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Medicaid Is Key to Building a System of Comprehensive Substance Use Care for Low-Income People

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Robust and reliable funding for substance use disorder (SUD) services is essential for closing the treatment gap, where fewer than 13 percent of the 21 million-plus people who need substance use services get any.¹ (See Figure 1.) A comprehensive system of SUD care would provide a full continuum of treatment and recovery services to people living with all types of substance use disorders, integrate care for their co-occurring physical and mental health conditions, advance racial equity in treatment access and quality, and connect people with services to meet their social needs. Medicaid should be the foundation for funding comprehensive care for people with low incomes.*

The ripple effects of inaccessible SUD care include the placement of children into foster care, job loss, racial disparities in outcomes — and preventable deaths.² The Centers for Disease Control and Prevention (CDC) conservatively estimates that an average of 95,000 people died each year from excessive alcohol use between 2011 and 2015, the most recent years with available data.³ At over 71,000, deaths from drug overdoses set a new record in 2019. They are likely to be even higher in 2020, CDC provisional data show.⁴

To address the lack of access to care and improve outcomes for people with SUDs, the nation needs a comprehensive, adequately financed system in which every person with a SUD — regardless of their economic circumstances — can readily access evidence-based care. We outline key elements of such a system, for instance delivering evidence-based care, in the text box, “Critical Characteristics of a Comprehensive Substance Use System of Care.”

Medicaid should be the foundation for a system of care for people with low incomes. It can cover a rich array of clinical SUD treatment services, recovery supports, and other mental and physical health care. And in contrast to annually appropriated grant programs, Medicaid guarantees health coverage to all who qualify, so funding adjusts to meet rising need. Grant funding and other resources should complement Medicaid, paying for services that Medicaid doesn’t cover and funding treatment for people with SUDs who are under- or uninsured.⁵ Fully funding social services that

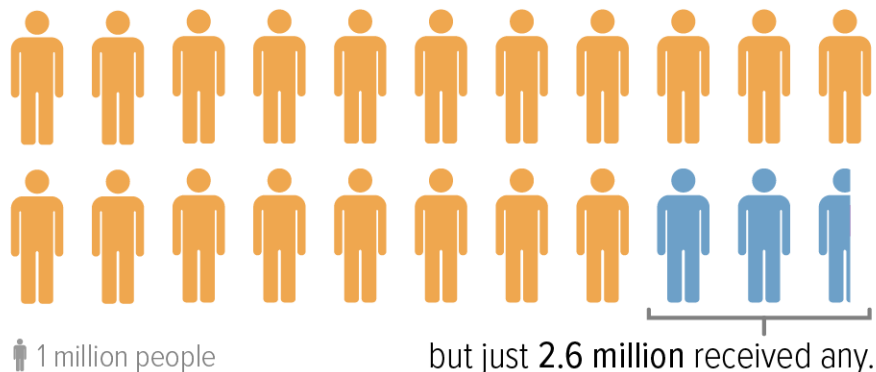
* Many thanks to Ali Safawi and Raquel de la Huerga for their assistance with the research for this report.

remove barriers to care, such as affordable housing and employment supports, is also critical to improving access to SUD treatment services and recovery outcomes.

FIGURE 1

Most Who Need Treatment for Substance Use Disorders Don't Receive Any

In 2019, 21.6 million people needed treatment...



Note: Survey responses were limited to U.S. civilians over the age of 12 not residing in an institution (e.g. prison or nursing home). The survey also excludes people with no fixed address, such as people experiencing unsheltered homelessness. "Receiving treatment" was defined as substance use treatment received within the past year at a hospital, rehabilitation facility, mental health center, emergency room, private doctor's office, prison or jail, or self-help group.

Source: 2019 National Survey on Drug Use and Health

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State and federal policymakers can make tremendous progress toward creating a comprehensive system of care for people with SUDs by fully leveraging Medicaid. Among other steps, they can:

- Expand Medicaid coverage in the 12 states that have not yet adopted expansion (and promptly implement expansion in Missouri and Oklahoma, which adopted it last year through ballot initiatives);
- Ensure that state Medicaid plans cover the full continuum of SUD services and that Medicaid beneficiaries have access to providers who deliver it;
- Ensure that grants and other temporary funding streams complement Medicaid to expand access to services, rather than fund services Medicaid covers or could cover; and
- Expand and improve access to federal programs, such as affordable housing and child care programs, that address unmet social needs that create barriers to care.

Critical Characteristics of a Comprehensive Substance Use System of Care

It's essential that a truly comprehensive SUD system of care:

Provide a full continuum of treatment and service options that are tailored and coordinated to meet behavioral and physical health needs. Substance use treatment is not one-size-fits-all. A wide range of services should be available, including early interventions, outpatient services, residential and inpatient services, and physical and behavioral health care to treat co-occurring health conditions.^a

Make high-quality services available to people with all types of substance use disorders. High-quality treatment and services should be available regardless of an individual's SUD diagnosis. Trends in substance use change, so a system of care should respond to emerging crises in real time while continuing to address existing needs.

Provide services rooted in latest evidence and reflecting best practices. For instance, medication assisted treatment — which combines medication with behavioral therapy — for opioid use disorder is strongly supported by research yet remains under-used.^b

Advance racial equity. All people with SUDs should have access to the best available care regardless of their race or ethnicity. While substance use disorders and inadequate access to treatment are serious problems among all racial and ethnic groups, communities of color face additional barriers to treatment. The SUD system of care should be tailored to meet the needs of communities of color.

Connect people to the non-health resources and social services they need to begin treatment and maintain recovery. The most effective treatment programs for substance use disorders combine substance use treatment and mental health services with social supports, including housing, child care, vocational supports, educational services, legal services, and financial supports.^c

^a American Society of Addiction Medicine, "The ASAM Criteria," <https://www.asam.org/resources/the-asam-criteria/about>; U.S. Department of Health and Human Services, Office of the Surgeon General, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," November 2016, <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

^b Substance Abuse and Mental Health Services Administration, "MAT Medications, Counseling, and Related Conditions," <https://www.samhsa.gov/medication-assisted-treatment/treatment>.

^c Maria Paino, Lydia Aletraris, and Paul Roman, "The Relationship Between Client Characteristics and Wraparound Services in Substance Use Disorder Treatment Centers," *Journal of Studies on Alcohol and Drugs*, Vol. 77, No. 1, January 2016, <http://www.jsad.com/doi/pdf/10.15288/jsad.2016.77.160>; National Institutes for Health, National Institute on Drug Abuse, "Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)," updated January 2018, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-drug-addiction-treatment>.

Maximize Medicaid's Sustainable and Reliable Funding

The Affordable Care Act's (ACA) Medicaid expansion dramatically increased health coverage for many people with SUDs. Prior to expansion, many low-income, non-elderly adults with SUDs were not eligible for Medicaid — and were largely left uninsured — because they didn't meet the strict eligibility criteria for federal disability programs. Moreover, the ACA required states to include SUD

treatment as a covered benefit for people eligible under Medicaid expansion. But more can be done to further leverage Medicaid to improve SUD care and services by further expanding Medicaid, covering all services Medicaid can cover, and taking steps to increase provider participation.

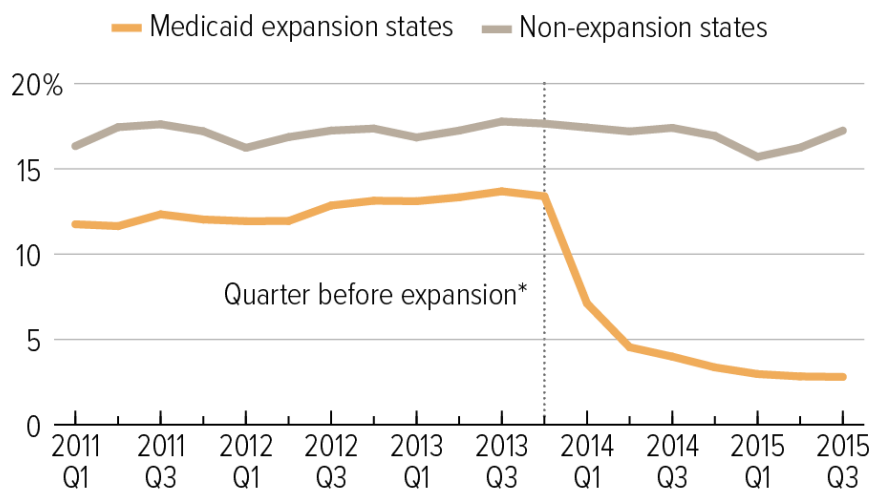
All States Should Expand Medicaid Eligibility

Health coverage is essential for people with SUDs to obtain comprehensive care, but many low-income people remain uninsured, particularly in states that have yet to expand Medicaid. In the states that have expanded Medicaid, the program has been a powerful tool for improving coverage and access to care for people with SUDs. The uninsured rate among people with opioid-related hospitalizations fell dramatically in states that expanded, from 13.4 percent in 2013 (the year before expansion took effect) to just 2.9 percent two years later. (See Figure 2.)

After Kentucky expanded Medicaid in 2014, the number of Medicaid beneficiaries using substance use treatment services in the state jumped by 700 percent. One study finds that Medicaid expansion increased treatment facility admissions in which patients were given medication assisted treatment (MAT) — the gold standard treatment for opioid use disorder — by about 50 percent.⁶

FIGURE 2

ACA Medicaid Expansion Reduced Share of Opioid-Related Hospitalizations in Which Patient Was Uninsured



*The Affordable Care Act (ACA) gave states the option to expand Medicaid to adults with income up to 138 percent of the poverty line starting in 2014.

Source: CBPP analysis of Healthcare Cost and Utilization Project data from the Agency for Healthcare Research and Quality. Analysis includes 26 states for which data are available for all of 2011-2015 and which either expanded Medicaid in January 2014, or had not expanded as of October 2015.

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Yet 12 states have yet to adopt Medicaid expansion under the ACA (and Oklahoma and Missouri won't implement it until July). This leaves millions without coverage, including for SUD care. And it

leaves states with fewer resources to address the substance use and overdose death crises and protect access to care during the COVID-19 pandemic and recession.⁷ If the remaining 14 states implemented expansion, at least 4 million uninsured people would become eligible for Medicaid coverage.⁸ Implementing Medicaid expansion in all states would also help narrow racial inequities in health coverage rates and remove a key barrier to SUD care. Nearly 60 percent of the uninsured people who could gain coverage in the remaining non-expansion states are people of color.⁹

A Tailored Response Is Needed to Promote Equitable SUD Treatment and Services

Lack of access to health coverage and SUD care is a major problem among all racial and ethnic groups, but people of color often face greater barriers to high-quality SUD treatment services. Black people, Latinx people, Native Americans, and Pacific Islanders are more likely than white people to be uninsured, which can prevent access to quality SUD treatment.^a There are also racial disparities in access to some treatment services, with one study finding that Black people were much less likely than white people to be prescribed buprenorphine, one of the three drugs that the Food and Drug Administration approved to treat opioid use disorder.^b While available research is mixed, some studies find that people of color who get treatment face greater barriers to completing treatment programs, are more likely to report having negative experiences during treatment, and may have worse treatment outcomes in part due to differences in the quality of treatment they receive.^c

Communities of color also often experience the substance use crisis differently than white communities. For instance, the rate of increased overdose deaths from synthetic opioids such as fentanyl — a major driver in the uptick in opioid overdose deaths in recent years — varies by race and has been highest for Black and Latinx people.^d A one-size-fits-all response to the opioid epidemic will fail to address these differences.

Punitive responses to substance use also continue to disproportionately harm communities of color. Black people are much more likely than white people to be arrested and incarcerated for drug-related charges despite having very similar rates of drug use.^e Involvement with the justice system can interrupt treatment, and jails and prisons often lack quality SUD treatment services, leaving people at greater risk of relapse and overdose when they return home from jail or prison.^f

a Samantha Artiga, Kendal Orgera, and Anthony Damico, “Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017,” Kaiser Family Foundation, February 2019, <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/>.

b Pooja Lagisetty *et al.*, “Buprenorphine Treatment Divide by Race/Ethnicity and Payment,” *JAMA Psychiatry*, May 2019, <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2732871>.

c Sara Matsuzaka and Margaret Knapp, “Anti-racism and substance use treatment: Addiction does not discriminate, but do we?” *Journal of Ethnicity in Substance Abuse*, January 2019, <https://www.ncbi.nlm.nih.gov/pubmed/30642230>.

d See the Substance Abuse and Mental Health Services Administration on “The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue,” July 2020, <https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Hispanic-Latino-Population-An-Urgent-Issue/PEP20-05-02-002>, and on “The Opioid Crisis and the Black/African American Population: An Urgent Issue,” April 2020, <https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001>.

e Hamilton Project, “Rates of Drug Use and Sales, by Race; Rates of Drug Related Criminal Justice Measures, by Race,” October 2016, https://www.hamiltonproject.org/charts/rates_of_drug_use_and_sales_by_race_rates_of_drug_related_criminal_justice

f German Lopez, “How America’s prisons are fueling the opioid epidemic,” *Vox*, updated March 26, 2018, <https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction>.

While Medicaid expansion is already a great financial deal for states, the American Rescue Plan Act (the Act) provides an additional financial incentive for the remaining states to quickly expand Medicaid coverage. If they do, the Act gives them a two-year, 5-percentage-point increase in their federal medical assistance percentage (FMAP) for all non-expansion enrollees, who account for most of a state's Medicaid enrollees and costs.¹⁰ In addition to increasing coverage, the enhanced federal match gives states a big boost in federal funding that they could use to further enhance SUD services, such as by covering additional services in their state Medicaid plans or increasing provider reimbursement rates.

State Medicaid Programs Should Cover Full Continuum of SUD Services

State Medicaid programs should cover the range of treatment and recovery supports that people with SUDs need. The American Society of Addiction Medicine's (ASAM) nationally recognized criteria recommend that SUD continuum of care seamlessly transition people between different levels of care — from early interventions to outpatient services and residential and inpatient services — as their treatment and recovery needs change.¹¹ Services should also include recovery support services that reduce barriers to recovery, such as peer supports and supportive housing and supported employment.¹² And the SUD continuum of care should also ensure access to treatment for co-occurring conditions, such as serious mental illness, diabetes, or HIV/AIDS.¹³

States have multiple ways to fund a full continuum of clinical care and an array of recovery support services in their Medicaid programs. Yet only 12 states' Medicaid plans covered services across all ASAM levels of clinical SUD services in 2018, according to the Medicaid and CHIP Payment and Access Commission's most recent comprehensive analysis.¹⁴ Federal policymakers should encourage states to cover the full continuum of SUD services in their Medicaid programs. States can leverage new Medicaid funding from the American Rescue Plan Act to cover additional services, including the expansion incentive and the one-year, 10-percentage-point increase in federal Medicaid funds intended to enhance home- and community-based services, which includes many community-based SUD services.¹⁵

The following are some key avenues to covering SUD services.

Cover a range of outpatient and community-based treatment and recovery support services

States can use Medicaid's rehabilitation services option and section 1915(i) to cover outpatient treatment, such as counseling, MAT, intensive outpatient programs, and case management.¹⁶ These community-based services help people begin and maintain recovery from SUDs while continuing to work, care for loved ones, and maintain important social connections.¹⁷ Access to community-based services, including telehealth, has also been essential for protecting access to care while maintaining social distance during the COVID-19 pandemic. While all state Medicaid programs cover at least *some* outpatient services, gaps remain. Several did not cover intensive outpatient services in 2018, for instance.¹⁸

State Medicaid programs also vary widely in their coverage of recovery support services and cover some types of these services rarely.¹⁹ Recovery supports include peer support services delivered by people with lived experience with SUD recovery, supported employment services that help people enter and succeed in the competitive job market, and tenancy supports that help people find and maintain stable housing and are often paired with rental assistance to provide supportive housing —

a proven strategy for ending homelessness for people with behavioral health conditions.²⁰ While 38 states covered at least some peer support services for people with SUDs in 2018, only four covered tenancy support services.²¹ (See Figure 3.) While many states covered peer support or comprehensive community support services for at least some people with substance use disorders, some states limit coverage of those and other recovery support services to certain settings or beneficiaries, such as people transitioning out of institutional care or those with co-occurring mental health conditions.

FIGURE 3

Few States Cover Key Support Services for People Recovering From Substance Use Disorders

Number of state Medicaid plans in 2018 that covered:



Source: MACPAC, 2019.

Couple community-based care with residential and inpatient services

Federal Medicaid funding is usually not available for inpatient and residential substance use treatment facilities due to Medicaid's institution for mental disease statutory exclusion.²² But in 2015, the Obama Administration issued guidance (later continued by the Trump Administration, with revisions) outlining how states could use section 1115 demonstrations to cover residential and inpatient SUD services, coupled with community-based services “to ensure a robust continuum of care.”²³

To date, over half of states have approved SUD 1115 demonstrations.²⁴ While some have used their SUD demonstrations to significantly improve access to community-based services, the Centers for Medicare & Medicare Services (CMS) should ensure that *all* states with demonstrations make meaningful progress toward ensuring access to community-based care. Residential and inpatient services are not appropriate for everyone with a substance use disorder.

In addition, without adequate community-based services, people transitioning out of intensive treatment may face gaps in services when they return home from residential or patient care, putting their recovery at risk. In 2018 nearly 3 out of 4 Medicaid beneficiaries who exited inpatient or residential treatment received no outpatient or community-based services within 30 days of discharge.²⁵

CMS should also require that states approved for new or renewed demonstrations maintain prior levels of funding for SUD services. State SUD treatment grants funded by general revenue can help fill gaps in treatment and recovery services that Medicaid does not cover.²⁶

In addition to demonstration waivers, under the SUPPORT Act²⁷ states can cover up to 30 days of residential and inpatient care annually through a state plan amendment. In order to qualify for the option, states must use other Medicaid authorities to cover all levels of care under the ASAM criteria — including community-based services. States must also ensure that at least two forms of MAT are available in inpatient settings, implement evidence-based clinical screening tools, maintain state and local SUD funding, and ensure that patients have access to appropriate outpatient services when transitioning out of higher levels of care.²⁸ This option took effect in October 2019 and continues through September 2023. To date, Idaho is the only state that has used it.²⁹

Use Medicaid's health home option to coordinate and integrate care for beneficiaries with SUDs

Health homes provide intensive care coordination to manage all aspects of Medicaid beneficiaries' health care, including physical health, behavioral health, and social services needs that can affect access to care. Thirteen states have used health homes to serve people with SUDs as of September 2018.³⁰ State officials and providers that implemented health homes in Maryland, Rhode Island, and Vermont for people with opioid use disorders reported that the health homes improved access to appropriate care, enabled better assessment of needed social services, and enhanced communication between different provider systems.³¹

Use Medicaid's mobile crisis option to prevent unnecessary hospitalizations and incarceration for beneficiaries with SUD

Mobile crisis teams led by behavioral health professionals help de-escalate behavioral health crises and connect people to community-based services. This, in turn, avoids costly emergency department

visits and hospitalizations³² and may also prevent the arrest and incarceration of people with behavioral health conditions, who are disproportionately represented in the nation's jails and prisons and among fatal police shootings.³³ To encourage more states to expand access to these mobile crisis intervention services, the American Rescue Plan Act provides an 85 percent enhanced federal matching rate for three years and \$15 million in planning grants to states that opt to cover them.

End utilization management practices that hinder Medicaid beneficiaries' access to evidence-based services

Unnecessarily restrictive policies that prevent or delay receipt of services can undermine coverage of evidence-based services. Substance use treatment experts and stakeholders are increasingly raising concerns that some utilization management practices, such as excessive prior authorization requirements for MAT, prevent or delay access to potentially lifesaving SUD care.³⁴ As of 2019, 40 state Medicaid programs had prior authorization requirements on at least some medications for treatment of opioid use disorder.³⁵ State and federal policymakers — including CMS — should assess current utilization management strategies to determine whether policies create barriers to care.

Policymakers Should Help SUD Providers Fully Participate in and Leverage Medicaid

Even if state Medicaid programs cover a full range of SUD services, Medicaid beneficiaries may lack access to comprehensive care when there aren't enough qualified SUD providers participating in Medicaid. This lack of provider capacity — an estimated 40 percent of counties lack an outpatient treatment program, for example — is due to several factors.³⁶ There are far fewer psychiatrists, substance use counselors, and social workers than needed to serve people with SUDs, and even fewer SUD providers participate in Medicaid.³⁷ Providers may lack resources to set up the infrastructure necessary to participate in Medicaid. And Medicaid payment rates, which states have broad discretion to set, are often too low, as are Medicare and private coverage payment rates.³⁸ These and other provider capacity challenges require policy solutions and resources from outside the Medicaid program, such as loan forgiveness programs that can encourage providers to work in underserved areas. But state and federal policymakers can also improve provider capacity using existing Medicaid capabilities.

Resources and technical assistance to help providers meet requirements to participate in Medicaid

Providers new to Medicaid may need help launching information and electronic medical records systems, setting up a process to review utilization of services, and tracking Medicaid quality measures that grant-funded programs often don't require.³⁹ Helping providers create these systems would not only allow them to participate in Medicaid but also enhance the quality of the services they provide. Many states have done little to help treatment providers overcome barriers to participating in Medicaid and much work is needed.⁴⁰

Some states are implementing a two-phase provider capacity demonstration program under the SUPPORT Act to help increase provider capacity. In September 2019 CMS awarded 18-month planning grants to 15 states to help them assess the need for substance use treatment services, support recruitment of providers, and provide training and other technical assistance to SUD providers.⁴¹ In the second phase, up to five of those states will receive enhanced federal matching rates for 36 months for substance use services they deliver under their Medicaid state plans. If the demonstration is successful, federal lawmakers should expand it to additional states to address provider capacity more fully.

Adequacy of SUD payment rates

States have broad discretion in setting Medicaid payment rates. Many providers, researchers, and officials have raised serious concerns that Medicaid behavioral health payment rates are too low to ensure enough qualified providers accept Medicaid.⁴² Reimbursement rates in Medicare and private health plans offer little guidance: behavioral health payment rates in public and private health insurance plans are also widely considered low and are often cited as a major reason that a high share of behavioral health care providers choose not to accept insurance reimbursement.⁴³

While more research is needed, some studies suggest that payment rates can affect access to behavioral health care.⁴⁴ For instance, in addition to other measures to cover more services and enhance provider capacity, Virginia significantly increased — in some cases quadrupled — provider payment rates for a number of SUD services through its 1115 SUD demonstration, known as the Addiction and Recovery Treatment Services (ARTS) program.⁴⁵ After implementing ARTS, Virginia saw a 173 percent increase in outpatient providers billing for ARTS services, and an increase in the number of SUD practitioners participating in Medicaid from about 1,000 to nearly 3,000.⁴⁶ Fifty-seven percent more Medicaid beneficiaries used SUD-related treatment services in the Virginia program's first year than in the prior year.

Similarly, while other factors may also have had an impact, New Jersey saw a significant increase in providers applying to participate in Medicaid after raising Medicaid payment rates for multiple SUD services. Many New Jersey SUD providers reported that the rate increases contributed to greater service availability.⁴⁷ States seeking to improve access to SUD care for Medicaid beneficiaries can leverage enhanced federal Medicaid matching rates to increase SUD reimbursement rates, such as the enhanced funding for home- and community-based services in the American Rescue Plan Act. States also receive a 90 percent federal matching rate for services delivered to Medicaid expansion enrollees.

States that decrease reimbursement rates, meanwhile, can likely expect declines in access to SUD services, as happened in Montana.⁴⁸ And when Maine cut reimbursement rates for methadone MAT services in 2010 and 2012, providers reported that the cuts reduced access to and quality of care.⁴⁹ Low reimbursement rates reportedly made it harder for affected clinics to expand capacity and contributed to higher caseloads, with 50 patients per counselor increasing to 150.⁵⁰

Coordinate and Target Grants and Other Short-Term Funding to Complement Medicaid

A comprehensive SUD care system for people with low incomes requires additional resources on top of the foundation that Medicaid should provide. Grants, which alone are neither sufficient nor the right mechanism to fund a full continuum of SUD services, play an essential role in filling funding gaps, building provider capacity, and promoting racial equity when coordinated with Medicaid and other funding. The same is true for other sources of capped or short-term funding, such as funds from opioid lawsuit settlements. (See text box, “Use Funds From Opioid Lawsuits to Improve Access to SUD Care.”)

Before Medicaid expansion, SUD providers lacked reliable funding sources and depended on grants, fees, and donations, which do not automatically adjust based on need.⁵¹ But relying too heavily on grants to fund SUD services has several limitations. For example, grant funding often

doesn't keep up with need, substance-specific grants (such as opioid grants) don't address the full spectrum of need, and information is often lacking on how the grants are used and the outcomes they produce.

Whenever possible, federal and state policymakers should use grant funding to complement the services that state Medicaid programs cover rather than to pay for Medicaid-funded services. Better coordinating Medicaid and grant funding would help ensure that more people with substance use disorders can obtain the treatment and the comprehensive supports that they need.

States should use grants to fill care and recovery support gaps

On its own, new and existing grant funding will continue to fall short of need.⁵² The Substance Abuse Prevention and Treatment (SAPT) block grant — the primary source of federal grant funding for SUD treatment (\$1.9 billion in 2018) — fell by 10 percent between 2010 and 2018, adjusted for inflation.⁵³ Since 2018, policymakers increased the SAPT block grant modestly, and funded \$1.5 billion in new grants annually to address the opioid crisis. They also provided more than \$3 billion in emergency grants to help maintain access to SUD services during the COVID-19 pandemic, which is needed to help SUD providers facing heavy financial losses recover from staff layoffs, program closures, and measures that have delayed care.⁵⁴ In addition, the American Rescue Plan Act gave states and localities \$350 billion in fiscal relief to cover unexpected pandemic-related costs and revenue losses from the pandemic, and they can dedicate some of that funding to SUD services they might have provided if the pandemic had not reduced their revenues.

While recent increases in grant funding were needed, the urgency of the substance use crisis continues to grow. Drug overdose deaths have continued to rise, reaching an all-time high of over 71,000 deaths in 2019 and likely even higher in 2020, according to preliminary CDC data.⁵⁵ But cities, counties, and local providers that receive grant funds aren't guaranteed to receive the same amounts from one year to the next, making it hard to plan to meet changing service needs. State and local officials and providers have raised concerns about the sustainability of federal grants and called for more reliable funding to address ongoing and future SUD treatment needs.⁵⁶

In addition to leveraging Medicaid for SUD services, all states should use the various available federal and state grant funding to serve people with SUDs who are under- or uninsured. Coordinating and targeting grant funds helps avoid duplicating what Medicaid can cover, improving overall access to care. For example, North Carolina used a large majority of its opioid grant funding to increase access to medication assisted treatment for people without insurance.⁵⁷ Increasing enrollment in the ACA marketplace coverage — which includes SUD coverage — can also help free up grants to better serve people without insurance. The American Rescue Plan Act boosted premium tax credits through 2022, making marketplace coverage more affordable.⁵⁸

States should also use grants to test new and emerging treatment strategies and build SUD provider capacity within Medicaid.⁵⁹ For instance, Pennsylvania used a section 1115 demonstration to maximize Medicaid services, including by adding more SUD services to the state's Medicaid plan, and directed new federal opioid grant funding to help people with opioid use disorders find and maintain stable housing.⁶⁰ Pennsylvania has also used opioid grants to provide medication assisted treatment to people in correctional facilities and train SUD providers on important evidence-based practices.⁶¹

Federal policymakers should limit use of substance-specific grants

Recognizing the acute need for more SUD treatment funding in light of the opioid crisis, federal policymakers in recent years have dedicated additional grant funding to serve people with opioid use disorders, including \$500 million in 2017 and \$1.5 billion each year since. But the need for substance use services varies across states and communities, with some experiencing spikes in deaths from non-opioid substances. Federal lawmakers recently allowed states to use State Opioid Response grants to serve people struggling with “stimulants” in addition to opioids, but not people with alcohol or other substance use disorders.

Improve transparency on use of grant funds and better evaluate programs’ impact

New grant programs have been layered onto numerous existing grants that states receive from several federal agencies, adding to the challenges state and local officials face in coordinating and administering these resources.⁶² Federal policymakers lack information about how states and localities use SUD grant funds, including whether their programs are duplicating Medicaid, using evidence-based services, achieving desired outcomes, advancing racial equity, and serving those with heightened barriers to care, such as people experiencing homelessness.⁶³ And while some grant programs are beginning to report quality of life and other outcomes that are a high priority for people living with substance use disorders, too often treatment programs only measure whether participants completed the program or abstained from substance use for a short period of time.⁶⁴ Policymakers need more information to assess what additional investments and policy changes are needed to ensure grants are coordinated with other funding streams and improve recovery outcomes.

Use Funds From Opioid Lawsuits to Improve Access to SUD Care

As the opioid crisis continues to claim tens of thousands of lives each year, dozens of states and hundreds of counties, cities, and tribes are suing to hold prescription opioid manufacturers and distributors financially (and in some cases criminally) responsible. Several suits have already resulted in settlement agreements, though most suits are still pending and more settlements could come.^a Many of the jurisdictions involved in ongoing suits aim to reach a large settlement that has been compared to the multi-billion-dollar Master Settlement Agreement reached between states and tobacco companies in 1998. However, even a large opioid settlement would almost certainly be much smaller and pay out over a shorter period than the tobacco settlement, which awards funds to participating states every year in perpetuity.^b

The tobacco settlements offer a cautionary tale about how such funds can be diverted from their intended purpose.^c While states have spent portions of the tobacco settlements on tobacco cessation and other health-related items, large amounts of the settlement funds have been regularly diverted to fill state budget shortfalls.^d

Like grant funds, the opioid lawsuit awards or settlement funds would provide resources in the short term and won't be a sustainable source of funding for treatment. Thus, new resources from opioid lawsuits should supplement and support — rather than duplicate — Medicaid and other existing resources that fund SUD services.

a German Lopez, "The thousands of lawsuits against opioid companies, explained," Vox, October 17, 2019, <https://www.vox.com/policy-and-politics/2017/6/7/15724054/opioid-epidemic-lawsuits-purdue-oxycotin>.

b Jan Hoffman, "Payout From a National Opioids Settlement Won't Be as Big as Hoped," *New York Times*, February 17, 2020, <https://www.nytimes.com/2020/02/17/health/national-opioid-settlement.html>.

c Public Health Law Center at Mitchell Hamline School of Law, Tobacco Control Legal Consortium, "The Master Settlement Agreement: An Overview," January 2019, <https://www.publichealthlawcenter.org/sites/default/files/resources/MSA-Overview-2019.pdf>.

d U.S. Government Accountability Office, "Tobacco Settlement: States' Allocations of Payments from Tobacco Companies for Fiscal Years 2000 through 2005," February 2007, <https://www.gao.gov/assets/120/115580.pdf>.

Robust, Sustained Investments Needed in Affordable Housing, Child Care, and Other Social Services

People with low incomes often face barriers to SUD care because of unmet basic needs. The conditions in which people live — such as their housing, nutrition, and transportation — can affect behavioral health outcomes as well as health care use and costs. For instance, the inability to pay rent and the threat of losing housing causes stress that can trigger substance misuse and relapse.⁶⁵ People leaving inpatient or residential treatment often need affordable housing assistance to safely re-enter their communities, particularly those who would otherwise face homelessness or can't live with family or friends because those living environments would threaten their recovery. Lack of transportation and child care can prevent people from initiating or consistently engaging in community-based treatment or recovery support services.

Unmet basic needs often reflect systemic racism and contribute to racial disparities in treatment outcomes. For example, a long history of discriminatory housing policies — such as redlining and race-based covenants — present-day landlord discrimination, and criminalization of homelessness create additional barriers to housing for people of color, and Black people in particular. These and

other discriminatory practices contribute to the higher rates of homelessness among Black people than white people in every state, putting the recovery of those with SUDs at outsized risk.⁶⁶

Low-income individuals, including many Medicaid beneficiaries, also face higher risk of unmet social needs that interfere with their SUD recovery. Hennepin Health — the accountable care organization providing Medicaid coverage in Minneapolis and its surrounding suburbs — found that 43 percent of its Medicaid members reported a lack of stable housing.⁶⁷ While Medicaid can provide an important bridge to social services, direct investments *outside* of the health care system in affordable housing, child care, voluntary employment services, and other supports are essential.⁶⁸

New resources included in the American Rescue Plan Act are a down payment on the investments needed to ensure that people with low incomes can access SUD services and maintain recovery. The Act will reduce severe levels of hardship for tens of millions of people most affected by the COVID-19 pandemic and recession — especially Black and Latinx families — by providing housing assistance that will prevent millions of impending evictions, funding that will make child care more affordable for many families, and food assistance to address widespread food insecurity.⁶⁹

States and localities can use the substantial new assistance to build a stronger and more equitable economy in the coming years, including by removing obstacles to SUD care and helping people in recovery work and maintain stability. For instance, states can use the nearly \$15 billion in Child Care and Development Block Grant funding — available for over two years — to ensure that people with SUDs have the child care they need to work and participate in recovery services. The \$21.6 billion in emergency rental assistance — which communities have up to four years to spend — can help families affected by SUDs and facing financial hardship from the pandemic get caught up on rent and maintain stable housing.

And states, localities, tribal nations, and U.S. territories can use the \$350 billion they received in fiscal relief to cover unexpected costs and revenue losses from the pandemic. That includes SUD services that governments might have provided if the pandemic had not reduced their revenues and perhaps also new services aimed at addressing hardship faced by providers and people with SUDs that reduce access to services. Treasury guidance expected in the next few weeks will help states, localities, and other governments understand the full range of possibilities.

Policymakers should build on the progress the Act provides by making sustained investments in housing, child care, and other social services to lower barriers to SUD recovery for years to come. Otherwise, the gains achieved by these historic investments will diminish as funding returns to pre-pandemic levels that were rife with inequities. Prior to the investments made in connection with the current health and economic crisis, just 15 percent of children who qualified for assistance from the primary federal program that funds child care for low-income working parents — the Child Care and Development Block Grant — received any because of limited funding in 2015.⁷⁰ Similarly, 3 in 4 households that qualify for federal rental assistance don't receive it because of limited funding, making it very unlikely that someone newly in recovery will receive a Housing Choice Voucher or other housing assistance that would provide stable, affordable housing.⁷¹ If policymakers made Housing Choice Vouchers an entitlement program like Medicaid and SNAP — meaning that the program would automatically assist all eligible applicants — many more people in recovery would have access to the stable housing.⁷²

Medicaid can play an important role in connecting beneficiaries to resources that help enrollees meet their social and basic needs, especially if social services programs are fully funded. States are increasingly focusing on limiting unnecessary health care spending by helping enrollees meet their basic needs. For instance, Washington State’s Medicaid program covers tenancy supports and supported employment for people enrolled in its Foundational Community Supports supportive housing program, including people with substance use disorders.⁷³ CMS recently issued updated guidance about how states can cover housing-related services and supports, including tenancy services, and other services that help address beneficiaries’ social needs.⁷⁴ States should fully use Medicaid authorities to create cross-sector partnerships and help beneficiaries address the unmet basic needs that undermine their health.⁷⁵

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- ¹⁷ MACPAC, 2018. Note that while the ASAM criteria categorize “outpatient” and “intensive outpatient” as two different levels of care on the continuum, these two groups of services can both be provided under Medicaid state plan amendments without any demonstration waivers.
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