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Medicaid waivers and access to behavioral health services:

What we know and what we might expect

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Abstract

Recently, a number of state Medicaid programs were granted permission to implement administrative barriers to enrollment. The impact of these provisions on access to mental health and substance use disorder treatment has been largely unstudied, despite Medicaid being the largest provider of mental illness and substance use disorder treatment. However, peer-reviewed literature on the implications of contractions or expansions of Medicaid eligibility may shed light on the potential impact of these waiver provisions on access to behavioral health services. In this column, I review the literature on the effect of past Medicaid contractions and expansions on treatment use, the current policy landscape, and the steps that states or localities may take to offset these administrative burdens to Medicaid enrollment. In general, there is little states or localities could do to offset the federal funding lost via Medicaid disenrollment. Re-directing saved monies to other safety net programs could increase access to care, but these programs lack benefits provided by the Medicaid program. Without any other backstop, the implementation of these provisions would likely exacerbate the behavioral health crises in the United States.

Keywords

Medicaid; mental illness; substance use disorder; insurance coverage; state health policy

Introduction

After nearly a decade of expansion, states are implementing programs and policies through Section 1115 waivers that are designed to shrink enrollment in their Medicaid programs by erecting bureaucratic barriers or reducing coverage for previously incurred health care expenses. Simultaneously, the United States is experiencing a behavioral health crisis – the opioid epidemic continues to devastate communities, overdose deaths from other illicit substances are on the rise, and there is an increasing recognition of the prevalence of mental illness and suicidality in many populations. Since Medicaid is the largest provider of treatment for mental illness and an increasingly important provider of substance use disorder treatment, states' contractions of Medicaid have direct implications on access to behavioral health services.

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These implications are amplified by COVID-19. Historic rates of unemployment and the countercyclical nature of the Medicaid program mean that Medicaid enrollment increased in 2020 and will undoubtedly continue to do so. Additionally, long periods of physical and/or social isolation coupled with economic uncertainty may be associated with increased behavioral health care needs. As an example, the number of drug-related overdose deaths in Erie County, NY was up 100% in the first four months of 2020 relative to the same time period in 2019.

Below, I describe the effect of changes to the Medicaid program on receipt of behavioral health services, how recent policy might mitigate reduced access, and how policymakers might preserve access to behavioral health services.

Previous changes to the Medicaid Program

Perhaps one of the best-known contractions of the Medicaid program occurred in 2005 when Tennessee rescinded TennCare (Medicaid) eligibility for more than 190,000 low-income adults between 21–64 years of age. A recent working paper[1] looks at the impact of this large-scale disenrollment on the receipt of inpatient health services for behavioral health conditions in the two years after disenrollment. In general, the authors found no change statewide in inpatient stays for mental health and substance use disorder treatment, regardless of payer.

However, the authors did find significant changes in payment source for these services after the disenrollment. For mental health treatment, payment sources primarily shifted from TennCare to private sources of insurance and Medicare. For substance use disorder treatment, payment for inpatient stays shifted almost exclusively to people paying out-of-pocket. The authors found no change in payment source for specialty substance use disorder treatment or prescription drugs.

Another recent study[2] found that adults with a mental illness who lose Medicaid coverage and become uninsured experience a 35% decline in the likelihood of receiving any outpatient mental health treatment compared to similar adults who did not lose Medicaid coverage. This does not necessarily provide a direct counterpoint to the TennCare study, which looks at the receipt of inpatient behavioral health services. Taking these results and the TennCare disenrollment together suggests there may be differences in elasticity for care as the result of losing health insurance coverage, specifically Medicaid.

Additionally, the insurance effects for behavioral health care services may be asymmetric – patients are more likely to seek care when gaining coverage but do not stop treatment when losing coverage. The empirical base for this proposed asymmetry is mixed with respect to Medicaid expansion. A recent paper[3] found that the expansion of Medicaid under the Affordable Care Act (ACA) led to steadily increasing rates of substance use disorder treatment in the four years after expansion. Other work has found no increase in receipt of mental health[4] or substance use disorder[5] services after Medicaid expansion.

The 2021 Policy Environment

Since the Great Recession, there have been a number of federal and state policy changes that might mitigate the impact of economic downturns on Medicaid coverage of behavioral health services. These policy changes protect access to behavioral health care services from contractions of services or benefits within the Medicaid program but may not guarantee Medicaid coverage to low-income adults, even in the midst of the largest economic downturn since the Great Depression.

First, the ACA significantly increased the population eligible for Medicaid, and all but 12 states have expanded their Medicaid program to include all low-income adults. What is more, the ACA required that Medicaid programs cover mental health/substance use disorder treatment services at parity with medical and surgical benefits for all expansion adults and those whose benefits are provided through a Medicaid managed care organization (MMCO). With more than two-thirds of beneficiaries in a MMCO, many previously eligible Medicaid beneficiaries have parity-level coverage for behavioral health services, limiting a state's ability to curb spending by cutting access to behavioral health care services during an economic downturn.

However, MMCO penetration varies by state. In eight states (DE, HI, KS, NE, NH, NJ, TN, VA) more than 95% of Medicaid enrollees are in managed care; in four states (AK, CT, WY, VT), less than 5% of Medicaid enrollees are in managed care. This variation leads to potentially unequal access to behavioral health services by MMCO penetration for non-ACA expansion beneficiaries. Additionally, assessing parity for non-quantitative treatment limits (e.g., network adequacy and drug formularies) is difficult, and MMCOs may reduce access along these dimensions to reduce spending.

Second, recent bills have included expanded access in non-financial ways. The Comprehensive Addiction Recovery Act of 2016, the SUPPORT for Patients and Communities Act of 2018, and the Coronavirus Aid, Relief, and Economic Security Act of 2020 all increase non-financial access to substance use disorder treatment. The provisions in these bills extend prescribing authority for MOUD to nurse practitioners, require Medicaid programs to cover all MOUD, and expand the use of telemedicine for behavioral health, respectively.

Third, in spite of the progress made by previous legislation, the fate of the ACA is still unresolved as *Texas v. United States (California)* has been taken up by the Supreme Court. The lawsuit, which seeks to invalidate the entirety of the ACA, now has competing groups of states as plaintiffs and defendants. A Supreme Court ruling in the plaintiffs' favor could strike down the entire ACA as unconstitutional, eliminating the parity regulations in the law and reversing the Medicaid expansion decision of 39 states. This could result in a decrease of $4.5 billion in funding per year for mental health/substance use disorder treatment and a loss of insurance coverage for 1.25 million people with a mental illness and 2.8 million Americans with a substance use disorder. With a Democratic majority in the House, a split in the Senate, and a Democratic president, however, the federal government could drop its support of this lawsuit and mount a defense against it.

Even though it is likely that the Supreme Court upholds the ACA, many states are actively trying to reduce enrollment in their Medicaid program through Section 1115 waivers, which could restrict access to treatment for mental illnesses and substance use disorders. These contractions include the implementation of Medicaid work requirements – 8 approved (AZ, GA, IN, NE, OH, SC, UT, WI), 7 pending (AL, ID, MS, MT, OK, SD, TN); the elimination of retroactive eligibility – 7 approved (AZ, IA, IN, AZ, FL, GA, IA), 1 pending (UT); the implementation of lockouts for premium non-payment – 4 approved (IN, MI, MT, WI), 1 pending (UT) or delays in program renewal – 1 approved (IN); and the conversion of federal funding to a Medicaid block grant – 1 approved (TN).

Maintaining access to behavioral health services

Given these threats to the Medicaid program, how can local and state policymakers maintain access to these services for their constituents?

The Medicaid program is not the only public funding stream for behavioral health services. The Substance Abuse and Mental Health Services Agency (SAMHSA) provides states with funds via block grants and other grant-funding mechanisms. In FY 2019, these mechanisms provided state and local governments with $1.41 and $3.35 billion for mental health and substance use disorder treatment programs, respectively. However, these funding streams were projected to account for just 13% of all and 21% of public spending on mental health treatment in FY2020. For substance use disorder treatment, SAMHSA grants were projected to cover 28% of all and almost 40% of public spending in FY 2020.

While states have flexibility in how they spend the monies provided through SAMHSA's block grants, award amounts are not directly controlled by state and local governments. SAMHSA's budget is set by the federal government, which appropriates funding as allowed by the federal budget. Thus, these funding streams are likely less responsive to increased need due to state contracture of Medicaid eligibility and benefits. And these funding sources cannot be relied upon to cover the resultant gap in mental health and substance use treatment.

The Medicaid program, which is more directly controlled by states, provides a greater proportion of funding for mental health treatment and an equivalent amount for substance use disorder treatment compared to SAMHSA's block grants. However, in general the spending associated with Medicaid programs is not politically palatable in many states, and Medicaid is one of many programs targeted in efforts to shrink welfare programs.

States that implement policies to constrict enrollment in Medicaid could take the money saved from these actions and increase the capacity of safety net mental health and substance use disorder treatment providers. Or states could implement a carve-out eligibility category for adults with a behavioral health condition. Rather than providing the full suite of Medicaid services, these programs would provide access to mental health and substance use disorder treatment for eligible adults.

Prior to expanding Medicaid eligibility up to 138% FPL, Virginia[6] and Utah,[7] implemented programs that expanded Medicaid eligibility to include adults with a serious mental illness

and very low incomes. In Virginia, adults with incomes up to 80% FPL and a diagnosed qualifying serious mental illness qualified for limited medical and behavioral benefits through the Medicaid program. Similarly, Utah also initially expanded its Medicaid program to parents with incomes up to 60% FPL and to adults with incomes up to 5% FPL who also experienced chronic homelessness, were involved in the carceral system, or in need of treatment for a diagnosable serious mental illness or substance use disorder. However, both of these programs cost the states as much as full Medicaid expansion would have and covered considerably fewer people. The smaller expansion would receive the state's current match from the federal government, rather than the higher federal match rate for the expansion population. Thus, implementing these kinds of restrictions on Medicaid eligibility and services to save state dollars seems unlikely to meet both goals.

Indeed, in response to the TennCare disenrollment, more than half of the disenrollees enrolled in the Mental Health Safety Net. However, this safety net was under-funded to provide adequate care to every person (in 2020, the additional funding amounted to $971 per disenrollee). Community and faith-based care networks also briefly expanded capacity, but these programs could not and did not provide the full spectrum of mental health and substance use disorder treatment. Additionally, these kinds of programs are often not required to provide evidence-based treatment or adhere to an insurer's conditions of participation. Thus, it is likely that these stopgap measures are inadequate to meet the needs of people with mental illness or substance use disorder.

Conclusion

Ultimately, it seems likely that state contraction of Medicaid programs will result in less access to care for mental illness and substance use disorder, regardless of the steps taken to mitigate these gaps in care. The Trump administration approved Tennessee's Medicaid waiver for a modified block grant on January 8, 2021, 12 days before Biden's inauguration. Although this waiver does not explicitly include barriers to enrollment or renewal, the perceived uncertainty around the waiver could discourage some beneficiaries from enrolling. The Biden administration is not only unlikely to approve other states' waivers that deter enrollment but it may also roll back provisions (including work requirements) that were implemented by previous administrations. Additionally, current lawsuits to strike down the ACA could prevail, in spite of seemingly positive oral arguments. In the midst of multiple behavioral health crises and a pandemic that exacerbates these crises, reducing eligibility for or limiting the scope of behavioral health benefits provided by the Medicaid program will undermine the progress made on these fronts. And now is certainly not the time to let up.

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Highlights:

- During the Trump administration, states were allowed to implement bureaucratic barriers to enrollment in their Medicaid programs.
- These barriers may reduce Medicaid enrollment and, subsequently, have an impact on access to treatment for mental health and substance use disorders.
- There are few actions that state or local policy makers could implement to offset this decline in treatment access as a result of these changes to the Medicaid program.