182106/
[16] https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/RoadtoRecovery
[17] https://www.who.int/mental_health/media/en/712.pdf
[18] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
[19] PL 111-148
[20] *National Federation of Independent Business, et al v. Sebelius, Secretary of Health and Human Services, et al.*
[21] https://www.advisory.com/daily-briefing/resources/primers/medicaidmap

In the states that adopted full Medicaid expansion, individuals can qualify solely based on income if their income is below 138% of the federal poverty level.[22] States that expanded Medicaid using an "alternative model," as referenced in the map below through 1115 waivers[23] have implemented eligibility requirements that may include policies that mandate premiums, implement health behavior incentives, and institute work requirements.[24] In states that have not expanded Medicaid, individuals may qualify based on income, household size, disability, family status, and other factors.[25] Any type of alternative model adopted by the states must be structured to not discourage participation.

States that expanded Medicaid have realized better health outcomes looking at a number of different metrics.[26] Improvements in measures of self-reported health or positive health behaviors following Medicaid expansions have been reported, including mental health,[27] in particular for adults with chronic conditions who frequently use the healthcare system.[28] Additionally, some states that expanded Medicaid realized cost savings by spending less on uncompensated care and on mental health programs, for example.[29]



[22] https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/
[23] https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/
[24] http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers
[25] https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/
[26] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00929?journalCode=hlthaff
[27] https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834959/
[29] https://www.cbpp.org/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims

Cost to States

There is concern about increased fiscal cost to individual states. Starting in 2014, the federal government paid the full cost of expansion, states began covering a portion of expansion's cost in 2017 and, starting in 2020, are responsible for 10 percent of its cost. Given recent spending levels, expansion states will collectively pay more than $7 billion in 2020. For the median expansion state, expansion will cost more than $100 million.[30]

Medicaid expansion has been found to save money in a few specific areas, at least partially off-setting this cost. First, expanding eligibility allows states to cut spending in other parts of their Medicaid programs. Second, it allows states to cut spending outside of Medicaid — particularly on state-funded health services for the uninsured. Finally, expansion may increase state revenues due to taxes related to Medicaid expansion or taxes on increased economic activity.[31]Of particular interest are the areas in which expanding Medicaid reduces state spending. Two of the most common areas are treatment for substance use and costs incurred in correctional facilities.[32,33]

A May 2020 Commonwealth Brief on The Impact of Medicaid Expansion on States' Budgets concluded that:

> "Studies that examine the fiscal impact of Medicaid expansion on specific states or the effects across all states find consistent results: expansion leads to significant budget savings and significant revenue increases (even without imposing additional taxes). Consequently, the actual net price of expansion is well below the sticker price to states of 10 percent. In some cases, states' net price is negative. Medicaid expansion can provide states with additional resources to fund other priorities or cut taxes.
>
> Given that each states' Medicaid program is different, fiscal effects and pathways to savings vary widely. Not every state that expands Medicaid will experience large savings in their traditional Medicaid programs, but many will. Not every state will experience large savings outside Medicaid, nor revenue growth, but some will. While the paths may differ, the available evidence points in the same direction: states pay, at most, only a small fraction of the cost of Medicaid expansion."

Medicaid and the Opioid Crisis

The societal monetary costs and associated collateral impact to society due to SUDs are very high. It is estimated that opioid use and misuse cost the United States economy $78.5 billion on an annual basis.[34] When health care and criminal justice costs are included, the number reaches

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[30] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[31] Ibid
[32] https://www.rwjf.org/en/library/research/2015/04/states-expanding-medicaid-see-significant-budget-savings-and-rev.html
[33] https://www.kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/
[34] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5975355/

$442 billion.[35] In 2014, health insurance payers spent $34 billion for treating all SUDs.[36] Opioid use disorder in and of itself may have added $10.8 billion to the cost of treating commercially insured patients across the United States in 2016 alone.[37]

Medicaid plays an essential role in addressing the opioid crisis and increasing access to treatment. Early screening for substance and opioid use disorders is an effective prevention mechanism, as is coordinated care across systems, which can be facilitated by Medicaid. Medicaid was responsible for over 20% of SUD-related spending in 2014, and that share is projected to increase to 28% by 2020.[38] It is clear that expanding Medicaid-provided treatment services can have a far-reaching effect to provide treatment and recovery services to Medicaid patients. Implementation of evidence-based prevention and treatment interventions can have a benefit of more than $58 for every dollar spent. Studies show that every dollar spent on SUD treatment saves $4 in health care costs and $7 in criminal justice costs.[39] Ensuring that individuals suffering from OUD have access to appropriate treatment is an important factor in reducing overdoses and overdose deaths and allowing people to enter treatment and progress into recovery. Between 2010 and 2017, Medicaid spending on OUD treatments increased from $190 million to $887 million.[40]

Treatment Coverage:

- Medicaid covers nearly four in 10 of the 2 million non-elderly adults suffering from OUD, making the program a critically important tool to help people access treatment
- The rate of buprenorphine[41] prescriptions was higher in expansion states versus non-expansion states[42]
- All state Medicaid programs cover at least two types of medications for addiction treatment (MAT), and most (40 of 51) cover all three types (methadone, buprenorphine and naltrexone).[43] MAT is the gold standard for treating OUD[44]
- 28.5% of Medicaid beneficiaries with an SUD had an OUD – over 1.1 million people[45]
- Medicaid coverage does increase treatment utilization. 44% of adults with an SUD who are covered by Medicaid accessed needed SUD treatment, as opposed to 24% of those with an SUD who had private insurance [46]
- Medicaid covered over half (54%) of all non-elderly adults with OUD who reported receiving treatment in 2016,

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[35] https://addiction.surgeongeneral.gov/vision-future/time-for-a-change
[36] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4975.pdf
[37] https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2019/costs-comorbidities--opioid-use-disorder.ashx
[38] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4975.pdf
[39] https://addiction.surgeongeneral.gov/vision-future/time-for-a-change
[40] https://www.urban.org/sites/default/files/publication/99798/rapid_growth_in_medicaid_spending_and_prescriptions_to_treat_opioid_use_disorder_and_opioid_overdose_from_2010_to_2017_1.pdf
[41] A partial opioid agonist prescribed for managing OUD
[42] https://www.urban.org/sites/default/files/publication/100817/2019.08.19_av_state_medicaid_rx_oud_final_v3_1.pdf
[43] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/
[44] https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf
[45] https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/sud-data-book.pdf
[46] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/

- Medicaid finances almost one quarter of all treatment for substance use disorders (21%).[47]

Overdose Fatalities:

- Medications for addiction treatment decrease overdose fatalities but are traditionally underutilized, in part due to inadequate insurance coverage. The 2018 National Survey on Drug Use and Health found that of those individuals who needed treatment, lack of insurance coverage was the second most common reason why they did not seek treatment– one in three people had inadequate insurance coverage.[48] Expanding access to Medicaid facilitates this access for patients in need.[49]
- There was a 6% decrease in total opioid overdose deaths (particularly in heroin and synthetic opioid-related fatalities) in states that expanded Medicaid compared to non-expansion states.[50]The authors of the cited study calculated that the Medicaid expansion saved over 8,000 lives between 2014 and 2016.[51]

Medicaid and Mental Illness

In the United States, only 41% of people who had a mental illness in the past year received professional health care or other services.[52] Medicaid is the single largest payer for mental health services and covers more than one in four adults with a serious mental illness. Medicaid financing and coverage facilitate access to a variety of behavioral health services, including psychiatric care, counseling, medications, inpatient treatment, supportive housing, and case management.[53]

- Medicaid expansion removes barriers for people with mental illness by allowing people to qualify based on income, rather than a disability determination, which can be difficult to obtain in a timely manner and may inadvertently prevent people from accessing Medicaid services. This helps people receive mental health services when they need them.
- In states that have already expanded Medicaid, people are less likely to skip medications due to cost, more likely to seek regular care for their ongoing health conditions,[54] and report improvements on their overall health[55]
- Medicaid expansion has led to more people with serious mental illness using mental health services[56] and fewer people delaying or skipping necessary care[57]

Medicaid and COVID-19

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[47] Ibid
[48] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
[49] https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose
[50] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476
[51] Ibid
[52] https://www.mentalhealthfirstaid.org/2019/02/5-surprising-mental-health-statistics/
[53] https://www.kff.org/infographic/medicaids-role-in-behavioral-health/
[54] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420
[55] https://www.nber.org/papers/w22265.pdf
[56] https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2014.302521
[57] https://doi.org/10.1007/s10488-018-0875-9

As a result of the current economic downturn, more people are becoming eligible for Medicaid due to job and income loss.[58] At the end of April 2020, the unemployment rate had increased to 14.7%.[59] Most of these newly unemployed individuals -- potentially nearly 17 million people by the start of 2021 -- are seeking health coverage, putting stress on both the operational and clinical side of Medicaid. In general, enrollment in and spending on Medicaid grows during economic downturns.[60] Understanding that unemployment and economic vulnerability correlate to an increase in substance use and misuse,[61] continuous coverage and care is critical so that people developing a SUD can be diagnosed early on.

Medicaid traditionally supports unemployed or underemployed people. Studies of adults who gained coverage in Ohio[62] and Michigan[63] under Medicaid expansion found that gaining health coverage helped a majority look for work or remain employed. Losing coverage — and, with it, access to treatment of SUDs such as opioid use disorder and mental illness — will have the reverse result of impeding future employment. As it stands, the estimated cost of lost productivity due to mental illness in the United States is estimated to be $500 billion annually.[64]

This group tends to expand, at least temporarily, during economic downturns and natural disasters, and the COVID-19 pandemic embodies both. The COVID-19 pandemic clearly qualifies as a natural disaster as defined by the United Nations Office of Disaster Risk Reduction[65]: disaster as a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources. Continuous coverage is critical, as prevalence of mental health problems in disaster-affected populations is found to be two to three times higher than that of the general population (varying from 8.6% to 57.3%).[66] – it is clear that the impacts of COVID-129 on mental health will continue for some time, and in combination with increased unemployment, Medicaid will be a critical tool to address this issue.

The restrictions put in place to stem the spread of COVID-19 have also impacted the ability of healthcare providers to provide care and have reduced government agencies' operation capacity to handle an increase in Medicaid enrollees.[67] Therefore, the ability to handle an increase in people who need care has been reduced. Ideally, impacted people transition back into the workforce quickly. As always, their physical and mental health conditions will follow them. Medicaid services are critical to servicing these populations and ensuring they are as healthy as possible when reentering the workforce as unemployment rates decrease in the years following the pandemic.

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[58] https://www.kff.org/health-reform/issue-brief/changes-in-income-and-health-coverage-eligibility-after-job-loss-due-to-covid-19/
[59] cbo.gov/publication/56335
[60] https://www.kff.org/medicaid-enrollment-and-spending-growth-is-accelerated-during-economic-downturns-medicaid/
[61] https://www.sciencedirect.com/science/article/pii/S0955395917300877
[62] http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf
[63] http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches
[64] https://www.mhanational.org/sites/default/files/Mind%20the%20Workplace%20-%20MHA%20Workplace%20Health%20Survey%202017%20FINAL.pdf
[65] https://www.undrr.org/terminology/disaster
[66] Udomratn P. Mental health and the psychosocial consequences of natural disasters in Asia. Int Rev Psychiatry. 2008;20:441–4.
[67] https://www.cbpp.org/research/health/streamlining-medicaid-enrollment-during-covid-19-public-health-emergency

Recommendations

Medicaid is a critical program for those people and families who need it most. Its importance is clear during the current economic downturn. Medicaid spending makes up a considerable portion of any state's budget. When economic downturns occur, not only are more people likely to qualify for Medicaid, but also a state's ability to pay for additional coverage is strained. The benefits of healthcare coverage outweigh the costs, and the federal government should provide adequate funding to ensure states can maintain and meet increasing coverage demands during these times.

As states consider implementing Medicaid expansion or are making coverage decisions, policymakers should seek to minimize barriers to care. Covering telehealth, removing prior authorization requirements, discontinuing arbitrary coverage limits, and eliminating work requirements can lead to better access and health outcomes, including people with mental illnesses and SUDs.[68] For example, removing the barrier of requiring prior authorization for MAT has been found to increase utilization of this treatment and decrease emergency room visits.[69] Work requirements have been found to reduce enrollment in Medicaid without realizing an improvement in the number of people employed.[70] Additionally, states that have implemented work requirements experience higher rates of opioid overdose deaths than other states and have fewer substance use disorder treatment facilities.[71] Hindering access by implementing work requirements may have negative repercussions for individuals with substance use disorders.

Many states expanded access to telehealth during the COVID-19 pandemic to increase access to care, and these policies should be made permanent.[72] The federal government also needs to maintain the enhanced Federal Medical Assistance Percentages (FMAP) for Medicaid expansion to ensure states can maintain enrollment. Pertaining to FMAP and economic downturns (such as that associated with the COVID-19 pandemic), the Government Accountability Office (GAO) previously found that during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula does not reflect current state economic conditions. GAO previously developed a formula that offers an option for providing temporary automatic, timely, and targeted assistance. Congress should use this formula for any future changes to the FMAP during the current and future economic downturns to help ensure that the federal funding is targeted and timely.[73]

States must play close attention to the needs of people who are incarcerated. Estimates suggest nearly two-thirds of incarcerated persons have a history of SUD.[74] Releasing

[68] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4124-z
[69] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764598?resultClick=24
[70] https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas.pdf
[71] https://labblog.uofmhealth.org/industry-dx/overdose-rates-are-higher-but-opioid-addiction-care-harder-to-find-medicaid-work
[72] https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/
[73] https://www.gao.gov/assets/710/707837.pdf
[74] https://www.drugabuse.gov/publications/drugfacts/criminal-justice#:~:text=While%20the%20exact%20rates%20of,population%20has%20an%20active%20SUD.

individuals who are incarcerated without connections to healthcare providers, medical coverage, safe and stable housing, or a support system can greatly increase their risk of relapse, overdose and death. Individuals returning to the community after incarceration are much more likely to die from an overdose than the general population.[75] States must continue Medicaid coverage for people who are incarcerated, or ensure that coverage is in place prior to reentry, to facilitate hand-offs to community services such as those mentioned above.

Ensuring that access to SUD treatment providers and mental health professionals through Medicaid is critical. States should implement safeguards and standards to monitor access and ensure managed care plans are complying with state and federal requirements meant to ensure parity with other healthcare treatments. For-profit managed care plans must be monitored and held accountable for compliance with all applicable laws as well. To ensure a healthy workforce as the U.S. emerges from the COVID-19 pandemic, Medicaid expansion is key. Additionally, behavioral health service providers face bureaucratic barriers and are reimbursed at significantly lower than medical or surgical providers, depressing their participation in the Medicaid program.[76] States need to ensure adequate payment rates for these providers to ensure they are willing to participate in the program.

This position statement reflects the opinions of the National Safety Council but not necessarily those of each member organization.

Adopted by the National Safety Council, July 2020

[75] https://www.fiercehealthcare.com/hospitals/industry-voices-incarcerated-people-need-health-coverage-to-help-stop-drug-overdose-and
[76] https://www.healthaffairs.org/do/10.1377/hblog20200205.346125/full/