Medicaid Connections: Substance Use Health and Justice

Webinar hosted by:
Anka Consulting
Georgetown University Center for Children and Families
Johnson Policy Consulting

August 18, 2026

MEDICAID CONNECTIONS WEBINAR SERIES

Every Third Tuesday
AT 2PM ET

Medicaid Connections Series

Medicaid is the invisible backbone of advocacy, promoting health and well-being for low-income people. It covers birthing for moms and babies, comprehensive benefits for children, coverage for low-income adults, and it helps keep the lights on at many hospitals that accept all types of insurance. Deep cuts to the program could significantly affect people's lives.

Medicaid Connections webinars are a place for those who are not long-time health advocates, as well as those who are, to come together to help ensure all people can access and benefit from the services they need to improve their health and well-being.

Future Topics

- **Immigration: Health & Justice** – October 20, 2026 at 2 pm ET
- **Mental Health and Well-being: Health & Justice** – December 15, 2026 at 2 pm ET
- **Family Preservation: Health & Justice** – January 19, 2027 at 2 pm ET

Meet our Speakers

Moderator:
Anne Dwyer
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Silvana Mazzella
Lead Executive Officer,
Prevention Point

Today's Plan

1. Brief History of Substance Use Policy and Practices and Intersection with Health
2. Medicaid's role for covering SU treatment, a well as mental and physical health services
3. Medicaid Threats for People Who Use Drugs
4. Panel Discussion
5. Audience Q & A

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Historical Perspectives on Mental Health and Substance Use and Medicaid Policy

Kay A. Johnson
Johnson Policy Consulting
Medicaid Connections Webinar
September 15, 2026

- Few federal policies on mental health before 1960. Too many people live in institutions in poor conditions.
- Kennedy set mental health as priority and LBJ carried on.
- Medicaid EPSDT amendments, ADA, and MHPA are major breakthroughs.

1960-1966

10/31/1963 Kennedy signs Community Mental Health Act (CMHA). LBJ amends CMHA in 1965, funding for grants. 1965 Medicare & Medicaid created. Medicaid restricts funds for people in mental institutions.

1967-1983

1967 EPSDT enacted. 1972 Nixon cuts funds. 1974 & 1975 Ford vetos CMHA extension. 1977 Carter Commission. 1980 Carter signs Mental Health Systems Act. 1981 Reagan repeals, cuts funds, & block grants CMHA.

1984-1990

Six incremental expansions of Medicaid for mothers, infants, and children. 1989 EPSDT amendment. 1990 Americans with Disabilities Act (ADA) applies for both mental and physical disabilities.

1991-2007

1995 Clinton vetos Medicaid block grant. 1996 Mental Health Parity Act (MHPA), for group plans. 1997 BBA extends parity to Medicaid MCOs and CHIP. 1999 Surgeon General Report. 2003 Bush New Freedom Commission.

- Combination of MHPAE and ACA resulted in stronger protections of parity in coverage for MH/SUD services.
- ACA led to more adult coverage through Medicaid expansion and marketplace plans.
- CMS issued guidance about MH/SUD coverage, particularly for Medicaid MCOs and EPSDT.

2008-2009

2008 Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity (MHPAE) Act signed by Bush, requires parity in group coverage for mental health and SUD benefits. 2009 CHIP parity strengthened.

2010-2014

2010 Affordable Care Act mandates MH/SUD coverage for small group and individual plans. ACA extends requirement to Medicaid beyond MCOs. ACA Medicaid 133 FPL mandate becomes Medicaid expansion option.

2015-2019

2016 Final rule on MH parity in Medicaid MCOs and CHIP. 2016 The 21st Century Cures Act. 2017 Congress fails on Medicaid block grant and repeal of ACA. 2018 SUPPORT Act.

2020-2024

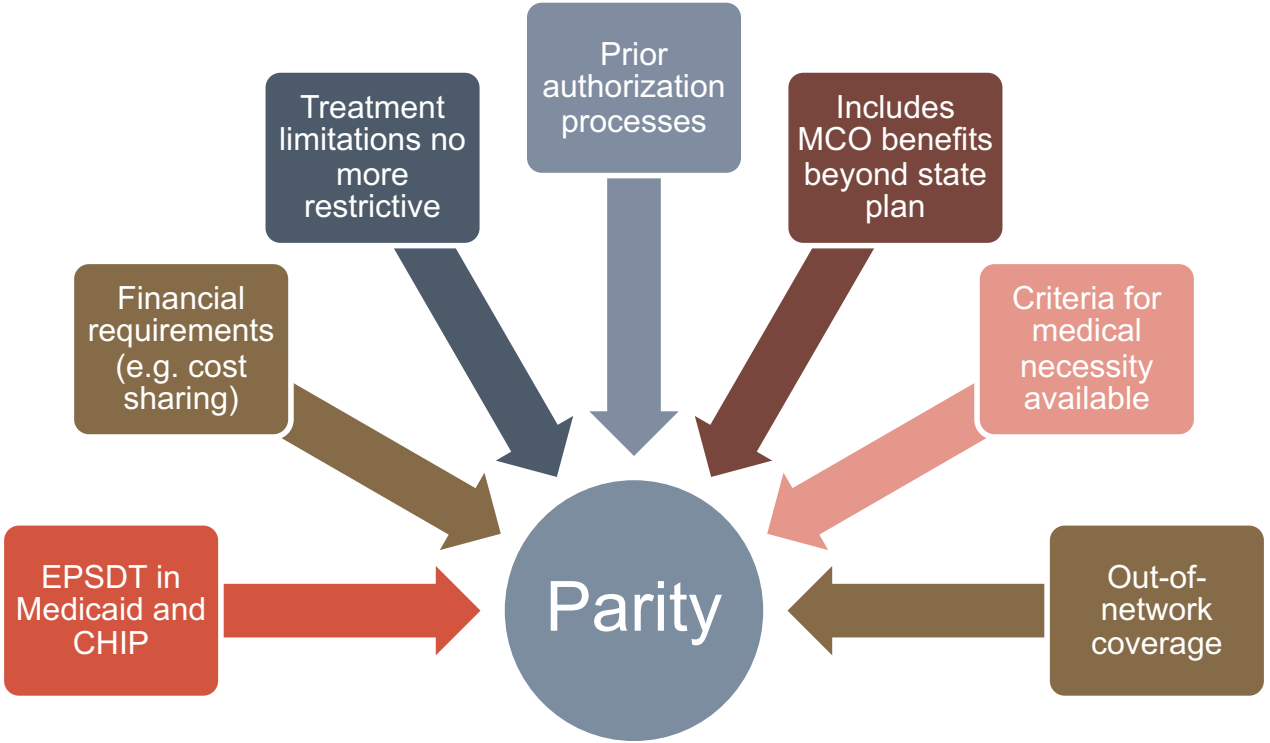
2020 amendment to MHPAE. 2021 Surgeon General report. 2024 new final rules for MHPAEA (don't apply to Medicaid or CHIP). 2021-2024 CMS Informational bulletins. 2020-24 COVID PHE protections on coverage, then unwinding.

2025-26

2025 OBBBA adds Medicaid work requirements, limits provider taxes & directed payments, more hurdles for eligibility & enrollment. 2026 CMS issues EPSDT Behavioral Health Tookit, affirming range of coverage.

Key Medicaid/CHIP Parity Requirements

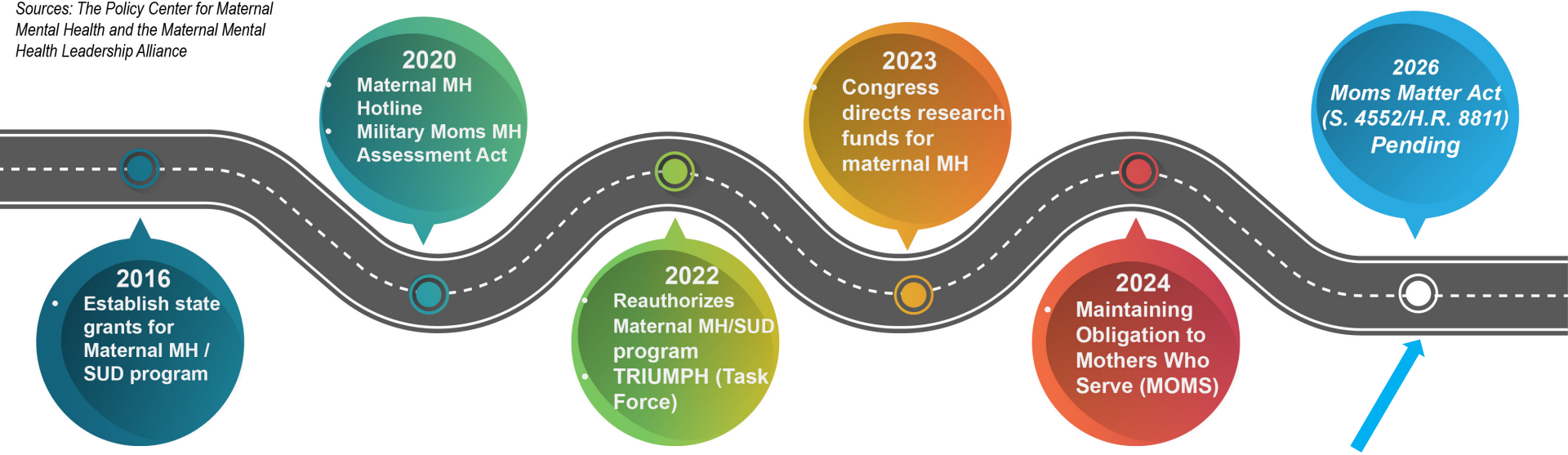
Note: While most requirements for MCOs, CMS encourages parity for all Medicaid enrollees



State Medicaid agency responsibility to use clear MCO contract language, collect data, and otherwise effectively monitor MH/SUD parity.

Recent Congressional Action on Maternal Mental Health

Sources: The Policy Center for Maternal Mental Health and the Maternal Mental Health Leadership Alliance



FY26 Appropriations:

- $8 million for Maternal Mental Health Hotline
- $12 million for Maternal Mental Health and Substance Use Disorders (MH-SUD) Program

Also see: Mondestin T & Johnson K. *FY26 Appropriations Act Funds Maternal Health Initiatives, Falls Short of Investments Needed to Address Maternal and Infant Mortality Crisis*. Georgetown University Center for Children and Families. Blog. Feb 13, 2026. https://ccf.georgetown.edu/2026/02/13/fy26-appropriations-act-funds-maternal-health-initiatives-falls-short-of-investments-needed-to-address-maternal-and-infant-mortality-crisis/
Mondestin T & Johnson K. *A Look at Maternal Heath Legislation in the 118th Congress*. Georgetown University Center for Children and Families. Blog. Oct 28, 2024. https://ccf.georgetown.edu/2024/10/28/a-look-at-maternal-health-legislation-in-the-118th-congress/
Black Maternal Health Caucus. Appropriations Wins. FY 2023-FY2025. (Website, undated). https://blackmaternalhealthcaucus-underwood.house.gov/our-work/appropriations-wins#:%7E:text=%2410%20million%20through%20HRSA%20for,major%20priority%20of%20the%20BMHC

EPSDT Settlement Examples

Salazar v DC

- Settlement December 2025, requires expert consultation and accountability responsibilities.

Rosie D v Baker (Massachusetts)

- Home & community-based services (HCBS) for children with serious emotional disturbances.

Texas v US HHS

- Coverage of inpatient residential chemical dependency treatment.

C.K. v McDonald (New York); K/B/ v Michigan; and others

- NY settlement requires reform for intensive home & community-based MH services.
- MI required to arrange / contract for intensive home & community-based MH services.

B.K. by next friend Tinsley v. Snyder (Arizona); Katie A. ex rel. Ludin v. L.A. County (California)

- State must ensure and cover adequate behavioral health, wraparound, and therapeutic foster care services.

"Re-envisioning current systems to include and address the well-being and specific needs of diverse pregnant people who use drugs will help to equitably improve maternal morbidity and mortality.

Policies, practices, and programs should learn how to do this and be held accountable for providing nonjudgmental, non-punitive, evidence-informed, culturally, and linguistically effective care. Substance use, mental and physical health treatment, and social services must be integrated to center well-being and family preservation."

...

"Throughout our country's history, we have employed a punishment system that leads to inequitable outcomes for the parent-infant dyad, especially for Black, Indigenous, and other families of color impacted by substance use. We can do better."

Kimá Joy Taylor. **A Different Vision: Centering Love Not Punishment for Families Affected by Substance Use**. *Maternal and Child Health Journal*. 2023.

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Substance Use: Health and Justice and the Fight For Medicaid

Kimá Joy Taylor, MD, MPH
Anka Consulting
Medicaid Connections Webinar
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Georgetown University McCourt School of Public Policy
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An estimated **99%** of children in foster care have Medicaid coverage.

Medicaid finances **more than 4 in 10** births across the nation

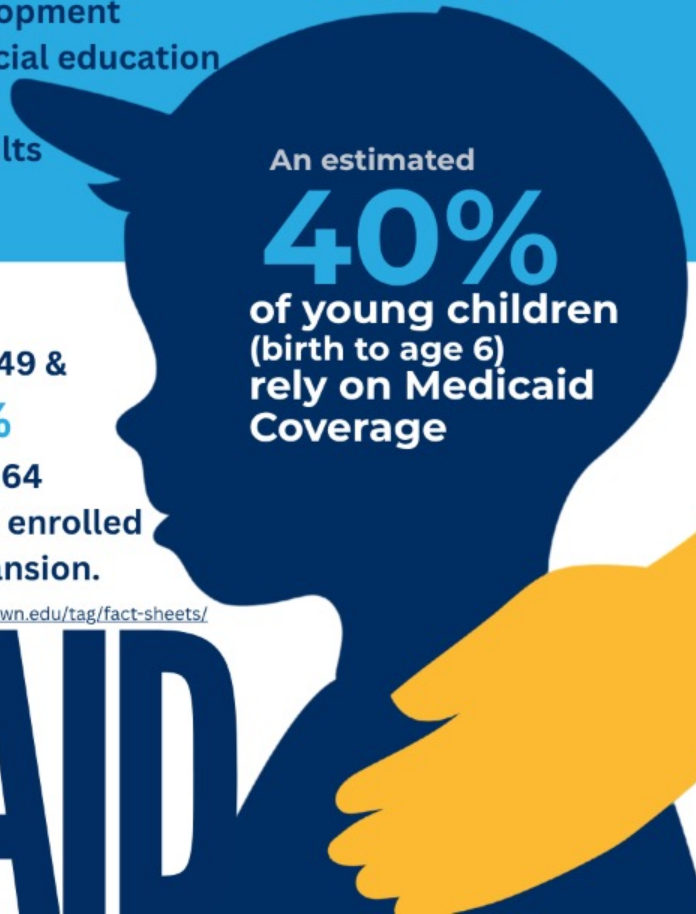
Medicaid covers **more than 1 in 4** childcare staff in the US

INFANTS & TODDLERS WITH DISABILITIES ENROLLED IN MEDICAID AND PART C:

- Show improvements in early development
- Show reduced need for school special education
- Grow up with better health
- Have less severe disabilities as adults

NEARLY HALF of adult women ages 19-49 &

MORE THAN 60% of older women ages 50-64 covered by Medicaid are enrolled under the Medicaid expansion.



An estimated **40%** of young children (birth to age 6) rely on Medicaid Coverage

See Georgetown CCF fact sheets for more information: https://ccf.georgetown.edu/tag/fact-sheets/

Holistic Threat

- Wellness of people who use drugs is out of vogue
- Real threat; not paranoia; do not let others make you think it is you
- People are more than their SU, but people are threatened with punitive responses because of their SU; some more than other
- AND the other pieces that are being taken away/cut are also a one-way ticket to punitive systems which is then reinforced for people who use substances

Try not to tune out

- Lots of information and impacts, but that is what people face everyday without reprieve or tuning out
- Tunneled, siloed vision is a luxury right now

History

- Drug use was rarely treated as a health concern; used as tool to battle communities for moral, racist and protectionist reasons.
- Historical reality has had huge ramifications for research, legislative, administrative, social and clinical responses and has often meant when changes are made, they are not developed to provide equitable outcomes
- This is not the first substance use or even opioid use epidemic
- This is not the first time doctors have fueled an opioid epidemic
- This is not the first time we have sought to regulate the prescriptions and found that people then turn to illicit drugs (opioids, methamphetamine, alcohol)—people have use disorders
- This is not the first time response and concern differed based on demographics
- Not the first-time slow progress is being made only to face for hostile, punitive backlash. Why do we need to be hostile?

History

- Our past responses have repeatedly been inadequate-- stepwise, racist, non-evidence informed, moral, punitive instead of health based and comprehensive- Though at times they included appropriate clinical and social responses for some while demonizing and criminalizing others. But those were often shut down.
- Pretended criminalization and the justice system was a treatment response.
- Slow to provide any type of care to those who are not ready to enter treatment.
- Even while systems knew alcoholism and substance use were chronic health concerns.

History Disease Designation

- Dr. Benjamin Rush- (late 1700's)
- Dr. William Duncan Silkworth
- New York City Medical Society on Alcoholism in 1954
- American Medical Association (AMA) classified alcoholism as a disease in 1956 and included addiction as a disease in 1987.
- American Society of Addiction Medicine (ASAM) (2011) defining addiction as a chronic brain disorder, not a behavior problem, or result of making bad choices

History NOT an accident

Why is this SUD and Race conversation important? Most infamous-Nixon era response

- Harry Anslinger first head what would merge and become the Drug Enforcement Administration

  Created early **US drug policy included racial animus**; purposefully used fear to shape beliefs about substance use

- **War on Drugs (1971)/Criminal Justice Response** was largely defined by Nixon but embraced on bipartisan bases despite the fact it was NOT a health-based treatment response
- "During a 1994 interview, President Nixon's domestic policy chief, John Ehrlichman explained that the Nixon campaign had **two enemies: "the antiwar left and black people."**

  Ehrlichman: "We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did.""
  https://www.history.com/topics/the-war-on-drugs
- **HIV epidemic** - governmental promoted and enforced discrimination
- **Lessons can and should be learned from our history**; how to move and how to move if we want to achieve equitable outcomes, during these perilous times.

The Sequelae of the Legal Response

- Criminal legal Inequities and Injustices
- Child Welfare and Foster Care Inequities
- Denied Access to Education, Housing and Benefits:
- Wasted Taxpayer Dollars
- Shredded Constitutional Rights:
- Compromising Teenagers' Safety:
- Inadequate Access to and Outcomes from Evidence Informed Drug Treatment and other SU services
- Inadequate Access to and Outcomes from Evidence Informed Individual and Public Health Strategies
- **NOT a robust culturally and linguistically effective full continuum of health and social services for a health and social concern**

Current Opioid Crisis

- Substance use as a chronic health concern is not the “aha” moment that people who now focus on the opioid crisis want to pretend.

- Desire for the new “aha” moment is more of reflection of fear of being introspective, but that fear interrupts talking about and finding ways to build community trust and allows for lower quality care and ignoring of true best practices that improve health for populations that were previously harshly punished for a chronic disease

Current Opioid Crisis
Different Population, Shifting Response

- Deemed first as a prescription drug epidemic and seen as being caused by providers and manufacturers in a way that closed conversation about caring for people with other types or substance use to illicit opioids or other drugs
- Manifested and recognized in white populations in ways that reinforced racial bias.
- Started to move those with a moral frame around drug use to a public health frame-for some people who use some drugs
- Policymakers, Providers, Researchers, Advocates and Public that never talked about drug use entered the picture but rarely looked at past history or effective evidence informed community responses or solutions
- Ways policies implemented were chaotic and often caused re-learning of known solutions PDMP owned by law enforcement vs health department
- Societal indecision about pregnant parent—treat as chronic disease or criminalize? Society keeps going back and forth in dangerous ways. With the mother/parent as the pawn
- Led to creation of **Opioid Use Disorder System NOT a Substance Use Disorder System**

Legislative History

- Mental Health Parity Act (MHPA) of 1996
- Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
- Affordable Care Act of 2010 and parity expansion with Medicaid expansion
  - Medicaid essential benefit
  - Medicaid parity spread from large employers to individual and small groups and finally Medicaid expansion and Medicaid MOC's
  - Cigarette Use (a SU disorder) allowed to have higher premiums—why we need an SU not just an OU system
- Shift from public health block grant to Medicaid reimbursement

Why Should I Care About Medicaid?

- **Medicaid is the largest payer for Behavioral Health Services**
  - Includes MH and SU coverage for people of all ages
  - 21% of those covered by Medicaid have a diagnosed mild, moderate or severe SUD and that does not include alcohol
- Covers the costs of medications for use disorders—alcohol, nicotine, and of course opioids
- Treatment leads to improved outcomes and health care cost savings
- Covers naloxone
- Pays for behavioral therapies
- Covers contingency management in some places

Why Should I Care About Medicaid?

- Can be a backbone of diversion, reentry and family preservation programs
  - Decreasing contact with punitive systems and the collateral consequences that come from that contact
  - Again, cost savings from these deep end systems (that are also rife with inequities)
- Fraud Story is just that: A Story
  - If you look at Congressional Budget Office Scoring (their scoring); vast amount of savings coming from more people being uninsured. Not from clawing back money from providers, from people losing access to their wellness which affects all aspects of their lives

Medicaid Financing

- Medicaid is an entitlement—anyone who is eligible can apply
  - Thus, eligibility rules are important; as is Medicaid expansion because increases eligibility
  - Barriers and hoops are important-especially when they are intentional
  - As opposed to grant funding, entitlements have a built-in sustainability feature
  - Important to note, there will not be an onslaught of grant funding when cuts occur
- Federal State Arrangement—Federal Medical Assistance Percentage (FMAP)—the share of money the federal government pays to the state for Medicaid (50%-76.9% Mississippi)
  - States with lower incomes get a higher match
  - Territories are not so lucky
  - Thus, if a State spends less—the federal government gives them less—so when the federal government makes it harder for states to pay full entitlement the feds “save” money, at the cost of wellness and lives which have rippling employment, education, child welfare and other consequences

What is Changing??? What Do I Need to Think About?

- **The HR 1 law is MORE than just the work requirements**
- Lots of people/organizations/systems talk about those so I will not, but bear in mind when a disease is stigmatized and/or if a person has a history of criminal legal involvement it is often more difficult to find employment; often made more complicated it is for a drug related offense
- **Eligibility Changes**—As this changes, those who had Medicaid no longer have it and will not have access to SU services. Remember though Medicaid is an entitlement, that depends on eligibility
  - Immigration status
  - Recertification changes
  - Look back period changes
- **Benefit packages** can change—At best of times SU services do not include the full range of evidence informed benefits, can not let any be removed!

Learn more: https://ccf.georgetown.edu/subtopic/work-reporting-requirements/
https://ccf.georgetown.edu/2026/07/16/new-federal-medicaid-work-reporting-requirements-rule-threatens-coverage-for-vulnerable-americans-an-explainer-of-the-interim-final-rule/

What is Changing??? What Do I Need to Think About?

Exemptions - Devil is in the Details for All People But Especially those who use substances!!

- Pregnant and postpartum
  - KEEP THE POSTPARTUM EXTENSION
  - In danger when state policymakers need to find money; less access to services can lead to increased punitive responses for those who use drugs
  - Miscarriages are VERY common but often criminalized with people who use substances. If had SU exemption and have miscarriage, are there unfair consequences?
- Medically Frail (people with “chronic” SUD)
  - Self attest first time then documentation at the 6-month recertification
  - What does this mean for someone with an SUD, what does it mean for someone with SU who is not interested in Medicaid billable treatment?
- Parents/Caregivers for children under 14
  - Great and still if known history of SUD from prior exemption what can that lead to?
  - Stigma and racism are pervasive in the punitive systems

What is Changing??? What Do I Need to Think About?

- Uninsured
- More uninsured will exist, challenging already limited resources
- Federally qualified health centers, community health centers (FQHC's) as back stop

  People read about the increase in FQHC funding and have decided that this will backfill all the cuts. In fact, as more people become uninsured because of lack of access to subsidies and ineligibility for Medicaid, those additional funds may hopefully just keep a semi-level playing field for access to PRIMARY care
- Certified community behavioral health clinics (CCBHC's) as back stop

  No, these are inextricably linked to Medicaid; they do not have bundles of extra money to care for uninsured
- Few of these limited grant funded public health SU systems will survive PH budget cuts, and there were never enough to begin with
- Few people can pay out of pocket for MOUD

What is Changing??? What Do I Need to Think About?

- Workforce
- Searching for Medicaid savings often leads to cuts in provider payments which often leads to fewer providers accepting Medicaid meaning longer waits and reduced access
- Even if every person with a SUD wanted access to a full continuum of culturally and linguistically effective SU services, there is no capacity.
- In addition, many current practitioners are aging out or leaving the field. The field's workforce needs to grow and reflect the populations it serves. However, there are more barriers than ever

What is Changing??? What Do I Need to Think About?

- Data
  - Need robust PRIVATE disaggregated data including but not limited to overdose rates
- How to decrease barriers and increase enrollment
  - States seeking to find already existing ways to prove eligibility; some sources being discussed include:
  - School attendance, incarceration release information, claims data
- Privacy
  - What do free flows of data mean in an era where harm reduction is not supported, SU is being more severely punished?

Medicaid's Role in Crisis

- **All of this history holds lessons learned on how to advocate** for services, how to do so in ways that mitigate instead of increasing harm, how to have the unseen seen, how to ensure data does not lead to increased "unexpected" harm, how to center those inequitably harmed and punished
- We need to **work with the health care and other systems** to implement these lessons during these times of enormous change.
- **Medicaid changed the reality for many, if it disappears, we are back where we were**, if it is changed without impacted voices, we are back where we are, if equitable outcomes are not a centerpiece, we are back where we are
- **NOT just increased overdoses, but increased HIV rates, Hepatitis C rates and other poor physical health outcomes for people who use drugs**, increase family separations, increased criminal legal exposure and consequences—increased harm and decreased wellbeing for people
- **Medicaid is not perfect, but IT MUST BE SAVED** in a thoughtful, expansive way while we can also build something even better. But lives DEPEND on its existence and for that reason we cannot allow the perfect to be the enemy of the good.
- **Still dream and build a new tomorrow** but ensure that as many people as possible can be a part of that tomorrow

THIS IS A LOT! I AM EXHAUSTED JUST LISTENING!

- These are exhausting times, Medicaid is just one piece of the picture
- Mix Medicaid with the executive orders, agency changes, food cuts, education cuts and there is lot going on (NOT just in the policy realm but in your and others real lives)
- You do not need to know all about Medicaid, you have ensure you know enough about you, your families, your clients need so you can offer input to those who are Medicaid 24/7
- Siloes must go, no way anyone can do this all alone; find your people-and you will need new people
- Find the opportunities if/where they exist
- Keep Creating and Dreaming on what could be even as you may have to just focus on mitigating harm for now

What You Can Do

- Find advocacy, health care systems or other groups in your area that are working on State Medicaid changes and are seated at policy tables\;
- Provide education (through stories, one pagers-however you feel comfortable) but also **offer to be their SU soundboard or give them a point person**. Many people have NO idea about the SU aspects of Medicaid or the hidden harms with business as usual
- Take others education/one-pagers (housing, health care, food benefits, employment) and begin **building relationships with partners that center you, your families**, your clients overall needs to cross education and be ready for the crisis but also to dream and begin building for the future

Listen to Mustn'ts

Listen to Mustn'ts, child, listen to the Don’ts.

Listen to the Shouldn'ts, the Impossibles, the Won’ts.

Listen to the Never Haves, then listen close to me.

Anything can happen, child,

Anything can be.

Shel Silverstein

Now let’s hear from our panel!