

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

05-Dec-1996 05:31pm

TO: Molly Brostrom
FROM: Lahoma Romocki
AIDS Policy Council
CC: Patsy Fleming
SUBJECT: Treatment numbers

Molly,

Per your request for information on treatment dollars:

Patsy asked me to convey to you the need for an increase in funds for treatment. She is not proposing any specific amount.

The numbers we received from SAMHSA last week on Substance Abuse Treatment Numbers were:

Total population Needing Treatment:	11,960,951
IVDUs Needing Treatment:	1,527,643
IVDUs Seeking Treatment:	190,422
Women Needing Treatment:	4,145,571
Women Seeking Treatment:	1,057,423

My contacts at SAMHSA are Dr. Cynthia Prather and Adolfo Mata. Cynthia can be reached at 301-443-4969. Adolfo's number is 301-443-8461.

THE WHITE HOUSE

WASHINGTON

October 29, 1996

MEMORANDUM FOR CAROL RASCO

From: Janet Abrams

RE: **Federal Support for Substance Abusers**

Changes in public assistance programs made over recent months have created serious new challenges for low-income individuals with drug and alcohol addictions. Below is a summary of those changes, plus an inventory of federal programs which do provide support.

WELFARE REFORM

- The welfare reform bill requires all recipients to join the workforce, but a significant number of these individuals have serious addictions which may prohibit them from functioning effectively in jobs or training programs.
 - HHS estimates that at least 15% of women currently receiving AFDC have substance abuse problems likely to impair their ability to participate in the workforce.
 - The majority of these women do not get treatment for their addictions.
- The bill provides tools to punish individuals with substance abuse problems but offers relatively few new resources for treatment.

Provisions which penalize:

- The bill states that federal law will not prohibit states from drug testing welfare recipients or from sanctioning those individuals who test positive.
- *Grammar amend't:* Anyone convicted of a drug-related felony after the date of the bill's enactment will be banned from ever receiving cash assistance or food stamps. States can pass laws to opt out of this provision or to change the length of the ban.
- Legal immigrants with substance abuse problems will no longer have access to the drug treatment for which Medicaid pays. The bill ended federal Medicaid payments for legal immigrants, allowing states the option of providing Medicaid for those in the U.S. before 8/22/96.

= Child Welfare/Foster Care impact

Resources for addressing substance abuse problems:

- States have the option to use some of the federal monies intended to support individuals as they move into the workforce (to cover costs such as childcare) for substance abuse treatment. There will, of course, be many competing demands on these funds.

primarily where it will go?

A number of states that have offered drug treatment to AFDC recipients in an effort to prepare them for work report positive outcomes, e.g. Oregon and Utah have for several years been providing drug treatment to AFDC recipients under welfare waivers. For additional information on experience at the state-level, please see attached document, *Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform*.

CHANGES IN SUPPLEMENTAL SECURITY INCOME (SSI) AND SOCIAL SECURITY DISABILITY INSURANCE (SSDI) PROGRAMS

- Benefits for individuals currently disabled with substance abuse problems are eroding, and the federal structure for requiring treatment is being dismantled.
- Roughly 18 months ago, Congress took action in response to public outcry about the revelation that many substance abusers receiving SSI/SSDI assistance were using their monthly checks to finance their addictions. New rules were implemented limiting benefits to substance abusers to 3 years and requiring all individuals to go through treatment. A monitoring system of RMAs (Referral & Monitoring Agencies) was established to assure participation in treatment programs.
- More severe steps were taken in legislation enacted March 29, 1996: Provision was made to terminate all SSI and SSDI benefits for individuals coded as drug abusers/alcoholics (DA&A) as of January 1997. There are approximately 190 thousand people in this category.
 - It is estimated that 25% of individuals now receiving SSI and SSDI coded as DA&A will lose their cash assistance. 75% of the group is expected to requalify under another category.
 - This summer, all beneficiaries were sent notices of the impending discontinuation of benefits and were offered the opportunity to requalify under another disability category. So far half the beneficiary population has responded. Just over half of these people have been granted benefits under a different category; those turned down can appeal.
 - The people likely to be cut off from SSI benefits are concentrated in a small number of states. More than half of all individuals coded DA&A live in CA, IL, MI & NY. One explanation: In Illinois & Michigan, the

*when only 25% requalifying?

states cancelled their general assistance programs for the poor and tapped heavily into SSI.

- Since SSI is a categorical eligibility for the Medicaid program, loss of SSI may result in loss of Medicaid benefits for some. Medicaid has paid for these people's substance abuse treatment in the past. Females dropped from the SSI roles may hold onto their Medicaid benefits because they can qualify for AFDC.
- The March '96 legislation also lifted the requirement that substance abusers receiving SSI/SSDI must participate in addiction treatment. Now, those who will requalify under a different category (and certainly those dropped from the roles altogether) will be liberated from the pressure by Uncle Sam to seek professional help.
- With the treatment requirement lifted, the Social Security Administration is discontinuing its contracts with the RMAs which worked at the state level to enroll beneficiaries in appropriate treatment programs and monitor compliance. The state substance abuse program directors argue that Social Security should maintain the RMAs because so many on the SSI/SSDI rolls will continue to have substance abuse problems. Social Security says there is no point in the federal government spending money to monitor participation in drug treatment without any sanctions at its disposal. (Savings from discontinuing RMAs in FY97 equal \$200 million.)

*SSA says they're
benefit agency,
not state*

THE MOST VULNERABLE GROUPS

The changes outlined above put many individuals with drug and alcohol problems at significant risk of losing cash assistance for subsistence and/or access to medical care. The most vulnerable include:

- Women with substance abuse problems now on AFDC who do not get the treatment they need and are unable to meet their state's work requirements ... and their children.
- The estimated 25% of SSI & SSDI beneficiaries now coded as DA&A who will not requalify under another disability category. Many of these individuals (primarily men) will also lose their Medicaid coverage.

WHAT THE FEDERAL GOVERNMENT DOES OFFER SUBSTANCE ABUSERS

Of the Administration's \$15-billion budget for drug control efforts, roughly \$5 billion will be spent this year on "demand reduction" activities. 60% of the \$5 billion will pay for treatment; 40% will fund prevention efforts.

Below is a listing, by Department, of initiatives which help individuals with drug and alcohol problems. Please refer to the attached document, *The National Drug Control Strategy, 1996: Program, Resources and Evaluation*, for further detail.

Agriculture

- The WIC program, acting through state agencies, provides drug abuse prevention information to beneficiaries and refers individuals, when appropriate, to alcohol and drug abuse treatment. On average, WIC local agencies refer 10% of its women participants. This would equal 160,000 women in 1996. Approximate FY97 expenditure on prevention and referral activities will be \$15 million.
- The Food Stamp program, which provides no special assistance to substance abusers, is expected to provide an additional \$4 million in the coming year in benefits to those individuals dropped from SSI and SSDI rolls.

Defense

- DOD will spend \$84 million on demand reduction activities within the Armed Forces. The Department funds programs for the early identification and treatment of drug abusers within the Armed Forces and supports National Guard state demand reduction plans. DOD conducts random drug testing of active duty military, selected civilian employees, and national guard/reserves, plus drug education, prevention, and selected treatment programs directed at employees, family members, and their communities.

Education

- The Office of Elementary and Secondary Education will spend \$515 million for Safe and Drug-Free Schools and Communities State Grants and \$25 million on Safe and Drug-Free Schools and Communities National Programs.
- The Office of Special Education and Rehabilitative Research Services will spend \$116 million on drug-related treatment and treatment research costs. \$83 million of this total will be used for VR State grants to benefit drug-dependent individuals whose disabilities result in substantial impediment to employment. The balance includes funding for research into vocational rehabilitation for persons whose disability is drug dependency through the National Institute on Disability and Rehabilitation Research, Grants for Infants and Families, and drug-related activities under Special Education Support and Improvement.

Health and Human Services

- **Administration for Children and Families**

- ACF will spend \$82 million on drug-related prevention and treatment activities. Funds under the Consolidated Runaway and Homeless Youth program, the Youth Gang/Youth Initiative Program, the Community Schools Youth Services program, and 1/2 of the budget of the Abandoned Infants Program are used for drug related prevention activities. Funds under the Community-Based Resource Centers program, the Temporary Child Care/Crisis Nurseries program, and the other half of the budget of the Abandoned Infants Assistance program support treatment approaches for drug-exposed infants with special focus on problems of abandoned babies, babies born to crack-cocaine-using mothers, and children who have been abused or neglected by drug-using parents.

- **Centers for Disease Control and Prevention**

- CDC will allocate \$61 million to state and local health departments for the prevention of HIV infection among drug users.

- **Food and Drug Administration**

- FDA is working with NIH to expedite development of dependency-reducing drugs, with the aim of reducing illicit drug use and reducing the spread of AIDS. The agency also reviews all applications for narcotic addiction treatment programs and monitors the programs' compliance with federal standards; it will spend \$6.8 million on these monitoring activities in FY97.

- **Health Care Financing Administration**

- Medicaid-eligible individuals requiring drug abuse treatment can receive all necessary inpatient, outpatient, and physician services. (The one significant limitation on Medicaid coverage in this area is that the program will not pay for recipients aged 22-64 to be treated in large inpatient psychiatric facilities.)
- Medicare covers inpatient hospital treatment and necessary services in outpatient settings.
- In FY97, HCFA will spend approximately \$260 million for direct drug treatment program costs under Medicaid and \$60 million under Medicare.

- **Health Resources and Services Administration**

- HRSA will use \$43 million (which equals 6% of the total appropriated for Titles I, II, & III of the Ryan White Act) for the direct health care of persons with HIV/AIDS in substance abuse treatment settings.

- **Indian Health Service**

- The agency will spend \$42 million on substance abuse treatment and prevention services.

- **National Institutes of Health**

- The National Institute on Drug Abuse (NIDA) conducts research on the causes, consequences, prevention and treatment of drug abuse and addiction, as well as its behavioral biological and social bases. NIDA will spend \$489 million in FY97.
- The National Institute on Alcohol Abuse & Alcoholism also supports significant research. FY97 budget is \$212 million.

what are they finding?

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**

- SAMHSA provides the Substance Abuse Block Grant to the states for use in providing services to individuals with drug and alcohol problems. For FY97, the grant will be \$1.3 billion, almost \$100 million greater than last year's appropriation. In addition, the legislation which ended SSI & SSDI eligibility for people coded DA&A provided \$50M in both FY97 and FY98 to bolster state and local treatment efforts. This amount is being added to the Block Grant.
- The Mental Health Services Block Grant allocated by SAMHSA also supports communities in caring for individuals with addictions -- given that mental health difficulties are so often linked with substance abuse. This year, \$275 million will go out to the states through this mechanism.

Housing and Urban Development

- HUD's Drug Elimination Grant program provides funds to mobilize communities living in public housing against drug abuse. While the focus of this initiative is to increase the security of public housing by ridding drug dealers from the premises, funds can also be used for innovative drug education and treatment, counseling, referral, and outreach efforts to reduce the use of drugs in and around public housing projects. Approximately \$290 million will be awarded to public housing authorities this year.

Bureau of Prisons

- It is estimated that 30% of the inmates are drug-dependent and require treatment. The Bureau of Prisons will spend \$2 billion on drug-related activities within the federal prison system in FY97. (This figure includes hefty salary and facility expenses.)

Veterans Affairs

- The VA provides treatment and rehabilitation services to veterans with drug abuse and drug dependency disorders. The largest addiction treatment provider in the federal government, the VA will spend over \$1 billion on targeted drug treatment programs and on medical costs related to addiction in the coming year. Over 175 thousand veterans, most of whom qualify as indigent, are now receiving substance abuse services, which range from inpatient care to outpatient support at the Department's Methadone clinics.

Attachments

- *Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform*,
Office of National Drug Control Policy
- *The National Drug Control Strategy, 1996: Program, Resources, and Evaluation*,
Substance Abuse and Mental Health Services Administration

TO: CHR
CC: JBA, ED
FR: MBB

Jim Brown
56643

Commit to ↑ spending on drug treatment

1) Nat'l Drug Strategy

2) AIDS Strategy

7 Budget Summary
75th A.

OMB signed off on commitment
John Rice 5-6736/5-6791

I want to give you a heads up on some of the budget flags in my areas. I'm not sure how to react to many of them -- the proposals aren't ideal and won't be received happily, but I'm not sure how to assess in horrific budget environment. I raise them mostly as FYIs, but also for any thoughts on whether or not to pursue with OMB.

(OMB proposal followed by my comments)

VA. 5% reduction, including in medical care; \$300 million addback needed to avoid closing hospitals

On one hand, why take the political heat when it seems inevitable what the outcome will be? On the other, if we are serious about balanced budget, cuts will have to come somewhere...

Passing back a 5% cut seems to be asking for trouble with Sec. Brown; with significant prep from WH officials, Brown could perhaps be persuaded to live with a flat-line. POTUS decision eventually I assume.

HUD. Very grim. In public and assisted housing, are considering another reinvention proposal that would block grant the funding to states and localities -- yes, seemingly the same reinvention that we got skewered by the outside world for in 95. But the alternative of keeping the programs the same has very ugly cut options for reaching their target -- e.g. reducing elderly stock by 1/2, raising the rent contribution from 30 to 31%, freezing public housing subsidies. Raines reportedly favors the block granting; OMB has said they will work with us in developing the proposal.

5% cut to community and economic development programs.

Homeless assistance fund would remain at 97 level of \$823 million (we'd hoped for an increase back to \$1.12 level of 95; but in BB environment, I think have to be happy with level funding). HOPWA at FY 97 enacted level; with \$19 million possible addback (I let Jeff know).

Substance Abuse/SAMSHA. FY 97 \$2.135B, FY 98 proposal \$2.131; \$20 million possible addback.

SAMSHA ended up receiving \$37M more than we requested in 97--\$100M over 96, so they're doing pretty well. The proposal includes the \$50 M that was authorized along with the SSI DA&A changes, and OMB is planning to stipulate that it all be used for treatment. SAMSHA funds, as you know, go to states in a block grant, with some set-asides (e.g. percentage for prevention, treatment, etc.).

This funding may slightly help address concerns about the need for increased s.a. treatment given SSI and welfare reform changes. But I'm not sure how much of this funding gets to the populations primarily affected by these changes. Homeless advocates say that state programs don't generally reach out to the homeless. They are concerned about need for more treatment dollars for homeless/those impacted by SSI.

SCSEP(Senior Community Service Employment Program--Title V of Older Americans Act). 5% reduction (\$463/440 million to \$413M). \$27 million possible addback which would allow program to continue at current service levels.

In reauthorization and budget debates, we have opposed changes and cuts to program. Advocacy groups (NCSC in particular) strongly support. Congress gave \$100 million extra to the program in FY 97. Ken leaning toward addback; is aware of OPL and our past support.

TEFAP. Zero out; possible \$40M addback. (\$90M in FY 97)

USDA Food and Consumer Service program. TEFAP consists of: 1) commodity purchases (into which commodity purchases for soup kitchens has been folded; and 2) Administrative funds for Food Banks.

Welfare reform included a \$100 million pot of mandatory spending for commodity purchases (a Rep. Emerson proposal that we initially proposed based on argument that takes away from Food Stamps; as he became sick, became non-negotiable). Thus, in FY 97, TEFAP essentially received \$190M in total funding (\$100 M mandatory, \$90 M discretionary).

Proposal would zero out TEFAP funding, and include appropriations language that would require that \$40 million of new \$100M commodity pot be used for Food Bank administration. OR, would addback \$40M for administration. OMB argument: every dollar add back reduces what's available for Food Stamps.

OMB (Stacey Dean) doesn't think the appropriators will oppose cut (on behalf of now deceased Rep. Emerson).

Over the past few years, the Administration has been reducing TEFAP as private contributions have gone up.

SSA. 5% reduction.

Given all of changes SSA trying to deal with, likely to increase processing times, backlogs. FR apparently believes will force innovation.

I hope this isn't too much information with few recommendations, but I wanted to get this background around before I head off (to CA for my sister's wedding). I'll be back Monday if

*Radio
Address:
Cleaning
1800 # +
Citizens Recovery*

there are questions, follow up I can do then.

12/3

RMAs / SSI DATA

SSA Gen'l Counsel says no legal auth to continue RMAs

RMAs - just referring + monitoring, not treatment - no new slots
- experience shows that not successful

7 states ^{who are/were contractors} are sending letters

200,000

~100,000 appealed $\Rightarrow$ estimating 75-80% will be re-eligible
57% haven't

SSI DATA

207,000

189,000 referred

57,000 Treatment

75% alcoholics

25% drug use

2 Populations:

- Ref payees continue
- refer to states

- 1) those who will continue on SSI
- how to ensure they don't squander checks
- 2) those cut-off
- \$50 M SAMSHA

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

18-Sep-1996 11:27am

TO: RASCO_C
FROM: Skila S. Harris

SUBJECT: Please Advise

Message Creation Date was at 18-SEP-1996 11:27:00

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) says the state directors are reeling from the recent Congressional action and are looking for ways to salvage bits and pieces of the SSDI & SSI programs. At a minimum they are hoping to maintain the State Referral and Monitoring Agencies (RMA's) operated by Social Security. The elimination of the RMA evidently is a administrative decision made by Social Security and not part of the legislation. However it is a budget issue.

Since the safeguards once associated with the drug and alcohol addicted beneficiaries are no longer are part of the program -- requiring Representative Payees or the requirement to enter treatment -- NASADAD wants to make sure that the RMA still exist to make referrals to appropriate treatment and to monitor care.

They have two strong points:

* Under the new law those eligible for benefits will not only have a drug and alcohol problem but will qualify as the result of other serious physical or emotional disabilities. The complexity of the individuals' needs requires the kind of supervision offered by the RMAs.

* Because of there is no longer a automatic termination after three years and no treatment requirement, there is potential that without the involvement of the RMAs, benefices will continue receiving benefits indefinitely.

Evidently, Social Security sees itself as a payor not an agency responsible for programs that might move individuals off its roles. Also, the RMA's were created by the Cohen amendment in 1994 in reaction to abuse in the system. It is my understanding that no other category of beneficiaries has anything approaching this "case management" approach.

I don't know how to begin to see if Social Security has looked at this closely and if it is appropriate for me to even inquire. Please let me know whether you think I should pursue this and if yes, what I should do.

Let me tell you the bit I've learned about s.a. treatment at the VA, and then you can let me know what/if anything you need further.

Substance abuse treatment is provided to any veteran who is eligible for VA medical care (essentially, the low-income or service-connected disabled).

The VA is the biggest s.a. treatment provider in the federal government. They have a wide variety of types of facilities -- from inpatient to Methadone centers.

At the end of 1995, the VA was serving 55,000 veterans in inpatient care, and 128,000 in outpatient care. It's estimated that over 90% of these patients are eligible because of indigency.

Eligibility for VA care is not expected to change as a result of the recent welfare/ssi changes (one small impact may be on non-citizen immigrants such as Filippino veterans).

let me know if you have questions/need more info.

----- BOTTOM -----

Press RETURN to continue, GOLD MENU for options or EXIT to cancel

----- TOP -----

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Oct-1996 12:33pm

TO: Janet B. Abrams

FROM: Molly Brostrom
 Domestic Policy Council

SUBJECT: substance abuse treatment and VA

Let me tell you the bit I've learned about s.a. treatment at the VA, and then you can let me know what/if anything you need further.

Substance abuse treatment is provided to any veteran who is

Press RETURN to continue, GOLD MENU for options or EXIT to cancel

DRUG ADDICTION and/or ALCOHOLISM (DAA) and REFERRAL and MONITORING AGENCIES (RMAs)

Background

When the SSI program was established in 1974, Congress expressed concern that alcoholics and addicts might use the cash assistance of SSI to support their alcoholism or addiction rather than for the purpose for which it was provided. As a result, Congress required that SSI payments in such cases be made to representative payees and that recipients undergo available treatment to aid in their recovery and rehabilitation. The *Social Security Independence and Program Improvements Act of 1994* extended representative payee and treatment requirements to Social Security Disability Insurance (SSDI) beneficiaries and included new restrictions on benefit payments to SSI and SSDI beneficiaries. In addition, the legislation required that SSA establish RMAs in each State.

RMA Responsibilities

Current RMA responsibilities include:

- determining if appropriate treatment is available;
- referring beneficiaries to treatment;
- monitoring progress under treatment plans; and
- reporting to SSA if a beneficiary is not in compliance with the treatment requirement.

RMA Referrals and Success Rates

As of August 1996, about 50,000 beneficiaries were in treatment, with another 72,000 either referred to treatment or awaiting referral. During the 12-month period ending August 1996, almost 75,000 referred cases were closed. About 60 percent were closed due to non-compliance (for which benefits are suspended), while a little over 5 percent were closed due to successful treatment. RMAs consider treatment successful if the beneficiary completed the plan of treatment. It does not mean the beneficiary left the rolls and entered the workforce.

1996 Legislation Ending DAA Benefits and RMA Phase-out

The *Contract With America Advancement Act of 1996* (P.L. 104-121) was enacted March 29, 1996. Among other things it prohibits benefits to beneficiaries whose drug addiction and/or alcoholism is a contributing factor material to the finding of disability. Therefore, effective January 1, 1997, we will no longer pay benefits to these individuals. Also, the legislation specifically eliminates the statutory requirements to:

- refer DAA beneficiaries for treatment and to monitor the DAA beneficiaries' compliance with treatment;
- impose sanctions against beneficiaries who refuse or fail to comply with treatment; and
- mandate that beneficiaries exhibit progress in treatment.

To phase out RMA contracts, SSA is exercising a "termination of convenience." After RMA contractors submit costs they have incurred up to the termination date of the contract, contractors and SSA will negotiate and settle on compensation due.

The legislation continues the representative payee requirements for DI or SSI beneficiaries who are incapable of managing benefits and who have a DAA "condition" as determined by the Commissioner. These are individuals who have been found disabled based on the severity of an impairment independent of DAA, but who also have a DAA "condition." (In other words, the DAA condition is not material to the disability finding.) SSA must refer these individuals to the appropriate State agency for treatment.

Discussion

SSA does not monitor the behavior of non-DAA beneficiaries and does not send them to treatment of any kind. Absent specific statutory authority, singling out persons with a DAA condition for such government interference, however well meaning, could open SSA to serious criticism and potential litigation. Furthermore, referral and monitoring would serve little purpose without the authority to suspend benefits for failing to comply with treatment.

The costs to SSA of RMA services--about \$928 million through FY 2000--cannot be justified given that the functions RMAs currently perform for SSA have been eliminated by the latest legislation. Congress has appropriated no funds for this purpose, and SSA operations would be adversely impacted. Diverting funds to the RMAs could prevent SSA from carrying out current statutory mandates.

OCT-23-52 17:47 FROM: CBO/BAD/HRCEU

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CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

October 20, 1995

Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office (CBO) has prepared the attached tables displaying the cost estimate for the reconciliation language (Subtitles C-J) approved by the Senate Committee on Finance on September 29, 1995.

The estimate shows the budgetary effects of the committee's proposals over the 1996-2002 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution.

This estimate assumes the reconciliation bill will be enacted by November 15, 1995; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

A handwritten signature in cursive script that reads "June E. O'Neill".

June E. O'Neill

Enclosure

cc: Honorable Daniel Patrick Moynihan
Ranking Minority Member

Estimating the number of DA&As who already have or will soon develop another disabling condition is a thorny issue. A sample of 1994 awards with a primary diagnosis of substance abuse found that two-thirds identified a secondary disabling condition (predominantly mental rather than physical). That fact must be interpreted with caution. In order to be worth noting, the secondary condition must be quite severe—but not necessarily disabling in its own right. On the other hand, there is no requirement to record secondary conditions; some of the one-third for whom none was recorded undoubtedly had them. And the health of many DA&A recipients certainly deteriorates over time, with or without continued substance abuse. Thus, CBO assumes that only about one-quarter of DA&A recipients would be permanently terminated from the program; the rest could requalify by documenting that they have another sufficiently disabling condition. Multiplying the number of recipients terminated times an average benefit yields savings of \$200 million to \$300 million a year in SSI benefits beginning in 1996.

Besides saving on benefits, the Social Security Administration would also be freed from the requirement to maintain contracts with referral and monitoring agencies (RMAs) for its SSI recipients. Those agencies monitor addicts' and alcoholics' treatment status and often serve as representative payees. Savings are estimated at about \$200 million a year in 1998 through 2002. There are no savings in 1996, and savings of just \$100 million in 1997, because the bill would preserve RMA services through January 1, 1997 for current recipients. The bill would also plow an extra \$100 million over two years (1997 and 1998) into an existing block grant program to states for the treatment of substance abuse.

The legislation would also eliminate Medicaid coverage for DA&As terminated from the SSI program, resulting in another \$100 million a year or so in savings. Because former SSI recipients would experience a reduction in their cash income, food stamp costs would increase slightly—by approximately \$30 million a year.

Disabled children. The bill would restructure the SSI program for disabled children. Under current law, low-income children can qualify for the SSI program and its federal cash benefits of up to \$458 a month in two ways. Their condition may match one of the medical listings (a catalogue of specific impairments, with accompanying clinical findings), or they may be evaluated under an individualized functional assessment (IFA) that determines whether an unlisted impairment seriously limits a child from performing activities normal for his or her age. Both methods are spelled out in regulation. Until the Supreme Court's decision in the *Zablay* case in 1990, the medical listings were the sole path to eligibility for children. Adults, in contrast, could receive an assessment of their functional and vocational capacities even if they did not meet their own set of listings. The court ruled that sole reliance on the listings did not comport with the law's requirement to gauge whether children's disorders were of "comparable severity" to impairments that would disable adults.

The bill would eliminate childhood IFAs and their statutory underpinning, the "comparable severity" rule, as a basis for receipt. Many children on the rolls as a result of an IFA

- trying to do outyrs not gimmicky

Substance Abuse

Welfare Reform

- ends Medicaid for legal imm's (stop option until 9/96)
- states can use TANF for s.a. trtmt

DA: A ended as qualif for ~~SSI~~/SSDI [SSI/OL req'd trtmt + provid access to Medicaid]

k2 have responded, k2 have req'd'd → only 25%

Resources

WIC → prev + referral FY97 \$15M

DoD → \$84M on Demand Reduction progs
Educ

HHS

^{FY97:}
HCFR → 260M for drug trtmt

ACF

CDC

FDA

^{Ryan White}
HRSA - \$43M for HIV/AIDS progs in s.a. trtmt

IHS

NIH

SAHSA - grants to states
- \$100M above FY97
\$50M for FY98

HWD

VA \$1B+

98 Budget

- \$50M → pt of
- kept PATH

701 St. Paul Street
Baltimore, MD 21202
410 547-6600
FAX 410 547-6624

OCT 15 1996

AC
The Annie E. Casey Foundation

October 4, 1996

Carol Rasco
Domestic Policy Advisor
The White House
Washington, DC

Dear Ms. Rasco:

On behalf of the Annie E. Casey Foundation, I am pleased to invite you to a seminar on welfare-to-work programs and substance-abusing populations we have planned in conjunction with the American Public Welfare Association (APWA), the National Association of State Alcohol and Drug Abuse Directors, The National Center on Addiction and Substance Abuse at Columbia University, the Legal Action Center, the Urban Institute, and the Welfare Information Network.

The seminar is scheduled for *Thursday, November 7, 1996*, and will be held at The Washington Court Hotel, located at 525 New Jersey Avenue, NW, Washington, DC 20001, 202/682-2100.

This one-day seminar is by invitation only and is designed to identify and discuss the range of legislative, programmatic, and operational issues and perspectives affecting individuals with drug and alcohol problems in welfare-to-work programs. It will bring together a range of key players from federal, state, and local government; state membership organizations; academia, treatment providers; and other organizations with interest and expertise in the area of substance abuse and welfare-to-work programs.

I myself will go. { We understand that you may wish to suggest that another staff member represent your organization at the seminar. Due to space limitations, however, we can only accommodate one staff member per organization. The seminar agenda is attached for your reference.

We ask that you make your own travel arrangements. However, *if you are coming from out of town and require hotel accommodations, please call Ursula Krieger with your arrival and departure dates so that APWA staff can make room reservations for you.* You will receive reimbursement for your travel, hotel, and meals (up to two nights) upon conclusion of the conference. You will need to complete the attached expense form and include appropriate receipts.

Your participation in this seminar will be invaluable to bring together key players from many fields of expertise to discuss the difficult issues of welfare-to-work and substance-abusing populations. Please *confirm your attendance* by contacting Ursula Krieger at the American Public Welfare Association (APWA), 810 First Street, NE, Suite 500, Washington, DC 20002-4267-202/682-0100; FAX: 202/289-6555 *by October 28, 1996.*

Sincerely,

Irene Skricki

Irene Skricki
Consulting Program Associate
Annie E. Casey Foundation

Enc.: seminar agenda and expense form

Seminar on
WELFARE-TO-WORK PROGRAMS AND SUBSTANCE-ABUSING POPULATIONS

November 7, 1996
Washington Court Hotel, Washington, D.C.

AGENDA

MORNING SESSION: 8:30 am to 12:30 pm

8:30 to 9:00 am **Continental Breakfast**

9:00 to 9:15 am **Welcome and Convene**
Workshop Purpose and Objectives

9:15 to 10:30 am **Framing the Issue**
Panel and Group Discussion

Panelists

Elaine Ryan, Director of Government Affairs
American Public Welfare Association

Laura Feig, Social Science Analyst
Division of Children and Youth Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

Karen Schrock, Chief
Center for Substance Abuse Services
Michigan Department of Public Health

The opening panel discussion will identify and discuss the legislative, regulatory, and practice environments, operating parameters, and perspectives affecting individuals with drug and alcohol problems in welfare-to-work programs.

10:30 to 10:45 am **Break**

10:45 to 12:30 pm **Perspectives, Issues, and Decision Points**
Panel and Group Discussion

Panelists

LaDonna Pavetti, Research Associate
Human Resources Policy Center
Urban Institute

Employer representative (TBA)

Neal Cash, Arizona Association of Behavioral Health Programs

Bob Anderson, Director of Criminal Justice/SSA
National Association of State Alcohol and Drug Abuse Directors

During this panel some major stakeholders will outline the critical research questions and findings, key decision points, and policy and practice concerns that, in combination, will influence implementation of welfare-to-work for drug and alcohol dependent clients. Among specific issues to be discussed are the use of, and protocols for, drug testing in various settings and for various purposes, front-line implementation issues, the employer/business perspective about hiring and retaining persons with substance abuse problems, and issues of concern to the advocacy community and treatment community, both public and not-for-profit.

12:30 to 1:15 pm Working Lunch

Client Speaker

Kathy Mitchell, Substance Abuse Counselor

Board Member of the National Organization on Fetal Alcohol Syndrome

Our lunch speaker will share invaluable insights about how she successfully moved from welfare to work and the resources or services she required to overcome a drug and alcohol dependency.

AFTERNOON SESSION: 1:15 to 4:00 pm

**1:15 to 2:30 pm Lessons from the Front-line
Panel and Group Discussion**

Panelists

Art Schut, President

Iowa Substance Abuse Program Directors' Association

Toni Moore, Program Coordinator

Alcohol and Other Drug Treatment Initiatives Program

Sacramento Department of Health and Human Services

Representative from Oregon Program (TBA)

Employer representative (TBA)

This panel will discuss actual day-to-day experiences of states and "lessons learned" in working with clients with alcohol or drug problems in welfare-to-work programs.

2:30 to 2:45 pm Break

2:45 to 3:15 pm Lessons from the Front-line (cont'd)

3:15 to 4:00 pm Wrapup and Next Steps

10/7/96

MEMORANDUM

TO: Diana Fortuna, Domestic Policy Staff

CC: Ken Apfel, O.M.B., Jack Gustafson, NASADAD

FROM: Jeffrey Merrill, University of Pennsylvania 

DATE: October 10, 1996

SUBJECT: Some Additional Information Related to RMAs

We really appreciate your taking the time to talk with us about the future of the RMAs. Your knowledge of the issue was truly impressive. As promised, I am sending you a copy of the note sent to Skila, which addresses the issue of why the RMAs should continue despite the removal of the DA&A category.

In addition, I promised to send you some data on the impact of the same type of assessment, treatment and monitoring on a similar population. In this case, the group involved more than a thousand low-income clients in Philadelphia. Most of these clients received public assistance, including Social Security or AFDC benefits. Sixty-five percent were male. As with the RMAs, the clients received assessment, referral and monitoring. The Addiction Severity Index (also used by RMAs) was administered at entry to treatment and six months post-treatment. To summarize, at the post-treatment follow-up:

- Overall, the severity of both alcohol and drug problems declined by an average of about 60%.
- Employment income almost doubled.
- Number of days worked almost doubled.
- Serious depression and anxiety symptoms declined by 40%.
- The percent who exhibited no psychiatric problems increased by one-fourth, and those in need of psychiatric treatment decreased by over 40%.

These numbers are impressive enough to indicate that if the RMAs can achieve even a fraction of these reductions in psychiatric disability and substance abuse, literally billions of dollars in SSA/SSI outlays could be avoided. Further, the relevance of these results to a successful welfare reform program, as well as the findings of other state studies (see attached), should not be overlooked. At a minimum, what these numbers suggest is that cutting the RMA program at this juncture deprives us from seeing whether they can be effective in helping people to help themselves become independent of public assistance. Given the huge investment already made in them, it makes little economic -- or policy -- sense to dismantle them just as we may be able

to assess their utility.

Finally, as we discussed, the contention in the GAO report that SSA's focus is principally on writing checks is a concern. Given the tremendous portion of Federal outlays that those checks represent, it makes no sense to ignore the potential benefit of the RMAs in making a sizable dent in reducing the budget.

I hope that this is helpful. Give me a call at (215) 665-2880 if I can be of further assistance.

Attachments

TREATMENT RESEARCH INSTITUTE

January 31, 1997

Additional Points Concerning the RMAs

At a recent meeting at ONDCP, some very valid questions were raised regarding the need to continue the RMAs. The following is a brief summary of the discussion that took place:

The underlying issue is whether, given the fact that since the DA&A program no longer exists and beneficiaries cannot be forced to use the RMAs (without losing their eligibility), why should the RMA program continue. In other words, can the RMAs only function effectively when they are linked to the mandate and sanctions that have now been wiped out?

This is a very legitimate issue. Part of the answer to this concern is based upon whether the RMAs are viewed as solely a mechanism to control a population, or as a resource to assist that population get off the disability roles.

There is no question that, without the threat of sanctions, not all beneficiaries will take advantage of such a resource. But, there is also no question that many beneficiaries will continue to look to the RMAs as a resource. Since the RMAs have been operating, the number of DA&A beneficiaries in treatment has increased 25 fold to 50,000 (with another 50,000 now in the queue to start treatment). Certainly the sanctions have played a major role in this increase. But we cannot ignore the fact the RMAs assess, refer and monitor these individuals. These are all critical to getting people into—and maintaining them in—treatment.

The recent GAO report (see attached), which underlines the need for SSA to have just such support mechanisms as the RMAs, makes the point that, if even a very small percentage of disabled beneficiaries can be put back into the work force, savings in the billions of dollars can be realized. At a time when the President is intent on controlling the Federal budget and on increasing the resources to enable substance abusers to obtain the needed help, why do away with this valuable resource? The elimination of these agencies at this point, particularly given the GAO report, makes neither economic nor political sense.

But the argument goes beyond this. One sanction that will remain is the option to require a beneficiary to have a Representative Payee (RP). The major impetus for both the recent legislation and the Cohen amendment was the concern that substance abusing beneficiaries were using their benefits to buy drugs. The RP was considered

important in preventing this. The RMAs serve both as an effective screening mechanism to determine whether a beneficiary needs an RP and as the RP itself. Why take away the very entities created to address a serious problem.

Finally, as welfare reform becomes a reality at the state level, the RMAs can be extremely valuable to states in addressing the needs of their AFDC populations and getting them back to work. While the focus of the RMAs is on substance abuse, they are also assessing the medical, legal, family and employment needs of beneficiaries. Many states already recognize the value of the RMAs. To get recipients back to work, states will need some means of assessing and coordinating services for them. Will they then have to reinvent something akin to the RMAs? Thus, why dismantle them now?

Jeffrey Merrill



National Association of State Alcohol and Drug Abuse Directors, Inc.

TREATMENT WORKS

An effective alcohol and drug policy must be balanced and comprehensive, with treatment, prevention, education, and law enforcement all playing important roles. Research has shown that alcohol and other drug (AOD) treatment is one of the most effective ways of reducing the social costs of AOD abuse. Therefore, it is critical that any alcohol and drug policy include a strong treatment component.

What follows is an overview of the most important AOD treatment effectiveness research.

CALIFORNIA DRUG AND ALCOHOL TREATMENT ASSESSMENT (CALDATA) STUDY

Published in 1994, the CALDATA study is one of the largest, most comprehensive, and most methodologically rigorous studies of treatment effectiveness completed by a State. CALDATA studied over 1,800 AOD treatment clients in four different modalities of public treatment programs, in order to determine the benefits and cost-effectiveness of AOD treatment. Its results were clear: *benefits to substance abusers and society at large were immediate and significant.*

Treatment is Cost Effective: Each day of treatment paid for itself, since taxpayers saved more than the treatment programs cost.

Overall, treating the 150,000 Californians enrolled in the public system in 1991 cost California taxpayers \$209 million, while the benefits received during treatment and one year afterwards were worth \$1.5 billion. As a result, for every dollar spent on AOD treatment, \$7 were saved.

Health Care: Hospitalizations were reduced by approximately one-third.

Crime: The level of criminal activity declined by two-thirds from before treatment to after treatment.

OTHER TREATMENT EFFECTIVENESS STUDIES BY THE STATES

In 1994 NASADAD also published a treatment effectiveness document, *Invest in Alcohol and Other Drug Treatment: It Pays*. This publication compiled treatment effectiveness reports from fifteen States: California, Colorado, Florida, Georgia, Iowa, Kansas, Kentucky, Maine, Minnesota, Missouri, New Mexico, Ohio, Texas, Washington, and Wisconsin.

The studies found that AOD treatment produced positive results in the following areas:

Health Care:

Reduced hospitalizations in Minnesota, which estimated it saved \$22 million in health care costs annually thanks to AOD treatment.

Cut in-hospital costs by half for treatment clients in a Washington State one-year follow-up study, compared to a non-treated control group.

Reduced hospital admissions by two-thirds, and emergency room utilization by two-fifths among 668 of Ohio's treatment clients.

Criminal Justice:

Cut criminal arrests by 56 percent among 668 of Ohio's treatment clients.

Reduced recidivism from 40 percent for untreated inmates to 26 percent for those who completed treatment in **Florida's** prison treatment programs.

Reduced the criminal arrest rate among treatment clients in **Colorado**, from 58.5 in the 24 months prior to treatment to 18.9 in about one year after treatment.

Employment productivity:

Increased employment among treatment clients in **Colorado** by 70%--from only 36% employed at admission to 61% employed about one year after completing treatment.

Increased employment in **Minnesota** as well--by 78%, from 23.1% before treatment to 41.2% six months after treatment.

Other reports and studies have found:

Ohio calculated that over a two-year period, 459 drug-free babies were born to previously addicted mothers enrolled in the State's treatment system, saving the State \$46,000 for each drug-free birth, for a total savings of \$21 million. The State government subsequently added \$10 million to its treatment budget for pregnant women.

Oregon released an outcomes study in April, 1995 which found that those who completed treatment had an arrest and conviction rate one-third less than those who failed to complete treatment. In addition, those who completed treatment had a 51 percent reduction in the number of annual hospital claims. (*Societal Outcomes of Drug and Alcohol Treatment in the State of Oregon*, Michael Finigan, PhD, April 26, 1995).

NATIONAL TREATMENT STUDIES

National studies also indicate the effectiveness of treatment. The Treatment Outcomes Prospective Study (TOPS), conducted from 1979-1981, collected data on 10,000 drug treatment patients nationwide.

According to the Department of Health and Human Services' 1991 report, *Drug Abuse and Drug Abuse Research*, TOPS found that "Drug abuse... significantly decreased after treatment," and "involvement in predatory crime decreased significantly" as well.

Currently, the National Institute on Drug Abuse (NIDA) is conducting the Drug Abuse Treatment Outcome Study (DATOS), an updated analysis of 10,000 treatment clients nationwide, which should provide additional evidence of treatment effectiveness.

TREATMENT AND CRIMINAL JUSTICE

Many of those closest to our nation's crime problem agree that reducing drug abuse and providing drug treatment are very important parts of any effort to control crime.

According to a January 1995 poll, 31 percent of the nation's police chiefs believe that "reducing drug abuse" would have the greatest impact on violent crime, almost twice the number that cited other factors, such as a better economy or longer prison sentences. And in 1994, more than nine out of ten prison wardens surveyed agreed that "expanding the use of drug treatment in prison or in the community" would help reduce crime.

TREATMENT AND PUBLIC HEALTH

The public agrees that treatment is crucial to our anti-drug efforts. A 1995 Gallup poll found that 77 percent of Americans favored increased spending for alcohol and drug treatment.

And according to a survey commissioned by Drug Strategies and conducted by Peter D. Hart Research Associates in February 1995, 53 percent of Americans view drug abuse as a public health problem best handled by treatment and prevention.

October 24, 1996

President William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

cc Jeremy
Molly
Janet A.

Dear Mr. President:

The undersigned organizations urge you to work to repeal the provision¹ of the welfare reform bill that denies cash welfare and Food Stamps to individuals with drug felony convictions. The provision, known as the "Gramm amendment," will jeopardize the availability of drug and alcohol treatment for women with children and punish those with old drug convictions, even if they are in recovery. The Gramm amendment is a significant barrier to self-sufficiency and could endanger the health and well-being of many individuals, families, and communities.

Women on welfare have higher rates of drug and alcohol problems than non-recipients,² and women arrested on drug charges constitute the fastest growing population in the criminal justice system.³ To reduce welfare dependence, prevent crime, and strengthen families, we must ensure that low-income women and women with drug histories have access to appropriate drug and alcohol treatment.

Unfortunately, the Gramm amendment will make it harder for treatment programs, particularly those serving women with children, to survive financially. These programs, many of which cannot get Medicaid reimbursement,⁴ pool their clients' public benefits (including welfare and Food Stamps) to support the full cost of treatment. For example, one women's program in Florida has estimated that 80 percent of its clients have drug felony convictions and that the loss of welfare payments and Food Stamps supporting them could leave a significant budget gap.

The majority of state and local welfare officials recognize that their caseloads include individuals with drug and alcohol problems who will need treatment to find and keep jobs.⁵

¹ Section 115 of P.L. 104-193.

² U.S. Department of Health and Human Services. "Patterns of Substance Use and Substance-Related Impairment Among Participants in the Aid to Families with Dependent Children Program (AFDC)," 1994.

³ Wellisch, Jean et. al. "Drug-Abusing Women Offenders: Results of a National Survey." National Institute of Justice, 1994.

⁴ Because the "Institution for Mental Diseases ("IMD") exclusion, a long-standing barrier to Medicaid reimbursement for drug and alcohol treatment, which disallows reimbursement for any health care or drug and alcohol treatment services provided to women otherwise eligible for Medicaid in settings with more than 16 treatment beds for individuals between the ages of 22 and 64.

⁵ Legal Action Center. "State, Local Welfare Officials See Important Role for Drug and Alcohol Treatment in Welfare Reform," 1995.

According to a 1995 study, 65 percent of state and local welfare directors believed that treatment services were extremely important and 34 percent called them "somewhat important" to welfare reform.

These officials also know that drug and alcohol treatment reduces welfare dependency. The National Treatment Improvement Evaluation Study (NTIES), just released by the Department of Health and Human Services, found that clients in federally funded treatment reduced their welfare dependence by 10.7 percent and increased their employment by 18.7 percent one year after treatment.

For those who are able to get treatment, the denial of Food Stamps and welfare after they leave treatment will jeopardize their recovery and make it more difficult for them to get and succeed at job training and employment. The Gramm amendment punishes mothers and children at the point when they need support most to maintain sobriety.

Moreover, the provision does not impose a time limit for benefit denials. Thus, a mother in recovery with an old conviction who has lost her job after years of employment would be ineligible for welfare or Food Stamps.

You have already spoken publicly about provisions of the welfare reform bill that need to be corrected. We urge you to include the Gramm amendment on that list and take action to repeal it.

Thank you for considering our views. For more information, contact Gwen Rubinstein at the Legal Action Center at (202) 544-5478.

Sincerely,

AIDS Action Council
AIDS Policy Center
American Association of Psychiatric Services for Children
American Civil Liberties Union
American Foundation for AIDS Research
American Group Psychotherapy Association
American Managed Behavioral Healthcare Association
American Medical Student Association
American Methadone Treatment Association, Inc.
American Psychological Association
American Public Health Association
American Society of Addiction Medicine
Americans for Democratic Action, Inc.
Association of Halfway House Alcoholism Programs of North America
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Bazelon Center for Mental Health Law

Betty Ford Center
Center for Science in the Public Interest
Child Welfare League of America
Cities Advocating Emergency AIDS Relief (CAEAR) Coalition
Coalition for the Homeless
College on Problems of Drug Dependence
Committee for Children
Employee Assistance Professionals Association
Gateway Foundation
Gay Men's Health Crisis
Hazelden Foundation
Housing Works
Legal Action Center
National AIDS Fund
National Alliance of State and Territorial AIDS Directors
National Association of Alcohol & Drug Abuse Counselors
National Association of Homes and Services for Children
National Association of People with AIDS
National Association of Protection & Advocacy Systems, Inc.
National Association of Psychiatric Treatment Centers for Children
National Association of School Psychologists
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of the Deaf
National Black Police Association
National Coalition for the Homeless
National Coalition of State Alcohol and Drug Treatment and Prevention Associations
National Community Mental Healthcare Council
National Council of Jewish Women
National Council on Alcoholism and Drug Dependence
National Health Care for the Homeless Council
National Mental Health Association
National Minority AIDS Council
National Parent Network on Disabilities
National Puerto Rican Coalition, Inc.
National TASC
Outreach Project, Inc.
TB and Citizen Action Project
Therapeutic Communities Association of New York
Therapeutic Communities of America
Union of American Hebrew Congregations
Villa Inn, Inc.
World Institute on Disability

cc: Vice President Gore
Mrs. Tipper Gore
General Barry McCaffrey, Director, Office of National Drug Control Policy
Carol Rasco, Assistant to the President for Domestic Policy
Donna Shalala, Secretary of Health and Human Services
Nelba Chavez, Administrator, Substance Abuse and Mental Health Services
Administration

NASADAD

Received 9/13/96

National Association of State Alcohol and Drug Abuse Directors, Inc.

Elly: Is it Maria or
Molly that works
this issue? I
need to

FAX TRANSMITTAL COVER SHEET

☒ Urgent ☐ Review ☐ Reply ASAP ☐ Comment

President
Luceille Fleming
Ohio

PLEASE DELIVER THE FOLLOWING PAGE(S) TO:

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Michigan

Vice President for Alcohol Abuse Issues
Robert Aukerman
Colorado

Vice President for Drug Abuse Issues
Joe M. Hill
Arkansas

Past President
Andrew M. Mecca, Dr. P.H.
California

Secretary
Elaine Wilson
Hawaii

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Tennessee

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Illinois

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Oklahoma

Michael Couty
Missouri

Leon PoVey
Utah

Elaine Wilson
Hawaii

Kenneth D. Stark
Washington

Executive Director
John S. Gustafson

NAME: Carol Rasco

ORGANIZATION: EOP

TELEPHONE NO: _____

FAX NO: 456-2878

FROM: Chris Rugaber for Jack Gustafson

DATE: 9/13

NUMBER OF PAGES INCLUDING THIS COVER SHEET: 2

MESSAGE FROM SENDER:

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National Association of State Alcohol and Drug Abuse Directors, Inc.

September 13, 1996

President
Luceille Fleming
Ohio

First Vice President
Karen Schrock
Michigan

Vice President for Alcohol Abuse Issues
Robert Aukerman
Colorado

Vice President for Drug Abuse Issues
Joe M. Hill
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Oklahoma
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Missouri
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Washington

Executive Director
John S. Gustafson

Carol Rasco
Assistant to the President for Domestic Policy
Executive Office of the President
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Ms. Rasco:

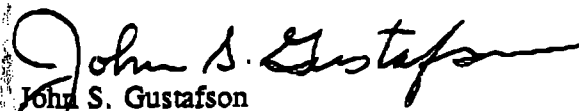
As you know, on March 29 of this year Congress passed a bill that eliminated the Drug Addicted and Alcoholic (DA&A) category from the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. This measure will remove over 250,000 individuals from the SSI/SSDI rolls and may also terminate the Referral and Monitoring Agencies (RMAs) that monitor their compliance with treatment requirements. Enclosed is a one-page analysis of the effects of this change.

NASADAD is concerned that this measure will have potentially explosive unintended consequences. Currently, DA&A recipients are required to undergo treatment and are automatically removed from the rolls after three years. Under Congress's new law, up to 80 percent of the DA&A population may reclassify for SSI/SSDI under different disabilities, and continue to receive benefits, with no treatment requirements, three-year time limit, or RMA.

Our analysis urges the President to restore personal accountability to SSI/SSDI by maintaining the RMAs for former DA&A recipients.

Anything you can do to raise the visibility of this issue would be appreciated. Please call me if additional background information would be helpful. Thank you very much for your assistance.

Sincerely,


John S. Gustafson
Executive Director

Enc.

JSG/csr

MAINTENANCE OF RMAs IS CRITICAL

(9/9/96)

Purpose: Because of Congressional action related to drug and alcohol addicted (DA&A) beneficiaries of SSDI and SSI, the SSA plans to eliminate, by the end of the year, the State Referral and Monitoring Agencies (RMAs). These RMAs are crucial both to beneficiaries and the programs. Their elimination will lead to both personal tragedy and a potential political disaster.

Background: Congress enacted legislation which eliminates SSDI and SSI eligibility solely on the basis of a drug and/or alcohol addition. This provision, which affects about 250,000 beneficiaries, were a part of a Bill extending the Debt Ceiling and permitting seniors to collect OASI benefits while working. Despite the SSDI/SSI provision, therefore, the President had little choice but to sign the legislation.

According to CBO and others, as many as 80% of DA&A beneficiaries could remain eligible because of another mental or physical disability. However, they could no longer be required to have a Representative Payee (RP) or to enter treatment, nor would they be subject to the sanctions, including termination, that had been imposed by the 1994 Cohen amendment. These mandates and sanctions were intended to correct the problems and abuses within the DA&A disability benefit program.

To implement the Cohen amendment, RMAs assess these beneficiaries, refer them to appropriate treatment, and then monitor their care. It is important to note that, over the two years, as a result of the combined impact of the treatment mandate and the RMAs, the number of DA&A beneficiaries in treatment increased 25 fold from about 2,000 to 50,000; another 50,000 are now in the queue to enter treatment.

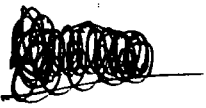
Impact: The effects of Congress' recent action will be cataclysmic (there have already been three suicides related to the notices rescinding benefits). While the President cannot be held responsible for the legislation eliminating DA&A eligibility, he would be responsible for dismantling the RMAs. There is nothing in Congress' action that would explicitly eliminate the RMAs; yet, without them:

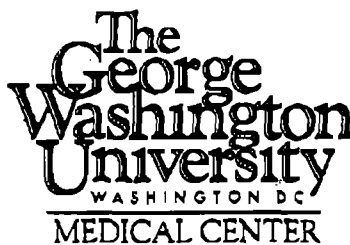
- Most beneficiaries will continue to receive benefits, but without either mandates for a RP or for treatment. While RPs can still be required, such determinations will be difficult without the RMAs. Further, beneficiaries will now be eligible indefinitely without automatic termination after three years, as was mandated under the Cohen amendment. This will add sizable costs to SSDI and SSI (conservatively estimated at \$2 billion over 5 years), and wipe out the provisions of the Cohen amendment intended to correct the very abuses that Congress was so concerned about.
- While treatment might still be available through block grant funds, the assessment, referral and monitoring which are so important to getting people into--and maintaining them in--treatment, will be terminated.

Since those who will remain eligible will have not only a DA&A problem, but other serious physical and emotional disabilities, they represent the most vulnerable of beneficiaries. Without the services of an RMA, the potential for both personal tragedies and a public relations disaster is considerable.

Action: At a time when the President wants to expand his anti-drug abuse efforts and promote more personal accountability, closing the RMAs would contradict that position, particularly since it would be directed at such a vulnerable segment of the population. Further, the SSDI beneficiaries were working people who earned their eligibility through paying FICA throughout their lives. Terminating the RMAs will be viewed as closing off a main route to rehabilitating their lives. Is this the President's desired message?

There is no reason, from either an economic or humanistic perspective, to close the RMAs. Also, as welfare reform is implemented, the RMAs can serve as a major resource to assist AFDC recipients in obtaining and keeping work (States are already very supportive of these agencies). But, without immediate intervention, the RMAs will disappear before they have had a chance to prove themselves and, when they are needed in the future, it will be too late to bring them back.





CENTER FOR HEALTH POLICY RESEARCH

MEMORANDUM

To: Carol Rasco
From: Sara Rosenbaum *SR*
Subject: Termination of benefits for persons with addiction and alcoholism-related disorders
Date: September 13, 1996

How are you? I can only imagine. I will call you after November 5th.

Two things:

1. Legalization provisions in welfare reform

I have attached a memo from me to Dennis Hayashi regarding the Section 401 and 403 prohibitions on assistance to individuals who are neither citizens nor qualified aliens. I gather that DOJ views the exclusions as broad. I think that the prohibitions in fact reach only programs whose eligibility criteria attach to communities, not individuals.

2. Services for SSA/SSI beneficiaries with addiction and alcoholism disorders

I recently was at a meeting at which the SSA Administration's management of the addiction and alcoholism disorder amendments was the topic of discussion. Basically, as I understand it, the Administration is terminating all support services for persons with these conditions as part of its implementation of 104-121. Despite appearances, the SSI/SSA amendments will in fact leave many persons with these disabilities on the rolls because they will continue to qualify as a result of a second disabling condition.

Despite this fact, SSA apparently is in the process of terminating all referral and management services for the population. As a result, there will be no more assistance through the RMA program for potentially tens of thousands of exceedingly sick and costly patients (with at least two disabling health conditions) who in fact will continue to receive

Carol Rasco
Page 2
September 13, 1996

benefits and who will no longer face termination of assistance after 3 years because of the repeal of the three-year time limit on benefits. This is an anomalous situation to say the least.

The RMA program is not a creature of statute. It was created by SSA. This is not a small program, and the states are wild over the loss of support. It seems to me that at the least all movement toward closing down the program ought to stop until later in the fall when the situation can be properly assessed. There apparently already have been several suicides, and sooner or later the story of the shutdown of services and the anomaly of the 1996 legislation will make the news. I am enclosing the summary that was passed out at the meeting, and I know that the state officials would like to discuss this with you or Jeremy.

2:enc.

same as
NASADAD
attachment

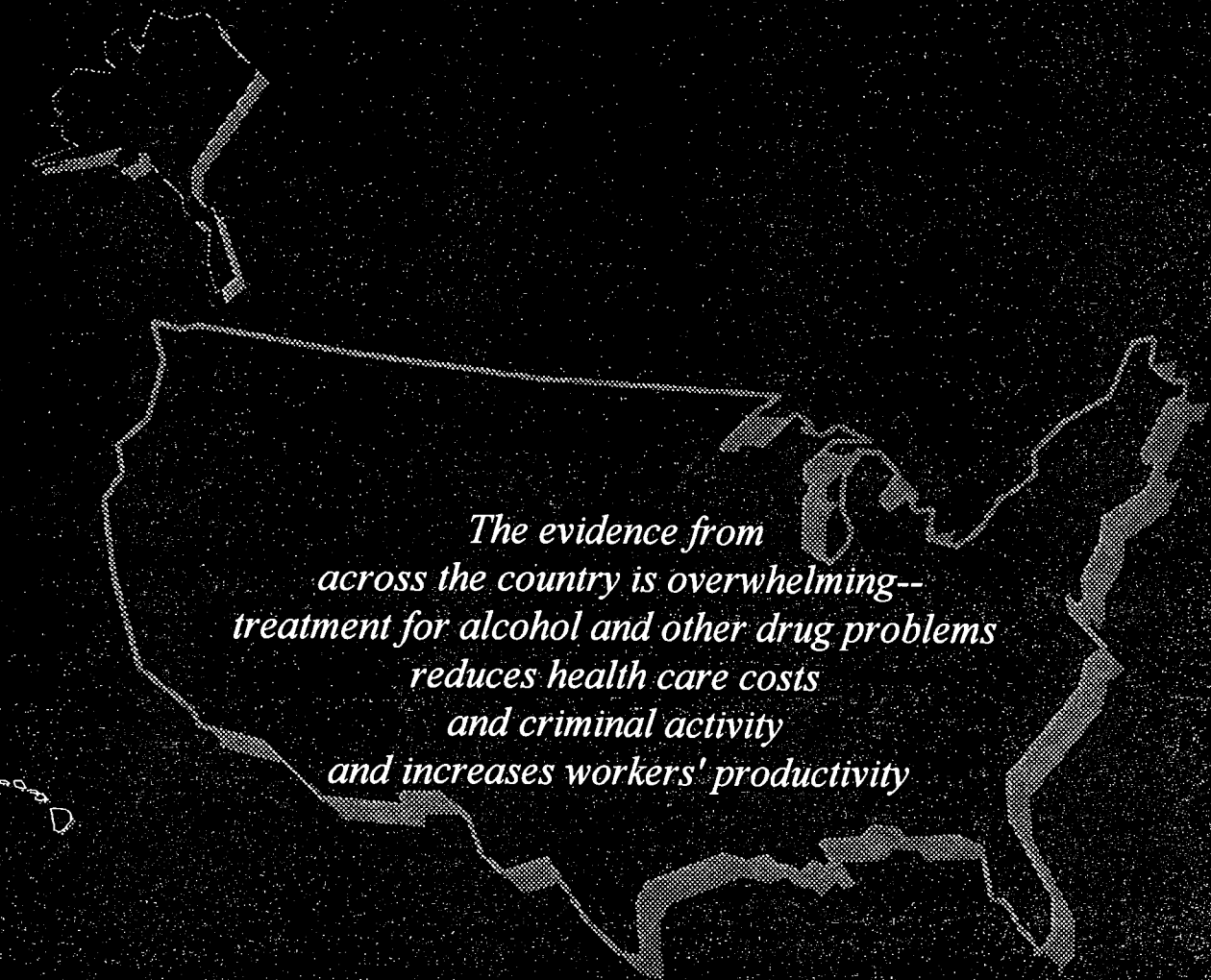
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INVEST IN TREATMENT FOR ALCOHOL AND OTHER DRUG PROBLEMS: IT PAYS



*The evidence from
across the country is overwhelming--
treatment for alcohol and other drug problems
reduces health care costs
and criminal activity
and increases workers' productivity*

National Association of State Alcohol and Drug Abuse Directors, Inc.
444 North Capitol Street, N.W., Suite 642
Washington, DC 20001
(202) 783-6868 FAX (202) 783-2704