Medicaid Waivers and Access to Behavioral Health Services: What Is Known and What Can Be Expected

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In the past 5 years, Medicaid programs have implemented administrative barriers to enrollment. The impact of these provisions on access to mental health and substance use disorder treatment has been largely unstudied. This column reviews the literature on the previous changes to Medicaid enrollment and treatment use, current policy landscape, and steps that states or localities may take to offset these administrative burdens. Redirecting savings to other safety-net programs may increase access to care, but these programs lack the comprehensive benefits provided by Medicaid. Without another backstop, the implementation of these barriers will likely exacerbate the United States' behavioral health crises.

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After nearly a decade of expansion, states are implementing programs and policies through Medicaid 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 crisis continues to devastate communities, overdose deaths from other illicit substances are on the rise, and there is increasing recognition of the prevalence of mental illness and suicidality in many populations. Because 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.

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, New York, rose by 100% in the first 4 months of 2020, relative to the same 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 policy makers 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 ages 21–64. A recent working paper (1) examined the impact of this large-scale disenrollment on the receipt of inpatient health services for behavioral health conditions in the 2 years after disenrollment. In general, the authors found no statewide change in inpatient stays for mental health and substance use disorder treatment, regardless of payer.

However, the authors found 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

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 affect access to treatment for psychiatric and substance use disorders.
- There are few strategies that state or local policy makers can implement to offset this decline in treatment access as a result of these changes to the Medicaid program.

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 with similar adults who do not lose Medicaid coverage. This finding, however, does not necessarily provide a direct counterpoint to the TennCare study, which studied the receipt of inpatient behavioral health services. Considering these results and the TennCare disenrollment together suggests that there may be differences in elasticity for care resulting from 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 in regard to Medicaid expansion. A recent article (3) found that the expansion of Medicaid under the Affordable Care Act (ACA) led to steadily increasing rates of treatment for substance use disorder in the 4 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 may 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. Furthermore, the ACA required that Medicaid programs cover mental health and substance use disorder treatment services at parity with medical and surgical benefits for all adults covered by Medicaid expansion and for those whose benefits are provided through a Medicaid managed care organization (MMCO). Because more than two-thirds of Medicaid beneficiaries are enrolled 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 (Delaware, Hawaii, Kansas, Nebraska, New Hampshire, New Jersey, Tennessee, Virginia), more than 95% of Medicaid enrollees are in managed care; in four states (Alaska, Connecticut, Wyoming, Vermont), 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 nonquantitative 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 expanded access to treatment in nonfinancial ways. The Comprehensive Addiction Recovery Act of 2016, the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018, and the Coronavirus Aid, Relief, and Economic Security Act of 2020 all increase nonfinancial access to substance use disorder treatment. The provisions in these bills allow nurse practitioners to prescribe medication for opioid use disorder (MOUD), require Medicaid programs to cover all MOUD, and expand the use of telemedicine for behavioral health, respectively.

Third, despite progress made by previous legislation, the fate of the ACA remains 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 decisions of 39 states. Such a ruling could result in a decrease of $4.5 billion in funding per year for mental health and substance use disorder treatment and a loss of insurance coverage for 1.25 million people with mental illness and 2.8 million people with substance use disorders. 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.

Although it is likely that the Supreme Court will uphold 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 people with mental illness and/or substance use disorders. These contractions include implementation of Medicaid work requirements (eight approved by the Trump administration but stayed by federal courts or rescinded by the Biden administration [Arizona, Georgia, Indiana, Nebraska, Ohio, South Carolina, Utah, Wisconsin]), the elimination of retroactive eligibility (six approved [Arizona, Iowa, Indiana, Arizona, Florida, Georgia] and one pending [Utah]), implementation of lock-outs for premium nonpayment (four approved [Indiana, Michigan, Montana, Wisconsin], one pending [Utah], and one delay in program renewal approved [Indiana]), and conversion of federal funding to a modified block grant (one approved [Tennessee]).

Maintaining Access to Behavioral Health Services

Given these threats to the Medicaid program, how can local and state policy makers 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 Administration (SAMHSA) provides states with funds via block grants and other grant-funding mechanisms. In fiscal year (FY) 2019, these mechanisms provided state and local governments with $1.41 billion 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 spending and 21% of public spending on mental health treatment in FY 2020. For substance use disorder treatment, SAMHSA grants were projected to cover 28% of all spending and almost 40% of public spending in FY 2020.

Whereas 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 caused by state contracture of Medicaid eligibility and benefits. Moreover, these funding sources cannot be relied on 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 with 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. Alternatively, states could implement a carve-out eligibility category for adults with behavioral health conditions. 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 for individuals earning up to 138% of the federal poverty level (FPL), Virginia (6) and Utah (7) implemented programs that expanded Medicaid eligibility to include adults with serious mental illness and very low incomes. In Virginia, adults with incomes up to 80% of the FPL diagnosed as having a qualifying serious mental illness were eligible for limited medical and behavioral benefits through the Medicaid program. Similarly, Utah initially expanded its Medicaid program to parents with incomes up to 60% of the FPL and to adults with incomes up to 5% of the FPL who also experienced chronic homelessness, were involved in the carceral system, or were 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. Furthermore, with a more limited expansion, the state would receive its current match rate from the federal government, rather than the higher federal match rate for the Medicaid expansion population. Thus, implementing these kinds of restrictions on Medicaid eligibility and services to save state dollars seems unlikely to meet either goal.

Indeed, in response to the TennCare disenrollment, more than half of those disenrolled from Medicaid enrolled in the Mental Health Safety Net. However, this safety net was underfunded to provide adequate care to every person. (In 2020, the additional funding amounted to $971 per person disenrolled.) 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 to 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 disorders.

Conclusions

Ultimately, it seems likely that state contraction of Medicaid programs will result in less access to care for individuals with mental illness and/or substance use disorders, regardless of the steps taken to mitigate these gaps in care. The Trump administration approved Medicaid waivers that will continue to serve as considerable barriers to enrollment and renewal in Medicaid as long as they are in place. For instance, Tennessee's modified block grant waiver was approved on January 8, just 12 days before President Biden's inauguration. Although this waiver does not allow for the contraction of benefits or eligibility, the publicity of these changes may deter enrollment. The Biden administration, however, is unlikely to approve such waivers and has already rescinded approval for all Medicaid work requirement waivers. Finally, current lawsuits to strike down the ACA could prevail, despite oral arguments that seem to favor upholding the law. 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. Now is certainly not the time to let up.

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