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## Better Integration of Medicaid and Federal Grant Funding Would Improve Outcomes for People with Substance Use Disorders

By Peggy Bailey

Rising opioid-related death rates — more than 42,000 people died in 2016 due to opioid misuse, up from 8,400 in 2000 — underscore the need to strengthen the financing of substance use treatment services to make effective treatment more widely available.<sup>1</sup> The Affordable Care Act’s (ACA) Medicaid expansion gives states and the federal government the opportunity to better integrate Medicaid and grant funding to ensure that people with substance use disorders can obtain both the treatment and the wraparound supports they need.

The most effective treatment programs for substance use disorders (SUD) combine mental health and substance use treatment services with other supports, including housing, child care, vocational supports, educational services, legal services, and financial assistance.<sup>2</sup> Unfortunately, most SUD treatment providers offer fewer than half of the types of wraparound supports recommended by the National Institute on Drug Abuse, largely due to insufficient and poorly coordinated funding.<sup>3</sup>

The ACA’s expansion of Medicaid to more low-income adults has dramatically expanded coverage and access to treatment for people with SUDs. But to fully realize the promise of increased access, many providers who treat SUDs need help from states to meet the requirements to

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<sup>1</sup> Centers for Disease Control and Prevention, “Drug Overdose Death Data,” updated December 19, 2017, <https://www.cdc.gov/drugoverdose/data/statedeaths.html> and National Institute on Drug Abuse, “Overdose Death Rates,” revised September 2017, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.

<sup>2</sup> 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: 1, January 2016, <http://www.jsad.com/doi/pdf/10.15288/jsad.2016.77.160>; and 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>.

<sup>3</sup> Paino, Aletraris, and Roman.

participate in Medicaid. Most states have not invested, however, in the related efforts necessary to improve staffing and technological capacity.<sup>4</sup>

The Substance Abuse Prevention and Treatment (SAPT) block grant program, the primary source of federal grant funding for SUD treatment, has fallen while need has continued to rise. Federal policymakers did recently approve \$6 billion in new federal grant funding for 2018 and 2019 to supplement the SAPT. Of that \$6 billion, Congress recently allocated \$3.3 billion for 2018, with \$1.8 billion to agencies in the Department of Health and Human Services to expand SUD treatment and recovery services. But experts expect that even this additional funding will continue to fall far short of the need to treat people with opioid use disorders.<sup>5</sup>

More progress could be made by using grant funding to complement the services that Medicaid provides, rather than as an alternative source of funding for substance use treatment that Medicaid could pay for. Grant dollars can provide funding to increase the number of substance use treatment providers participating in Medicaid and to pay for wraparound supports, like housing, that Medicaid doesn't cover. By investing in providers' organizational capacity and allowing grant funds to be used for wraparound supports, policymakers can help Medicaid and grant funding work in tandem to ensure that people with SUDs get the comprehensive treatment and support services they need.

## Grant Funding Isn't Keeping Up with Need

While Medicaid funds a substantial share of addiction services, most substance use treatment services are funded by grants from federal, state, or local governments; philanthropic entities; or out-of-pocket payments rather than private or public health insurance. These resources fall far short of meeting the need. The 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. (See Figure 1.) Once the SAPT funds are distributed based on a formula to states and territories, the states generally regrant to cities, counties, and local service providers. The flat, fixed nature of the grant makes it unable to respond to rising need; in fact, block grant funding has not even kept pace with inflation.

Recognizing the acute need for more SUD treatment funding, federal policymakers recently dedicated an additional \$500 million in 2017 and another \$6 billion in the Bipartisan Budget Act, split between 2018 and 2019, to new federal funding to supplement the SAPT block grant. Need will continue to outstrip the combined new and existing funding, however.<sup>6</sup>

And this funding isn't guaranteed beyond 2019. That uncertainty may keep states from fully spending the funds because without a commitment of longer-term, stable funding, they may have difficulty encouraging new providers to enter the market and helping existing providers implement

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<sup>4</sup> Christina Andrews *et al.*, "Despite Resources From The ACA, Most States Do Little To Help Addiction Treatment Programs Implement Health Care Reform," *Health Affairs*, Vol. 34:5, May 2015, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1330>.

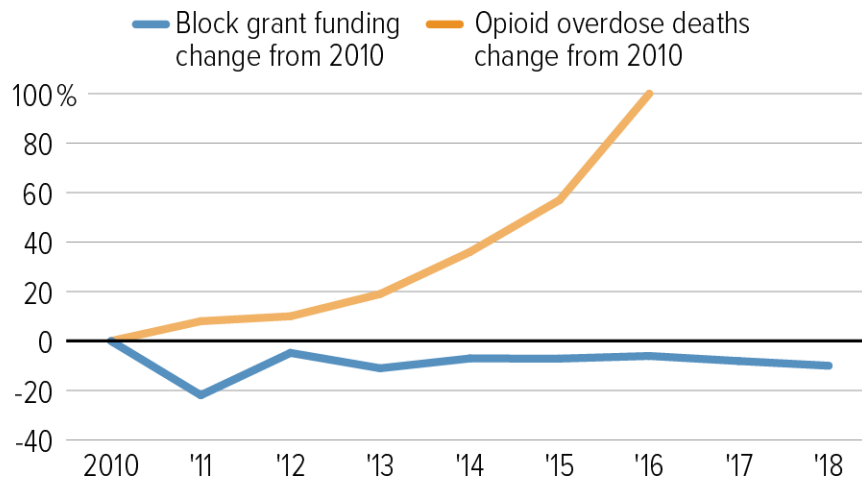
<sup>5</sup> Elizabeth O'Brien, "Here's What It Would Cost to Fix the Opioid Crisis, According to 5 Experts," *TIME*, November 27, 2017, <http://time.com/money/5032445/cost-fix-opioid-crisis/>.

<sup>6</sup> O'Brien.

emerging best practices or increase their capacity to serve more people.<sup>7</sup> These challenges can be mitigated by using grant funds to pay for supports and services that complement the stable, permanent funding provided by Medicaid.

FIGURE 1

### As Opioid Deaths Rose Dramatically, Federal Substance Abuse Prevention and Treatment Block Grant Shrank



Note: Funding for the Substance Abuse Prevention and Treatment block grant is adjusted for inflation.

Sources: Substance Abuse and Mental Health Services Administration and Kaiser Family Foundation analysis of Centers for Disease Control and Prevention data

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### Medicaid’s Expanding Role in Addressing the Opioid Epidemic

In contrast to annually appropriated programs like the SAPT block grant that are unable to expand to meet need, Medicaid guarantees health coverage to all qualifying beneficiaries. Through the ACA’s Medicaid expansion and with greater use of Medicaid waivers, the program has taken on a greater role in treating SUDs.

#### More Low-Income Adults with SUDs Eligible for Medicaid Under Expansion

Many more low-income people have become eligible for covered treatment services in the states that have expanded Medicaid under the ACA; these states receive additional Medicaid funding for these services. This leaves people in states that have not expanded Medicaid at a disadvantage and prevents those states from receiving additional funds to help people with substance use disorders.

<sup>7</sup> Rachana Pradhan and Brianna Ehley, “Most Opioid Money to States Sits Untouched a Year After Congressional Approval,” *Politico*, March 15, 2018, <https://www.politicopro.com/health-care/article/2018/03/most-opioid-money-to-states-sits-untouched-a-year-after-congressional-approval-415272>.

Prior to expansion, many low-income adults were not eligible for Medicaid and were therefore largely left uninsured because they did not meet strict disability criteria or were not 65 or older, pregnant, or caring for a child in their home. An SUD is not considered a disabling condition, so people with SUDs had to also have a serious mental or physical health condition to qualify for Medicaid on the basis of a disability. People with SUDs who live in the 19 states that have not expanded Medicaid still face this barrier to coverage.

Insurance eligibility is only part of the equation. The ACA also required states to include additional substance use treatment services as covered Medicaid benefits. People eligible for Medicaid as part of the ACA expansion must receive a benefit plan that's based on commercial health insurance coverage and includes all of the ACA's essential health benefits, including behavioral health services. The ACA doesn't prescribe which behavioral health services states must cover, leaving states with the flexibility to cover a wide range of substance use treatment services such as inpatient or outpatient detoxification, medication-assisted treatment, counseling services, and residential rehabilitation.<sup>8</sup>

With Medicaid expansion, 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.) These coverage increases have led to better access to services. For example, after Kentucky expanded Medicaid in 2014, Medicaid beneficiaries using substance use treatment services in the state rose by 700 percent.<sup>9</sup>

In the 19 states that have not expanded Medicaid, most low-income people with SUDs who don't have private insurance can't afford treatment and must still rely on programs that receive federal, state, and local grants, which, as noted above, are insufficient.

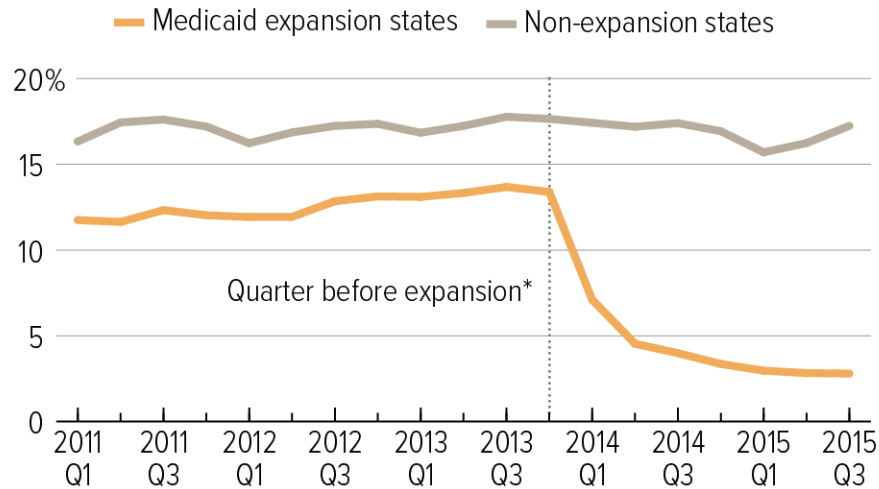
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<sup>8</sup> States that have expanded Medicaid receive at least a 90 percent federal match for alternative benefit plan services delivered to Medicaid expansion populations, including substance use treatment services.

<sup>9</sup> Foundation for a Healthy Kentucky, "Substance Use and the ACA in Kentucky," December 2016, [https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final\\_12\\_16-002-.pdf](https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf).

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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### States Can Use Medicaid Waivers to Provide More Comprehensive SUD Services and Treatment

Medicaid can cover many components of the continuum of SUD treatment services, including recovery services such as peer supports, supported employment, and case management; inpatient treatment; emergency detoxification; counseling; and clinical care.<sup>10</sup> To encourage states to provide the full continuum of services, both the Obama and Trump Administrations issued guidance to states encouraging them to use flexibility offered through Medicaid demonstration projects (using what’s known as “1115 waivers”) to expand substance use treatment services in their programs.<sup>11</sup>

Under the latest guidance, states can cover residential treatment services, which are otherwise not eligible for reimbursement under the Medicaid statute, as long as they also cover other crisis and

<sup>10</sup> In 2014, Medicaid provided about 21 percent of all spending on addiction treatment; see <https://www.kff.org/infographic/medicaids-role-in-behavioral-health/>.

<sup>11</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder,” July 27, 2015, <https://www.medicare.gov/federal-policy-guidance/downloads/smd15003.pdf>; and “Re: Strategies to Address the Opioid Epidemic,” November 1, 2017, <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>.

outpatient services.<sup>12</sup> For example, West Virginia’s waiver, the first the Trump Administration approved, added residential treatment, methadone-related services, and peer recovery supports to other benefits such as targeted case management, naloxone-administration services, outpatient services, and other crisis services that can be covered without a waiver. West Virginia’s waiver also requires new credentialing and certification standards for providers, which are designed to improve patient access to evidence-based services such as methadone treatment, peer recovery supports, withdrawal management, and short-term residential treatment.<sup>13</sup> Ten other states — California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Vermont, and Virginia — are implementing similar waivers, and Alaska, Arizona, Illinois, Michigan, New Mexico, North Carolina, and Wisconsin have proposals pending.<sup>14</sup>

## Increased Grant Funding Should Be Used to Strengthen Providers and Provide Wraparound Supports

As discussed above, Medicaid expansion has dramatically increased coverage and improved access to treatment for people with SUDs. One challenge, however, is that substance use treatment and recovery providers have a history of relying on grant funding, rather than Medicaid, which means they don’t meet requirements to bill Medicaid.<sup>15</sup> While states differ in what’s required, providers must have information systems to bill Medicaid, and they must comply with standards for electronic medical records.

Providers also must review utilization of their services and monitor and report on quality, activities that benefit patients but aren’t usually required in grant-funded programs.<sup>16</sup> Grant funding can be used to help defray one-time costs that new and existing substance use providers must incur to start participating in Medicaid. In addition to improving information technology and tools to measure outcomes, these grants can pay for staff training and continuing education, which help providers comply with Medicaid requirements. These improvements can also help SUD providers coordinate with mental and physical health providers who are treating the same patients by facilitating better data sharing and referral processes, which would result in better treatment

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<sup>12</sup> MaryBeth Musumeci, “Key Themes in Medicaid Section 1115 Behavioral Health Waivers,” Kaiser Family Foundation, November 10, 2017, <https://www.kff.org/report-section/key-themes-in-medicaid-section-1115-behavioral-health-waivers-issue-brief-9118/>.

<sup>13</sup> West Virginia Department of Health & Human Resources (DHHR) Bureau for Medical Services, “BMS Provider Manual: Chapter 504 Substance Use Disorder Services,” January 14, 2018, <https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20504%20Substance%20Use%20Disorder%20Services%20Manual.1.12.18%20Final.pdf>; and U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Re: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders,” October 6, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf>.

<sup>14</sup> Musumeci.

<sup>15</sup> Ellen Bouchery, Rebecca Morris, and Jasmine Little, “Examining Substance Use Disorder Treatment Demand and Provider Capacity in a Changing Health Care System: Initial Findings Report,” U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, September 2015, pp. 52-53, <https://aspe.hhs.gov/system/files/pdf/203761/ExamSUD.pdf>.

<sup>16</sup> Antoinette Krupski *et al.*, “Impact of Access to Recovery services on alcohol/drug treatment outcomes,” *Journal of Substance Abuse Treatment*, Vol. 37:4. 2009, <https://www.sciencedirect.com/science/article/pii/S0740547209000919>.

outcomes.<sup>17</sup> Unfortunately, most state substance use agencies haven't helped treatment programs make these investments and improvements, which would enable providers to bill Medicaid and strengthen their practices.<sup>18</sup>

As states use Medicaid to cover more substance use disorder services, they could also use grant funding to pay for services that Medicaid doesn't cover and to help build additional provider capacity. For example, Medicaid can't pay for housing, but an inability to pay rent and the threat of losing housing can lead to stress that triggers substance misuse and relapse, which can result in death.<sup>19</sup> People leaving inpatient or residential treatment also often need affordable housing assistance to re-enter their communities, particularly those who can't live with family or friends because their living environments would threaten their sobriety.

Housing assistance is scarce. Only 1 in 4 eligible households receive assistance, and families who manage to get on a waitlist often wait years to receive a voucher.<sup>20</sup> People with substance use disorders face additional barriers to federal housing assistance due to federal statutory requirements that impose time-limited bans against living in HUD-assisted housing for people evicted for drug-related activities and policies that allow housing agencies to prohibit people who have histories of past drug use or are considered at risk of engaging in illegal drug use from receiving assistance.<sup>21</sup> Federal grant resources can support state- and locally funded rental assistance that is not subject to these statutory requirements and can be designed to help people overcome these barriers. Grant funding also can be used for job training and placement services, alternative living environments such as sober living communities, child care, and life skills education.

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<sup>17</sup>Amanda Abraham *et al.*, "Geographic Disparities in Availability of Opioid Use Disorder Treatment for Medicaid Enrollees," *Health Services Research*, Vol. 53:1. February 2018, <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12686>.

<sup>18</sup> Andrews.

<sup>19</sup> Rajita Sinha, "Chronic Stress, Drug Use, and Vulnerability to Addiction," *Annals of the New York Academy of Sciences* 1141 (2008): 105–130, March 8, 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2732004/>.

<sup>20</sup> "Three Out of Four Low-Income At-Risk Renters Do Not Receive Federal Rental Assistance," Center on Budget and Policy Priorities, updated August 2017, <https://www.cbpp.org/three-out-of-four-low-income-at-risk-renters-do-not-receive-federal-rental-assistance>.

<sup>21</sup> HUD Housing Programs: Tenants' Rights (4<sup>th</sup> Edition), National Housing Law Project, 2014, <https://web.archive.org/web/20170824131126/http://nhlp.org/2012greenbook>.