

Medicaid, Substance Use Disorder and the Critically Ill Patient

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Overview

Medicaid offered healthcare coverage plays an essential role in the Commonwealth- providing access to care for one in five Virginians. When Medicaid members face life threatening medical illness, they frequently receive care in intensive care units (ICUs) which offer advanced lifesaving technology. These members face a long road to recovery—one which may be complicated by substance use disorders.

This brief summarizes recent findings from research examining Virginia Medicaid’s coverage of critically ill adult patients ages 19-64, particularly those with substance use disorders, using data from both Virginia Medicaid claims and hospital discharge data from Virginia Health Information.

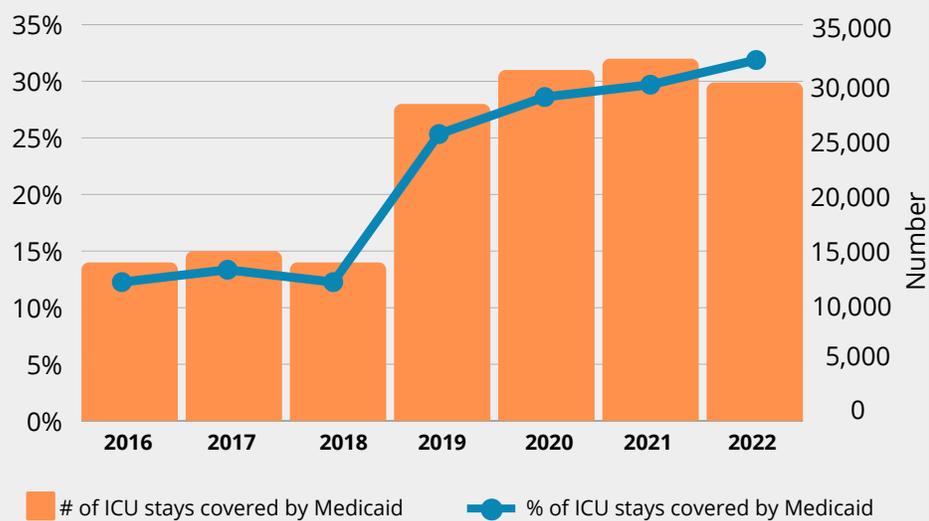
Key Findings

- Medicaid pays for 30% of ICU stays and a third of Medicaid readmissions are from ICU stays
- Substance use disorders are common among Medicaid members with an ICU stay- almost one in two members have a substance use disorder
- While opioid use disorders are common among those with ICU stays, these members are far less likely to receive both medications before and after their discharge than general Medicaid members
- Hospitalizations are a crucial opportunity to link Medicaid members to substance use disorder treatment

Medicaid’s Role in Caring for Critically Ill Patients

The share of Medicaid paid-ICU stays has risen dramatically with the expansion of Medicaid in Virginia. While 24% of Medicaid paid hospitalizations have an ICU stay, one-third of readmissions do. These patients are costly - 41% of hospital days and over 50% of charges for Medicaid-paid hospital stays are for members who spend time in the ICU. These members face a long road to recovery- over 50% experience new or worsening mental, cognitive or physical problems after discharge.¹

Medicaid Coverage of ICU Stays



Substance Use Disorders among Critically Ill Patients



1 in 2 ICU stays has a SUD diagnosis

Compared to all members, ICU stays are



4.2 times more likely to have any substance use disorder



6.7 times more likely to have alcohol use disorder



3.2 times more likely to have opioid use disorder

Almost one in two Medicaid members who are in the ICU have a substance use disorder diagnosis, with 24% having multiple substance use disorder. All types of substance use disorders, including alcohol, stimulants and opioids are far more common in the ICU than among general Medicaid members. This is true across age, gender, race/ethnicity, rurality and reason for Medicaid eligibility groups. Substance use disorders can impact care in the ICU in terms of managing pain and withdrawal as well as what happens to these members after they leave the hospital.² They may have less access to rehabilitative services and face challenges accessing needed follow-up care.^{3,4}

Missed Opportunities to Treat Medicaid members in the ICU with Substance Use Disorder

One in six Medicaid members with an ICU stay has an opioid use disorder, for which there are proven lifesaving treatment in the form of buprenorphine, methadone and naltrexone. Yet, less than 40% of members are on these medications before their ICU stay, compared to over 75% of general Medicaid members. Members are not being linked to care during their hospitalization: fewer than 7% of members are newly started on medication post-discharge. Importantly, hospitalizations represent a crucial time for treatment; models to provide substance use disorder care in the hospital are increasingly common. Expanding access to addiction treatment in hospitals may help improve both behavioral and physical health outcomes for these Medicaid members.⁵

Questions and Answers

How can we improve care for people with substance use disorder in the ICU?

Standardized protocols and strategies are needed to identify patients with substance use disorders and to ensure that their pain and any withdrawal symptoms are well managed. For patients already receiving treatment, continuing that in the hospital is crucial. For patients who are not actively in treatment, medication and psychosocial support as well counseling on harm reduction should be offered. Central to all efforts is to building trust and rapport with patients to reduce stigmatizing experiences.

What can we do to ensure the best possible care for this population afterwards?

Providing after care for physical and behavioral health needs, including substance use disorders is vital. Hospitals can help provide transitions to these sorts of services. Ideally, integrated models for behavioral and physical health may enable members to receive care all in one place.

References

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