Physician Leadership on National Drug Policy

Best Practices Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment

Initiated by Physician Leadership on National Drug Policy

WORK IN PROGRESS
A report of meeting discussion and policy recommendations

Friday, December 14, 2001
9:00 am - 4:00 pm

April 4, 2002

On December 14, 2001, the Physician Leadership on National Drug Policy sponsored a meeting at the Hall of the States in Washington, DC, entitled *Best Practices Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment.* PLNDP member Dr. Edward Brandt chaired the meeting funded by Robert Wood Johnson Foundation. The 23 participants included representatives from research, public health, policy, national organizations, and state agencies.

The need for this meeting arose from of a previous PLNDP briefing held in February, 2001, sponsored by the National Governors Association and the National Conference of State Legislatures, where there were many questions of how to address the needs of low-income substance abusers on the state level. This briefing in February provided the impetus for a PLNDP initiative and meeting reported here on providing access to substance abuse treatment for welfare and Medicaid recipients.

The meeting's objectives were to:

- Define the best practices for providing access to substance abuse treatment services for low-income populations.

- Identify model programs targeted at these populations and addressing such needs as how to develop and implement effective and cost-effective treatment models, how to incorporate screening mechanisms, and how to collect and quantify credible data.

- Identify policy barriers to providing TANF, Medicaid, and SSI-eligible populations with effective substance abuse treatment services, including those within other, related systems, such as the child welfare system.

- Review current evidence-based data on this subject.

- Define areas in which more research and focus is needed.

This “work-in-progress” report describes the meeting discussion and includes policy recommendations based on the participants’ suggestions. It is being circulated to the participants of the meeting, will be available nationwide to policymakers and is now available on the PLNDP web site (www.plndp.org).

In disseminating the report and policy recommendations, PLNDP will work collaboratively with national associations, including the American Public Human Services Association, National Governors Association, and National Conference of State Legislatures, to educate policymakers on the key priorities in this area. This will be particularly important as state and federal officials develop recommendations for the reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act.

I hope you find this material informative and if you have comments please do not hesitate to notify me.

Sincerely,

David C. Lewis

Best Practices Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment

December 14, 2001, at the Hall of the States, Washington, DC

Present: Edward N. Brandt (meeting facilitator), Sharon Amatetti, Sara Bachman, Victor Capoccia, Elena Carr, Finney Clarkson, Herman Diesenhaus, Arthur Evans, Roy Gabriel, Carolyn Holl, Nolan Jones, Jon Morgenstern, Mary Nakashian, Peggie Powers, Betsey Rosenbaum, David Rosenbloom, Gwen Rubinstein, Elaine Ryan, Phil Smith, Christa Sprinkle, Joy Wilson, and Wayne Wirta,
PLNDP Staff: David Lewis, Kathryn Cates-Wessel, and Kirsten Spalding.

INTRODUCTION

Substance abuse is a major national health problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addressing substance abuse among low-income populations is of utmost importance in the formation of Medicaid and welfare public policy, and specifically the reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act. Substance abuse has clear and serious effects on rates of welfare dependency and the length of time a family relies on welfare assistance. Estimates of substance abuse prevalence among welfare recipients range from 6.6 to 37 percent of the approximately 6.3 million TANF recipients**;** because substance abuse is misunderstood and under-diagnosed, it is difficult to determine accurate prevalence rates (Jayakody et al., 2000). However, it is clear that substance abuse is significantly more common among those on public assistance than those not receiving assistance and, furthermore, long-term welfare recipients are more likely to have substance abuse problems than short-term recipients (Olson and Pavetti, 1996). Substance abuse (including alcoholism, smoking, and drug addiction) has been associated with $172.1 billion in lost productivity, a loss greater than that for any other chronic behavioral health problem (National Institutes of Health, 1997). Studies suggest that chemical dependency is present in as many as 80 percent of all cases in the child welfare system (Young et al., 1998); this, in addition to the high rate of child welfare system involvement among welfare recipients, indicates the importance of this issue to the well being of children. Among children of substance abusers, the intergenerational risks for future substance abuse and welfare dependency are great. In fact, children of alcohol- and drug-dependent parents are up to four times more likely to develop substance abuse problems than children who do not have an alcohol- or other drug-dependent parent (Children of Addiction, 2002). Clearly, treatment improves outcomes for the individual, his/her children, and society. Treatment is both medically effective and cost-effective: societal cost savings per person per year total approximately $40,000 when drug addiction is treated, compared to when it is untreated (Institute of Medicine, 1996). Treating substance abuse problems among low-income individuals saves lives, families, jobs, and money.

There was consensus among the meeting participants regarding the key policy recommendations for addressing the substance abuse treatment needs of welfare and Medicaid recipients. The group agreed that many of the barriers to access stem from statutory limitations and a widespread lack of coordination and standardization in agencies, services, and practices. Of key importance, the participants felt, is the need for decreasing the stigma associated with addiction through education, and the implementation of programs and practices based on evidence-based data. The meeting participants suggested policy recommendations based on the day's discussion and their experience. The following policy recommendations represent those most frequently cited, as well as recurring themes within the meeting and the concerns of public officials with whom PLNDP has collaborated and consulted.

POLICY RECOMMENDATIONS

- Integrate substance abuse treatment and welfare/work by allowing treatment to qualify as a work activity under TANF, and training welfare caseworkers in identification and referral of substance abuse problems.

- Remove the prohibition in federal law under which TANF funds may not be used to pay for medical services, for the purpose of providing substance abuse treatment. Substance abuse is a key barrier to employment; removal of this limitation will assist states in removing barriers to employment.

- Remove substance abuse treatment from the IMD (Institutions of Mental Disease) Exclusion under Medicaid, to allow for greater capacity and cost-effectiveness of treatment.

- Increase Medicaid coverage of substance abuse treatment to a uniform benefit structure that supports an evidence-based continuum of care based on ASAM patient placement criteria.

- Attending to the need to reduce the risk of relapse, provide intensive and ongoing case management for welfare clients with substance abuse problems in order to address needed continuity of care.

- Identify areas where critical data for policymaking are lacking and provide support for research in these areas. Increase support for the evaluation of treatment modalities; use this information to implement evidence-based programs and practices that are effective, timely, and cost-effective.

- Increase integration of services and coordination among agencies on the federal, state, and local level, including welfare, child welfare, Medicaid, and substance abuse treatment agencies.

- Educate policymakers and welfare caseworkers on the nature of addiction and the effectiveness of treatment.

Immediate Action Steps

We recognize that limitations on public resources will make it difficult to move quickly to fully adopt practices and policies that will lead to a more comprehensive approach to treating low-income individuals for substance abuse problems. However, the following recommendations are actions that could be taken immediately to assist in the implementation of a policy initiative and promote better general understanding and practice in this area:

1. Operationalize and streamline administrative processes within Medicaid to increase accessibility of funds earmarked for early, periodic screening, diagnosis and treatment (EPSDT). EPSDT is an underutilized and poorly integrated, yet already established, funding source for children and adolescent (ages birth to 21 years old) health and mental health problems including substance abuse. There is also a need to increase awareness and provide education on how EPSDT works; doing so could significantly increase treatment access for low-income youth.

2. Establish within the Department of Health and Human Services (HHS) a Best Practices Institute for Low-Income Substance Abuse Treatment Programs. This could be included in the reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act. Major duties of the Institute would involve:
    a) sponsoring research projects designed to collect and disseminate information on program models which effectively treat low-income individuals with substance abuse problems;
    b) providing training opportunities for state and local officials to gain knowledge on the provision of substance abuse services to welfare recipients;
    c) increasing public awareness of the need for and value of effective treatment strategies;
    d) developing and maintaining a central warehouse or library of evidence-based screening tools for use in state and local programs.

3. Create an intergovernmental task force within HHS to be specifically charged with the responsibility of identifying policy barriers that prevent the use of the most effective treatment strategies for low-income individuals with substance abuse. State and local officials, researchers, and practitioners should be included in the task force.

4. Finance demonstration projects that will validate and promote more effective service delivery models (such as moving towards a case management approach to providing treatment for welfare recipients).

5. Provide financial incentives and waiver authority for states choosing to adopt comprehensive policies and practices designed to serve welfare recipients with substance abuse problems.

BACKGROUND BASED ON MEETING DISCUSSION

Temporary Assistance to Needy Families (TANF)

When Temporary Assistance to Needy Families (TANF) replaced the old welfare system in 1996, the number of individuals receiving public assistance declined greatly; however, research suggests that, among TANF recipients, having a substance abuse problem is a strong predictor of ongoing unemployment and is one of the most serious barriers to self-sufficiency and return to the workforce. Medicaid and welfare recipients with substance abuse problems typically have very high levels of co-occurring problems, in particular, mental illness and involvement with the child welfare system. Their access to substance abuse treatment is severely limited by compounding factors including financial pressures and lack of adequate housing, transportation, and childcare.

In initially identifying welfare recipients with addictions, several fundamental problems exist: TANF caseworkers are often untrained in screening and referral for substance abuse and have pre-existing biases about addiction as a disease; many states' welfare agencies do not use a standardized screening instrument or set of behavioral standards; systems of identification relying on self-stated use generally yield quite low identification rates; and caseworkers often have no leverage for getting a client into treatment because treatment is entirely voluntary. Many individuals, although positively identified as having a substance abuse problem, never obtain treatment. Some states have addressed these issues through training, the use of specific screening instruments and behavioral standards, the co-location of substance abuse health care professionals (or care coordinators) at welfare agencies, and intensive and ongoing case management of positively screened clients; other states, however, have not addressed these issues.

One state, in particular, is working to improve its approach: in New Jersey, care coordinators are highly trained individuals who provide intensive and ongoing case management of welfare clients with substance abuse problems, moving them through the treatment system. In the New Jersey Substance Abuse Research Demonstration project, the effectiveness of intensive case management was compared to a system where clients only received a referral to treatment. Overall, intensive case management doubled to tripled rates of treatment retention. In a separate study, CASAWORKS, a national demonstration program for substance abusing women on welfare, also employed intensive case management. Clients in CASAWORKS had dramatic reductions in substance use and increases in employment from the time of program entry to 12 months. Clearly, a simple referral to treatment is not enough; the group's consensus was that case management is necessary.

Because substance abuse treatment is a means of achieving self-sufficiency for this population, integrating work and treatment and, more specifically, allowing treatment to count as a work activity under TANF requirements, is important, as indicated by the participants. The welfare and treatment systems need a better understanding of one another and need to be joint stakeholders in programmatic outcomes. The philosophy of many programs, including CASAWORKS, is that work is treatment and treatment is work. Work issues must be addressed early in the treatment process, and ongoing income assistance must be provided for families

undergoing treatment. Relapse is recognized and understood within the treatment system; however, it is not recognized in welfare and employment, where people are likely to "relapse" on and off of welfare/employment. The chronicity of addiction needs to be addressed by introducing the concept of phased or graduated employment activities (i.e. part-time work eventually leading to full-time work). In addition, identifying timely treatment modalities is of great importance to TANF because of limits on the amount of time a family can spend on public assistance.

The immediacy of welfare politics and budget issues pose challenges to the goal of successful substance abuse treatment. Treating a person and continuing his/her welfare benefits increases the caseload. Plus, while there are financial bonuses for states that significantly decrease their numbers of welfare recipients through employment and that have high work participation rates, there are no bonuses for getting substance abusers into treatment. It seems that financial incentives are necessary to encourage states to address substance abuse in their TANF programs.

Medicaid and Funding of Treatment

Research has proven the effectiveness of treatment, yet Medicaid benefits are determined by individual states, and coverage of treatment services is either absent or very limited. Because of this lack of treatment options and the insufficient capacity of the public treatment system, the "continuum of care" is not appropriately supported. In addition, the inappropriate level or type of treatment is often provided; resulting in higher-than-necessary treatment costs and increased relapse rates. The current Medicaid system is overly focused on hospitals when, in fact, other primary care treatment settings are much more cost-effective than long-term hospital care. It was agreed that access to quality treatment and parity should be applied to public insurance.

Established in 1966 to prevent Medicaid from paying for long-term custodial care, the IMD (Institutions of Mental Disease) Exclusion prohibits Medicaid reimbursement of any services delivered in an institution with more than 16 beds that treats "mental diseases." Because addictions are considered "mental diseases," this has largely prevented the provision of residential substance abuse treatment for Medicaid recipients. All participants agreed that removing substance abuse treatment from the IMD Exclusion is necessary, as it would allow for a considerably greater capacity and cost-effectiveness of treatment. However, simply removing the IMD Exclusion would not enable Medicaid to pay for substance abuse treatment in its entirety, as financial constraints will remain.

According to meeting participants, it is clear that funding of public substance abuse treatment is very fragmented; each individual funding stream is narrow in what it can and cannot pay for, making treatment dollars difficult to manage. The level of funding is, also, insufficient, and treatment providers are forced to work with very limited resources. Although successfully treating substance abuse results in huge cost savings to society, those savings generally do not apply to any one state's or organization's annual budget. There is an obvious need for increased resources, as well as making funding streams more flexible and better integrated across systems. The current economic downturn and widespread cutting of appropriations, which is more dramatic at the state level, will make this difficult.

An example of a poorly integrated and underutilized funding source is Medicaid's early, periodic screening, diagnosis and treatment (EPSDT). Under EPSDT, states are required to provide any medically necessary service to children and adolescents, whether or not it is a benefit under a state's Medicaid plan. This includes any substance abuse treatment determined by a physician to be necessary. EPSDT is underutilized, and could significantly increase treatment availability for low-income youth if awareness about how EPSDT works was raised. Several meeting participants cited the need for increased utilization of EPSDT.

The largest payer of public treatment in the U.S. is the Substance Abuse Prevention and Treatment Block Grant. In many states, this block grant money is being rolled into Medicaid-funded behavioral health carve-outs. Because carve-outs primarily focus on mental health services, this has resulted in a shift where substance abuse treatment providers are increasingly working as mental health providers, and mental health standards are being inappropriately applied to substance abuse. Substance abuse treatment is being pushed "out of business" because the proportion of dollars given to mental health treatment is much greater.

Although the increasing placement of Medicaid recipients in managed care plans is commonly viewed as negative, access to substance abuse treatment has, in fact, increased dramatically under the Oregon Health Plan. In 1995, a statewide mandate placed Oregon's entire Medicaid population in managed care, and the percentage of Medicaid enrollees receiving substance abuse treatment more than doubled. Thus, managed care can be a means of improving treatment access when it is carefully implemented.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) recipients, who qualify for public assistance because of a physical, cognitive, or mental health disability, are increasingly being placed in Medicaid managed care plans. In addition to the great variation in covered services, the complex treatment needs of the SSI-Disabled are generally not addressed by these plans, and states do not design treatment programs with the physical, communication, and attitudinal barriers faced by this population in mind. Using managed care to more creatively address their needs is particularly important because the prevalence, severity, and costs of substance abuse among the SSI-Disabled are disproportionately high.

Child Welfare System

Families on TANF with substance abuse problems often have very high levels of involvement with the child welfare system. An example, from the New Jersey Substance Abuse Research Demonstration project, found that 84% of substance abusing women on TANF had been referred to a child welfare agency at some point. Nationally, studies suggest that chemical dependency is present in as many as 80 percent of all cases in the child welfare system (Young et al., 1998). Interestingly, some areas are using involvement in the child welfare system as a marker that a client may have a substance abuse problem, given the high prevalence of substance abuse in child welfare cases. Identifying timely and effective treatment modalities is of key importance for this population; when a child is removed from his/her home, the child welfare agency has a window of just 15 months to establish a permanency plan for the child. This is a very short

timeframe for parents with substance abuse problems to receive treatment. Furthermore, parents are denied Medicaid benefits when their children are removed from the home, further limiting their access to treatment. Not surprisingly, parents' fear of identification by the child welfare system often prevents them from obtaining treatment. It was suggested that additional emphasis on absentee fathers, many of whom have addictions of their own, and on stabilization of families is needed.

Cross-System Collaboration

Collaboration among agencies is of critical importance, all agreed, to better serve low-income substance abusers – in particular, communication and coordination of services among substance abuse, welfare, child welfare, Medicaid, and workforce development agencies. Such integration needs to occur on the federal level as well as at the state and local level. Patients should be assessed and treated holistically, from a cross-program perspective, and multiple systems need to be accountable for overall family outcomes. Standardization is also clearly lacking in the current system – in performance measures for treatment, in paying for care, and in using treatments with proven effectiveness.

Providing Effective Treatment

Quite often, patients are given the incorrect type or inadequate length of treatment. If treatment is inadequate, we cannot expect people to get better. Standardized systems of determining appropriate levels of care were recommended, such as the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. In New Jersey, where treatment recommendations are based solely on ASAM criteria, more units of service became available when levels of care were appropriately shifted. An example of this is mixing and matching treatment modalities, such as including methadone with other treatments. A continuum of care and providing the correct level of care is important and can be a means of improving cost-effectiveness and effectiveness of treatment.

Providing treatment that is specific to the populations being served – particularly gender-specific treatment – has a major impact on the success of treatment. Moreover, providing the "wrap-around" services that are necessary to recovery, such as childcare, transportation, and housing, is critical and its efficacy in treatment programs has been demonstrated.

Education and Research

Overall, the participants were in agreement that many of the issues associated with substance abuse and welfare/Medicaid can be attributed to a lack of knowledge regarding what addiction is and the effectiveness of treatment. Addiction must be recognized as an illness rather than a volitional behavior. Educating policymakers, welfare caseworkers, and treatment providers on the nature of addiction and the effectiveness of treatment is of utmost importance.

Research has clearly proven the effectiveness and cost-effectiveness of various forms of treatment, yet evidence-based programs and practices are rarely implemented in treatment programs around the nation. An emphasis on research and the dissemination of information

about treatment effectiveness and cost-effectiveness, and translating evidence-based data into practice, is critical, particularly in treating hard-to-serve individuals with multiple barriers to recovery and self-sufficiency.

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December 14, 2001
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