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The Impact of the ACA on Community Mental Health and Substance Abuse Services: Experience in 3 Great Lakes States

ISSUE BRIEF

Introduction

The Affordable Care Act (ACA) allowed states to expand Medicaid coverage to low-income childless adults, many of whom receive specialty mental health and substance use services through community mental health systems. Leading up to the passage of the ACA, community mental health providers and their professional associations were generally supportive of expanding Medicaid under the ACA. Medicaid covers specialty services central to quality mental health and substance use care, as well as other physical health services that many in the serious mental illness (SMI) and substance use disorder (SUD) populations lacked before 2010.

To date, 32 states have expanded Medicaid (including the District of Columbia), while the remaining 19 have not. This brief, which was developed with support from the Commonwealth Fund, examines the impact of the ACA on public mental health and substance use systems in three Midwestern states: Michigan and Indiana, both Medicaid expansion states, and Wisconsin, a non-expansion state.

The experience from these three states suggests that Medicaid expansion has had an important and overall beneficial effect in particular for the substance use population. The favorable impact is particularly important in light of the opioid epidemic.

Key Findings

- Prior to the Medicaid expansion, state and local funds paid for many services for the SMI/serious emotional disturbance (SED) and SUD populations. In Medicaid expansion states, most funding shifted to the federal government, providing both advantages and disadvantages: more people in need received insurance coverage, but that coverage was less flexible for SMI/SED populations than prior funding mechanisms.
- Funding for substance use services improved substantially in Medicaid expansion states, serving a particularly important role in enabling states to provide more services in the wake of the opioid crisis. In these states, many more individuals had Medicaid SUD treatment benefits than before expansion and federal block grant funds were freed up to provide additional substance use services. As a result of the additional funding provided, Michigan was able to increase the numbers of those who received SUD care by 14%.

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State Agencies for Mental Health and Substance Abuse Services

In the United States, approximately 18% of adults have some type of mental illness, and 4% of adults have serious mental illness (SMI).[1] In 2015, nearly 7% needed substance use disorder (SUD) services. Medicaid-covered individuals have higher prevalence of mental health or substance use disorder (38%) than low-income individuals who are privately insured (19%).[2] While the proportions of the population with SMI, serious emotional disturbance (SED) in children, or substance use disorder (SUD) are relatively small, the burden is great—both on individuals and their families, and on systems that deliver intensive, expensive behavioral health services.

All states have public mental health and substance use services systems, but the populations covered and financing and delivery of services vary by system. Services are sustained through a combination of funding sources, which can include:

- Medicaid, both traditional and expanded Medicaid in some states;
- Federal block grant funding for mental health and for substance use prevention and treatment;
- State general funds;
- Other insurance coverage (Medicare, private insurance); and
- Local funds, such as alcohol taxes.

The three Midwestern states highlighted in this brief—Michigan, Indiana, and Wisconsin—share similar demographics and economic bases, but have approached the coverage and provision of behavioral health services differently. (Figure 1)

Figure 1: Funding Flow and Service Delivery for SMI/SED and SUD Populations in 3 Midwestern States

	Flow of Funds	Medicaid Managed Care	Service Delivery
Michigan	State allocates federal and state funds to 10 regional entities (Prepaid Inpatient Health Plans) that manage and distribute funds to county community mental health programs.	Inpatient and outpatient mental health and substance use services are carved out[3] of the Medicaid managed care plans.	County level or multi-county level agencies that mainly contract for the delivery of services.
Indiana	State allocates state and federal funds via direct contracts with community providers.	Outpatient mental health services are carved out. Inpatient mental health, inpatient SUD and outpatient SUD services carved in.	State contracts with providers through county-level satellite community mental health centers.
Wisconsin	State allocates some state and federal funding to county offices of the state. Some block grant and other funds go directly from state to providers to improve services for more regional programs.	Some outpatient mental health services carved in and some carved out. Inpatient mental health, inpatient SUD and outpatient SUD mainly carved in except one psychosocial rehab program.	State supervises county-level delivery of mental health and substance use services. Some larger communities contract directly with providers for county services.

Source: Kaiser Family Foundation[4]

[1] 2015 data from the National Survey on Drug Use and Health. National Institute of Mental Health. Accessed 6/1/2017 at: https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml; https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

[2] Clemans – Cope, L. et al., Kaiser Family Foundation. "Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence." April 2016. Accessed 6/1/2017 at: http://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/

[3] Medicaid services that are "carved in" are covered by managed care organizations, and those "carved out" are covered by a Prepaid Inpatient Health Plan or fee-for-service Medicaid.

[4] Smith, V. et al., Implementing Coverage and Payment Initiatives. Health Management Associates and Kaiser Family Foundation. 2016. Accessed 5/2/17 at: http://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives.

Impact of Medicaid Expansion

Both Michigan and Indiana expanded their Medicaid programs under the ACA to cover low-income adults up to 138% of the federal poverty level (FPL), and both have experienced success enrolling individuals in these respective new programs.[5] [6] While Wisconsin did not expand their state Medicaid program, the state made changes that have somewhat increased enrollment in traditional Medicaid, including setting eligibility for childless adults with incomes up to 100% FPL and removing a previous enrollment cap.[7] (Figure 2)

Medicaid coverage may be especially important for individuals with SMI/SED because it pays for services such as case management and wraparound services which other insurers often do not cover. Studies have shown that Medicaid coverage can lead to important, positive clinical improvements in mental health status as well. One analysis of expanded Medicaid eligibility showed improved mental health for low-income parents compared to uninsured parents. [8] Another evaluation of a pre-ACA Medicaid expansion in Oregon showed improved self-reported mental health and reduced depression rates.[9]

Figure 2: Change in Medicaid and Children's Health Insurance Program (CHIP) Enrollment since Medicaid Expansion

	State Medicaid Expansion Enrollment	Change in Total Medicaid + CHIP Enrollment since 2013[10]
Michigan	659,801	22%
Indiana	427,482	34%
Wisconsin	n/a	6%

Sources: Michigan Department of Health and Human Services; Indiana Family and Social Services Administration; US Department of Health and Human Services

[5] Enrollment as of June 2017. Michigan Department of Health and Human Services. Accessed 6/6/17 at: http://www.michigan.gov/documents/mdch/HMP_County_Breakdown_Data_455353_7.pdf

[6] Enrollment as of April 2017. Indiana Family and Social Services Administration. Accessed 6/6/17 at: http://in.gov/fssa/ompp/4881.htm

[7] Kaiser Family Foundation. The Wisconsin Health Care Landscape. 2015. Accessed 6/6/2017 at: http://www.kff.org/health-reform/fact-sheet/the-wisconsin-health-care-landscape/

[8] McMorrow, S. et al., Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents. 2016. Accessed 6/6/2017 at: http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12432/abstract

[9] Baiker, K. et al., The Oregon Experiment - Effects of Medicaid on Clinical Outcomes. 2013. Accessed 6/6/2017 at: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321

[10] Center for Medicaid and CHIP Services. Accessed 6/8/17 at: https://www.medicaid.gov/medicaid/by-state/by-state.html

After the ACA: Shifts From Direct State and Local Expenditures To Federal Funding and Expanded Funding for Substance Use Services

Prior to the ACA, many uninsured or underinsured individuals received SMI and SUD services that were funded through state general funds, local community funds, and some federal block grant funds. When states expanded Medicaid, nearly the full cost of services for SMI and SUD shifted to the federal government. The Michigan House Fiscal Agency estimated that the state saved $235 million annually with the Medicaid expansion, of which $168 million was funding for mental health services previously covered by state general funds before the expansion.[16]

Before Indiana's Medicaid expansion began in February 2015, the state used mainly federal block grant funds to pay for services for the uninsured/underinsured individuals who met criteria for SMI or SUD services. As many of those individuals enrolled in the expanded Medicaid program, the state shifted the off-set block grant funding to provide other services such as housing supports, prevention activities, and community recovery supports. The state's Family and Social Services Administration and the state Medicaid office are currently working to estimate the savings associated with funding shifts and, more broadly, the Medicaid expansion.

Historically, addiction services and residential treatment options in particular have been very limited in most states. Of the 22 million people in the country who needed SUD services in 2015, only about

Addressing the Opioid Epidemic

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2015 there were 1.5 million adults in the U.S. with SMI who misused opiates in the previous year.[11] In states across the nation, addressing the opioid epidemic is a top priority.

Opioid overdose death rates have increased significantly in the U.S., from 12.3 per 100,000 in 2010 to 16.3 per 100,000 in 2015.[12] Opioid overdoses have quadrupled since 1999.[13] At the national level, multiple federal agencies and the United States Congress have mobilized to address the epidemic. Two major pieces of federal legislation—the Comprehensive Addiction and Recovery Act (CARA) of 2016[14] and the 21st Century CURES Act of 2016[15] — address harm-reduction strategies, provide some funding to states and to the NIH, and provide authority for the FDA to bring opioid treatments to market more quickly.

A Local Approach to a National Problem

A cross-sector community health coalition in southeast Michigan addressed the opioid epidemic locally. The group included front-line staff from law enforcement, health care providers, the public mental health system, drug treatment centers, public health, faith institutions, public libraries, pharmacists, and public schools. The coalition put forth five major initiatives in the first year:

1. Community education and engagement to reduce stigma for people in recovery
2. Naloxone access
3. Primary prevention among youth
4. Protocol for substance use treatment providers
5. Provider education on appropriate prescribing

Continued on Page 5

[11] SAMHSA CBHSQ Report, January 25, 2017. Accessed 5/2/17 at https://www.samhsa.gov/data/sites/default/files/report_2734/Spotlight-2734.pdf
[12] MMWR Weekly, December 30, 2016 Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015 https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm
[13] Centers for Disease Control and Prevention, Drug Overdose Death Data (2016). Accessed 6/1/17 at https://www.cdc.gov/drugoverdose/data/statedeaths.html
[14] Comprehensive Addiction and Recovery Act of 2016 (Public Law No: 114-198. Accessed 6/1/17 at https://www.congress.gov/bill/114th-congress/senate-bill/524/text
[15] 21st Century Cures Act (Public Law No: 114-255). Accessed 6/1/17 at https://www.congress.gov/bill/114th-congress/house-bill/34
[16] Michigan House Fiscal Analysis, September 14, 2016. Accessed 5/2/17 at: http://www.house.mi.gov/hfa/PDF/HealthandHumanServices/HMP_Savings_and_Cost_Estimates.pdf

11% received them.[17] State leaders interviewed for this study reported that expansions in Medicaid resulted in substantial funding enhancements for SUD services and reductions in historically long wait times for services. One main reason for the enhanced funding was that the federal government did not reduce the Substance Abuse Prevention and Treatment (SAPT) block grant when states expanded Medicaid, so more resources became available for SUD services.[18] As a result, states received enhanced resources to serve individuals seeking SUD services as opioid abuse became epidemic.

The freed-up SAPT funding created capacity to deliver supportive recovery housing and other services that Medicaid did not cover and that the state and local areas previously struggled to support. There was also new capacity to expand prevention efforts, such as supplying local first responders with naloxone to reverse opiate effects, and providing specific SUD services for women. The Prepaid Inpatient Health Plans in Michigan were also able to provide coverage for peer services and medication-assisted treatment that they previously did not have resources to cover. In Fiscal Year (FY) 2016, after the Medicaid expansion in Michigan,[22] 14% more people in the state received SUD services than in FY 2012.[23] Over that same time period, residential admissions for SUD treatment increased nearly 40%.[24] The Medicaid expansion also allowed the state to roll over some unused SAPT grant funds.[25]

Naloxone distribution to law enforcement first responders was a major early success, resulting in over 60 lives saved since August 2015. The work generated a new community nonprofit to reduce stigma for people in recovery.

The group facilitated education for prescribers in the community about the Michigan drug prescription monitoring system, and treatment providers implemented a new referral protocol.

In a second round of initiatives in 2015, the group adopted the Project Lazarus model to guide their work.[19] The model was started in Wilkes County, North Carolina in 2009, and is based on two premises: overdose deaths are preventable and communities are responsible for their own health.[20] In the first year of operation, the model demonstrated a reduction in the opioid-related death rate and in the number of overdose decedents receiving a prescription from a Wilkes County prescriber.[21] The model enables community-level coordination of activities from primary to tertiary prevention and activities targeting individual, family, community, and policy levels.

Adopting the Project Lazarus Model invigorated the coalition membership by giving clear direction for focused activities, while allowing the coalition to set goals based on local conditions. This coalition work continues to grow in 2017, with 7 workgroups focused on more than 10 activities.

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[17] Lipari, R. N., Park-Lee, E., and Van Horn, S. *America's Need for and Receipt of Substance Use Treatment in 2015.* The CBHSQ Report: September 29, 2016. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD.

[18] Personal communication: M. Scalera, Director of Clinical and SUD Services, Community Mental Health Partnership of SE Michigan, 1/16/17.

[19] Commonwealth Fund Transforming Care Series (2017). Combatting the Opioid Epidemic with Provider and Public Education. Accessed 6/1/17 at http://www.commonwealthfund.org/publications/newsletters/transforming-care/2017/march/q-and-a

[20] Project Lazarus (n.d.). Accessed 6/1/17 at https://www.projectlazarus.org/our-story

[21] Albert, S., Brason II, F. W., Sanford, C. K., Dasgupta, N., Graham, J. and Lovette, B. (2011), Project Lazarus: Community-Based Overdose Prevention in Rural North Carolina. Pain Medicine, 12: S77–S85. doi:10.1111/j.1526-4637.2011.01128.x http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2011.01128.x/full

[22] Michigan expanded Medicaid in April 2014.

[23] Haveman, J. et al., Presentation to House Appropriations Subcommittee on Community Health titled, "Behavioral Health and Developmental Disabilities Administration Fiscal Year 2015." 2014. Accessed 7/3/2017 at: https://www.michigan.gov/documents/mdch/BHDDA_Budget_FY2015_-_Senate_-_FINAL_449478_7.pdf; Zeller, L. et al., Presentation to the Appropriations Subcommittee on Health and Human Services. "Behavioral Health and development Disabilities Administration Fiscal Year 2018." 2017. Accessed 7/3/2017 at: http://www.michigan.gov/documents/mdhhs/BHDDA_FY18_Budget_Presentation__FINAL_553722_7.PDF

[24] CHRT calculations using Michigan Department of Health and Human Services data, reported by Prepaid Inpatient Health Plans, received through personal communication with J. Welehodsky, 7/14/2017.

[25] States can carry over SAPT block grant funds for two years.

Indiana's Medicaid expansion allowed more individuals, including those designated as "medically frail," [26] to receive Community Mental Health Rehabilitation services ("MRO" program) which can also target substance use services. Leaders in Wisconsin, a non-expansion state, also reported reduced county expenses for SUD treatment as more individuals enrolled in Medicaid.

Limitations of the Medicaid Expansion

One important unforeseen consequence of off-setting state general funds with Medicaid funds is the loss of spending flexibility that state general funds previously provided. Medicaid funds can only be used for defined benefits and defined populations, but community mental health agencies have historically depended on flexible general funds for services that Medicaid does not cover (e.g., jail services, diversion programs, Medicaid spend-down assistance) and for services for those who remain uninsured. In Michigan, as many uninsured individuals with SMI were enrolled in expanded Medicaid, the state quickly pulled back general fund allocations from community mental health agencies that struggled to maintain the non-Medicaid covered services. Many local communities in the state are now developing mental health millage proposals to supplement funding for community mental health services no longer provided by local agencies.

The Non-Expansion Experience: Wisconsin

After the passage of the ACA, Wisconsin did make some improvements in eligibility in their Medicaid program, but did not fully expand Medicaid as Michigan and Indiana have done. In addition to lifting the previous enrollment cap and covering childless adults up to 100% FPL, the state also funded a psychosocial benefit, referred to as Comprehensive Community Services, that had been paid (the non-federal share) by counties. This benefit is for individuals needing more than outpatient services but less than Assertive Community Treatment. At the same time, counties have been mandated by the state to cover other services, such as one focused on intoxicated drivers, which has further limited county funds for other substance use services. Many of these changes improved coverage and, while important, were more limited than changes in expansion states, affecting fewer individuals than full Medicaid expansion.

[26] Qualifying conditions include: alcohol and substance abuse; mental illness including major depression, schizophrenia, bipolar disorder or post-traumatic stress disorder. http://www.in.gov/fssa/hip/2465.htm
Many who have applied for disability benefits but been denied in the past may qualify as "medically frail" by showing history of mental illness. NAMI Indiana: http://www.namiindiana.org/news-and-updates/hip20-whatyouneedtoknow.

Conclusion

State Medicaid expansions are multi-faceted and have clearly brought opportunities for coverage for needed services, but also introduced challenges in reduced flexibility of funding. The shift in funds that previously paid for mental health and substance use services freed up state and local funds, as well as federal block grant funds, which allowed communities to address some gaps in services that are crucial for recovery in SUD populations, and states are beginning to capitalize on these opportunities. These systems changes have also brought challenges by reducing the availability of flexible funds for community mental health services for the SMI/SED populations such as jail diversion services.

These changes have both federal and state implications. If the Medicaid expansion is scaled back as recent reform proposals in Congress suggest, it will be enormously challenging for states to find the funds to care for these populations. As legislators consider further health reform at the state and national levels, it will be important to find ways to help address challenges such as the loss of flexible funding for mental health services, and to continue to increase services to address the opioid crisis. One federal option is to introduce more flexibility in the Medicaid program itself, as the new administrator of the Centers for Medicare and Medicaid Services has suggested she will do. And as states transition program funding from flexible general funds to more restrictive Medicaid program funding, they could allow for presumptive eligibility or other methods of creating temporary coverage for community mental health services while Medicaid applications are being processed, as is done in many states for prenatal services for pregnant women. States can also consider retaining Medicaid eligibility for incarcerated individuals awaiting trial.[27]

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[27] Michigan Association of Community Mental Health Boards. 2017-2018 MACMHB Policy Priorities. Accessed 5/2/17 at: https://macmhb.org/public-policy