INTERNAL USE ONLY

04/01/96

FACTSHEET ON ADMINISTRATION FY 1997 PROPOSAL

INDIVIDUALS RECEIVING SUPPLEMENTAL SECURITY INCOME (SSI) BASED ON DRUG ADDICTION AND ALCOHOLISM (DAA)

Talking Points

- The President signed the Contract with America Advancement Act on March 29, 1996. Provisions in that bill eliminate benefits for individuals whose DAA is a material factor in determining eligibility; effective immediately for new applicants and for those whose cases have not yet been finally adjudicated, and effective January 1, 1997 for those individuals who are already receiving benefits.

- Substance abuse counselors, those people on the front lines dealing with drug addicts and alcoholics, tell us that we are killing recipients by paying cash benefits to individuals with such severe addiction problems.

- President's Budget Document: "The budget supports key reforms to ensure that SSI continues to reach those most in need...[and] would deny benefits to adults who are on SSI due to substance abuse."

- Providing funds for treatment (such as the $50 million authorized to be appropriated), rather than paying cash benefits, is the preferable means for helping those individuals who would be able to work except for their substance abuse.

- In the past few years, the number of individuals receiving SSI disability payments based on DAA has increased significantly--from about 17,000 in 1989 to over 135,000 currently.

- This legislation will not cut those most in need off of benefits. Approximately 80% of the individuals currently being paid SSI based on DAA (108,000 of the 135,000) would requalify based on having other disabling impairments, such as cirrhosis of the liver or irreversible organic brain damage.**

Current Law and Issue

- The 1972 legislation which created the Supplemental Security Income (SSI) program included substance addiction as a disabling condition. In addition to meeting stringent medical criteria for disability, DAA recipients must accept treatment for their addiction and receive payments through a representative payee.

** As of September 1995, there were also about 30,000 DI beneficiaries receiving benefits based on DAA.

- Legislation enacted in 1994 limited the payment of benefits to 36 months, required treatment, if available, at approved facilities, and established progressive sanctions for noncompliance with treatment.

Current/Past Hill activity

- The Balanced Budget Act of 1995 (H.R. 2491), vetoed by the President, for other reasons, in December 1995, would have prohibited SSI cash benefits and Medicaid coverage to individuals whose DAA is a contributing factor material to their disability and would have required recipients to reapply within 120 days in order to obtain a redetermination of benefits.

Administration Proposal

- Would prohibit SSI eligibility to individuals whose DAA is a contributing factor material to the finding of disability.

- Would apply to applications filed on or after the date of enactment without regard to whether regulations have been issued and to benefits for current recipients beginning on or after January 1, 1997.

- Would also provide an appropriation of $50 million for each of FYs 1997 and 1998 to carry out activities relating to treatment of drug and alcohol abuse under the Public Service Act by supplementing an existing block grant program to the states.

Numbers affected

- Approximately 27,000 current recipients would lose eligibility.
- Approximately 50,000 fewer individuals would receive benefits each year.
- Programs savings through FY 2002 total $1.4 billion.

50 m / 50,000 = $1,000/yr

MAXIMUS

HELPING GOVERNMENT SERVE THE PEOPLE

SOCIAL SECURITY ADMINISTRATION/ WHITE HOUSE POLICY BRIEFING

Presented by:
MAXIMUS, Inc.

February 14, 1996

I. BACKGROUND ON MAXIMUS

- FOUNDED IN 1975 -- MAXIMUS IS THE LARGEST AND MOST EXPERIENCED HUMAN SERVICES MANAGEMENT FIRM IN THE NATION
- OUR MISSION IS "HELPING GOVERNMENT SERVE THE PEOPLE". WE WORK WITH FEDERAL, STATE, AND LOCAL GOVERNMENTS.
- HEADQUARTERED IN MCLEAN, VIRGINIA, MAXIMUS HAS OFFICES IN OVER 20 CITIES AROUND THE COUNTRY
- MAXIMUS EMPLOYS A STAFF OF OVER 600 PROFESSIONALS DEDICATED TO THE IMPROVEMENT OF HUMAN SERVICES PROGRAMS
- MAXIMUS HAS OPERATED OVER 1,000 PROGRAMS IN ALL 50 STATES IN A RANGE OF HUMAN SERVICE AREAS INCLUDING FOOD STAMPS, CHILD SUPPORT ENFORCEMENT, CHILD WELFARE, AND EMPLOYMENT AND TRAINING
- MAXIMUS HAS OVER TEN-YEARS OF EXPERIENCE IN WORKING WITH SSA AND ITS DISABILITY PROGRAMS

II. STATE/LOCAL HUMAN SERVICE PROGRAMS COMPLETELY PRIVATIZED BY MAXIMUS

CHILD SUPPORT ENFORCEMENT	EMPLOYMENT AND TRAINING	MEDICAID ENROLLMENT
• TENNESSEE - Nashville - Oakridge • MISSISSIPPI - Jackson - Vicksburg • MONTANA - Statewide • COLORADO - Colorado Springs • ARIZONA - Statewide • OKLAHOMA - Statewide • MASSACHUSETTS - Statewide • RHODE ISLAND - Statewide	• CALIFORNIA - Los Angeles County - Orange County - Lake County • MASSACHUSETTS - Statewide • TENNESSEE - Memphis - Knoxville - Kingsport • TEXAS - Dallas - Houston - San Antonio • WYOMING - Statewide	• NEBRASKA - Lincoln - Omaha • CONNECTICUT - Statewide • VERMONT - Statewide

III. HISTORY OF THE SSA RMA PROGRAM

- LEGISLATION EFFECTIVE IN 1974 MANDATED REFERRAL AND MONITORING OF INDIVIDUALS RECEIVING FEDERAL DISABILITY BENEFITS WITH A DRUG AND/OR ALCOHOL DISABILITY (DA&As)

- BY 1993, ALMOST 20 YEARS LATER, REFERRAL AND MONITORING AGENCIES (RMAs) WERE OPERATIONAL IN LESS THAN 20 STATES

- THERE WAS NO NATIONAL TRACKING SYSTEM OPERATIONAL TO IDENTIFY WHICH BENEFICIARIES WERE DA&As; FEW DA&As WERE IN TREATMENT; AND CONSIDERABLE FRAUD AND ABUSE EXISTED IN THE PROGRAM

- SSA RECOGNIZED THE NEED TO STRENGTHEN THE RMA PROGRAM. SSA TOOK THE INITIATIVE TO IMPLEMENT A NATIONWIDE PRIVATIZATION EFFORT TO INSTITUTE STRICT GUIDELINES AND MONITORING CONTROLS ON PROGRAM OPERATIONS.

- COMPETITIVE CONTRACTS WERE AWARDED BY SSA IN ALL STATES TO ADDRESS THE DEFICIENCIES OF THE PAST AND INSTITUTE AN IMPROVED NATIONWIDE RMA PROGRAM OPERATION

III. HISTORY OF THE SSA RMA PROGRAM

- WORKING CLOSELY WITH SSA, MAXIMUS DEVELOPED A NATIONAL AUTOMATED CASE TRACKING SYSTEM TO MONITOR THE REFERRAL AND TREATMENT OF ALL DA&As IN THE PROGRAM

- MAXIMUS DEVELOPED A NETWORK OF OVER 500 LICENSED TREATMENT PROVIDERS THROUGHOUT THE COUNTRY, RESPONSIBLE FOR PROVIDING REFERRAL AND CASE MANAGEMENT SERVICES FOR THE PROGRAM

- MAXIMUS CONTINUAL COMMUNICATIONS WITH STATE ALCOHOL AND OTHER DRUG (AOD) AGENCIES ENSURES THAT ALL AVAILABLE TREATMENT RESOURCES ARE ALLOCATED AT NO COST TO SSA

- THE PARTNERSHIP WHICH MAXIMUS HAS DEVELOPED WITH FEDERAL, REGIONAL, AND LOCAL SSA OFFICES, AND THE SUPPORT AND COMMITMENT THAT SSA HAS PROVIDED TO MAXIMUS, HAS RESULTED IN THE CONTINUED GROWTH AND SUCCESS OF THE RMA PROGRAM

IV. MAXIMUS RMA ACCOMPLISHMENTS

IN THE 20 MONTHS THE MAXIMUS RMA PROGRAM HAS BEEN IN OPERATION, THERE HAVE BEEN SIGNIFICANT ACCOMPLISHMENTS:

- **THE PLACEMENT OF OVER 45 PERCENT OF BENEFICIARIES REFERRED TO CASE MANAGEMENT INTO LICENSED TREATMENT FACILITIES**

  The RMA Has Placed 19,300 DA&As into Treatment, and Nearly 800 Individuals Have Completed Treatment Ahead of Schedule

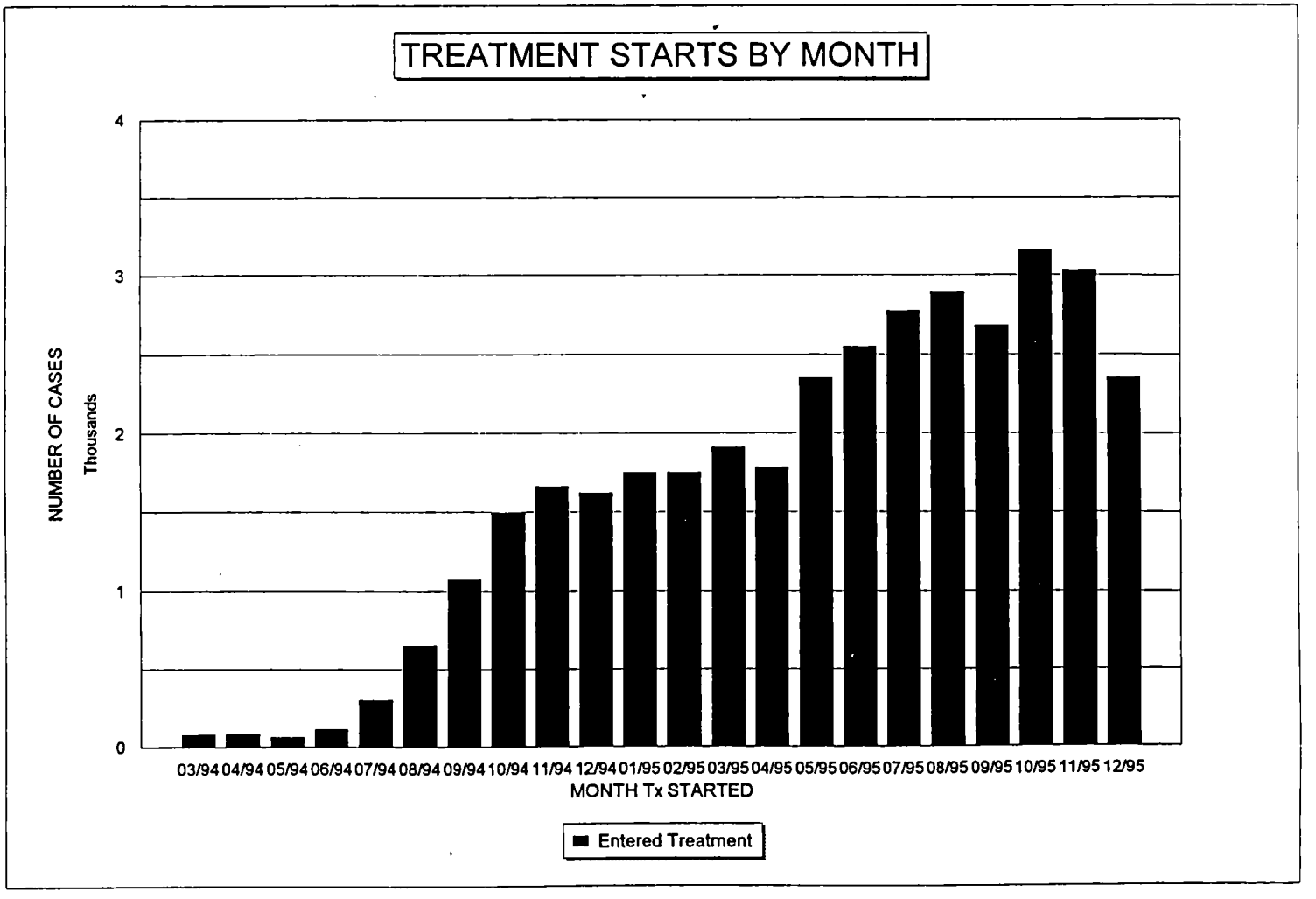
- **A REDUCTION IN THE NUMBER OF DA&As RECEIVING FEDERAL DISABILITY BENEFITS BY RECOMMENDING REMOVAL FROM THE ROLLS DUE TO NON-COMPLIANCE**

  Over 12,500 Cases Have Been Recommended for Termination of Benefits by the RMA Since Program Operations Began

- **A REDUCTION IN FRAUD AND ABUSE IN THE PROGRAM**

  The RMA Has Identified Over 3,200 Cases in Which Benefit Checks Were Sent to Incarcerated or Deceased Beneficiaries

IV. MAXIMUS RMA ACCOMPLISHMENTS



V. COST SAVINGS REALIZED THROUGH CONTINUED OPERATION OF THE RMA PROGRAM

- 75 PERCENT TO 80 PERCENT OF DA&As WILL REMAIN ON THE ROLLS EVEN IF DRUG AND ALCOHOL ADDICTION IS ELIMINATED AS A DISABILITY CATEGORY
- UNLESS TREATED, THESE BENEFICIARIES HAVE NO CHANCE OF ACHIEVING SUBSTANTIAL GAINFUL ACTIVITY
- CONTINUATION OF THE RMA PROGRAM CAN SAVE THE FEDERAL GOVERNMENT $25 MILLION IF THE PROGRAM IS CONTINUED IN FY 1997
- COST SAVINGS ARE REALIZED THROUGH TERMINATION OF BENEFITS FOR BENEFICIARIES NOT IN COMPLIANCE WITH TREATMENT, THROUGH REDUCTION OF PROGRAM FRAUD AND ABUSE, AND THROUGH SUCCESSFUL TREATMENT COMPLETIONS

V. COST SAVINGS REALIZED THROUGH CONTINUED OPERATION OF THE RMA PROGRAM

JUSTIFICATION FOR COST SAVINGS IN FY 1996

The number of cases served by the RMA in FY 1996 was estimated using actual case numbers received from SSA, taking into consideration cases closed throughout the year. Total DA&A cases served in FY 1996: 91,208 cases

The number of cases closed due to non-compliance with treatment, incarceration, or death was estimated using actual percentages of closures for these categories experienced to date in the RMA program. A breakdown of estimated closures for FY 1996 is as follows:

- Non-Compliance 22,018
- Death, Incarceration 10,222

Savings realized through closure of cases due to non-compliance with treatment, death, or incarceration were calculated using the following assumptions:

- Cases closed due to non-compliance with treatment would be removed from the rolls an average of six months per year.
- Cases closed due to incarceration or death would be removed from the rolls three months earlier than otherwise identified without an RMA.
- Monthly disability benefits were calculated using an average of $5,600 per client per year or $466.67 per month.

Calculation of Cost Savings for FY 1996

Savings realized due to non-compliance: 22,018 cases X 6 months not receiving benefits =	$61,649,166
Savings realized due to death/incarceration: 10,222 cases X 3 months not receiving benefits =	$14,311,413
Total Cost Savings:	**$75,960,579**
Cost of operating the RMA program: 91,208 clients X $550/client =	-$50,164,400
NET COST SAVINGS FOR FY 1996:	**$25,796,179***

* Does not include cost savings realized through successful treatment completions.

V. COST SAVINGS REALIZED THROUGH CONTINUED OPERATION OF THE RMA PROGRAM

JUSTIFICATION FOR COST SAVINGS IN FY 1997

The number of cases served by the RMA in FY 1997 was estimated using the carryover caseload from FY 1996; taking into consideration cases closed throughout the year; and assuming that 20 percent of cases would be dropped from the rolls due to the fact that their disability was only drug and alcohol. Total DA&A cases served in FY 1997: 61,586 cases

The number of cases closed due to non-compliance with treatment, incarceration, or death was estimated using actual percentages of closures for these categories experienced to date in the RMA program. A breakdown of estimated closures for FY 1997 is as follows:

- Non-Compliance 17,244
- Death, Incarceration 8,006

Savings realized through closure of cases due to non-compliance with treatment, death, or incarceration were calculated using the following assumptions:

- Cases closed due to non-compliance with treatment would be removed from the rolls an average of six months per year.
- Cases closed due to incarceration or death would be removed from the rolls three months earlier than otherwise identified without an RMA.
- Monthly disability benefits were calculated using an average of $5,600 per client per year or $466.67 per month.

Calculation of Cost Savings for FY 1997

Savings realized due to non-compliance:	17,244 cases X 6 months not receiving benefits =	$48,283,369
Savings realized due to death/incarceration:	8,006 cases X 3 months not receiving benefits =	$11,208,609
Total Cost Savings:		**$59,491,978**
Cost of operating the RMA program:	61,586 clients X $550/client =	-$33,872,300
NET COST SAVINGS FOR FY 1997:		**$25,619,678***

* Does not include cost savings realized through successful treatment completions.

VI. CONCLUSIONS

- THERE IS REGULATORY AUTHORITY, PUBLIC POLICY JUSTIFICATION, AND DEMONSTRATED SOCIAL NEED TO SUPPORT THE CONTINUATION OF THE RMA PROGRAM, EVEN IF LEGISLATION IS PASSED ELIMINATING DA&A AS A DISABILITY CATEGORY

- THE RMA PROGRAM CAN BE CONTINUED IN ITS CURRENT FORM FOR ALL INDIVIDUALS RECEIVING FEDERAL DISABILITY BENEFITS WITH A DRUG AND/OR ALCOHOL CONDITION, AT LEAST UNTIL ALREADY OBLIGATED FUNDS ARE EXPENDED

FAX COVER SHEET

TO: DIANA FORTUNA

FAX: (202) 456-7028

FROM: BETSEY WRIGHT

NUMBER OF PAGES (INCLUDING COVER):

DATE: January 19, 1996

ANY PROBLEMS WITH THIS TRANSMISSION PLEASE CALL 202-662-3753

MESSAGE:

CONFIDENTIALITY NOTE

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington D.C. 20004
202-638-2121
202-638-7045 Telecopy

DATE: **January 19, 1996**

TO: **DIANA FORTUNA**

FROM: **BETSEY WRIGHT**
CINDI BERRY

RE: **CONTINUATION OF RMA PROGRAM TO MANAGE SSI AND SSDI BENEFITS**

As a follow-up to our telephone conversation last month regarding termination of the drug addiction/alcoholism disability category in the SSI and SSDI programs, we are sending the following materials for your review: (1) a one-pager addressing the importance of continuing the RMA program; (2) an updated chart illustrating MAXIMUS' caseload; (3) copies of relevant general regulations which require beneficiaries to comply with prescribed treatment as a condition for receiving benefits (this requirement would remain nothwithstanding the proposed elimination of the DA&A program; we believe RMA enforcement is the only way to ensure compliance and accountability in the SSI and SSDI programs).

We would like to proceed with setting up a meeting so that the MAXIMUS folks can answer questions about the RMA and furnish you with detailed cost/savings data.

Issue: **Continuation of the Referral and Monitoring Agency (RMA) program is essential to ensure accountability, eliminate fraud and abuse, and save federal dollars in administering SSI and SSDI benefits.**

Background:

S. 1432, the Senior Citizens Right to Work Act, includes provisions which would deny Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits to individuals with a drug addiction or alcoholism condition if they cannot qualify based on another disabling condition. This action was prompted by reports of past abuse, particularly in the SSI program, but it reflects a lack of knowledge regarding recent successful efforts by the Social Security Administration to ensure compliance through improvements in the RMA system.

According to the Congressional Budget Office, the Social Security Administration, and the Congressional Research Service, 75%-80% of drug addicts and alcoholics (DA&A's) on the federal disability rolls will requalify for benefits under another disability category. However, S. 1432 would repeal current legislative treatment and monitoring requirements for these individuals, allowing them to abuse drugs and alcohol while remaining on the disability rolls. Continued substance abuse will prevent rehabilitation regardless of disability.

Rationale for Continuation of RMA Program:

(1) The RMA program is the only proven way to ensure that DA&A's are placed into appropriate treatment, complete treatment, and leave the federal rolls.

- Over the past 20 months, the Centralized RMA which manages the SSI program for SSA in 36 states, has placed 19,300 DA&A's into treatment. Nearly 800 individuals have completed treatment ahead of schedule.

- The CRMA has recommended that over 12,500 cases be terminated due to noncompliance with treatment, thereby ensuring that only those individuals who want help will get it and that those who are unwilling to participate in treatment will not receive federal money.

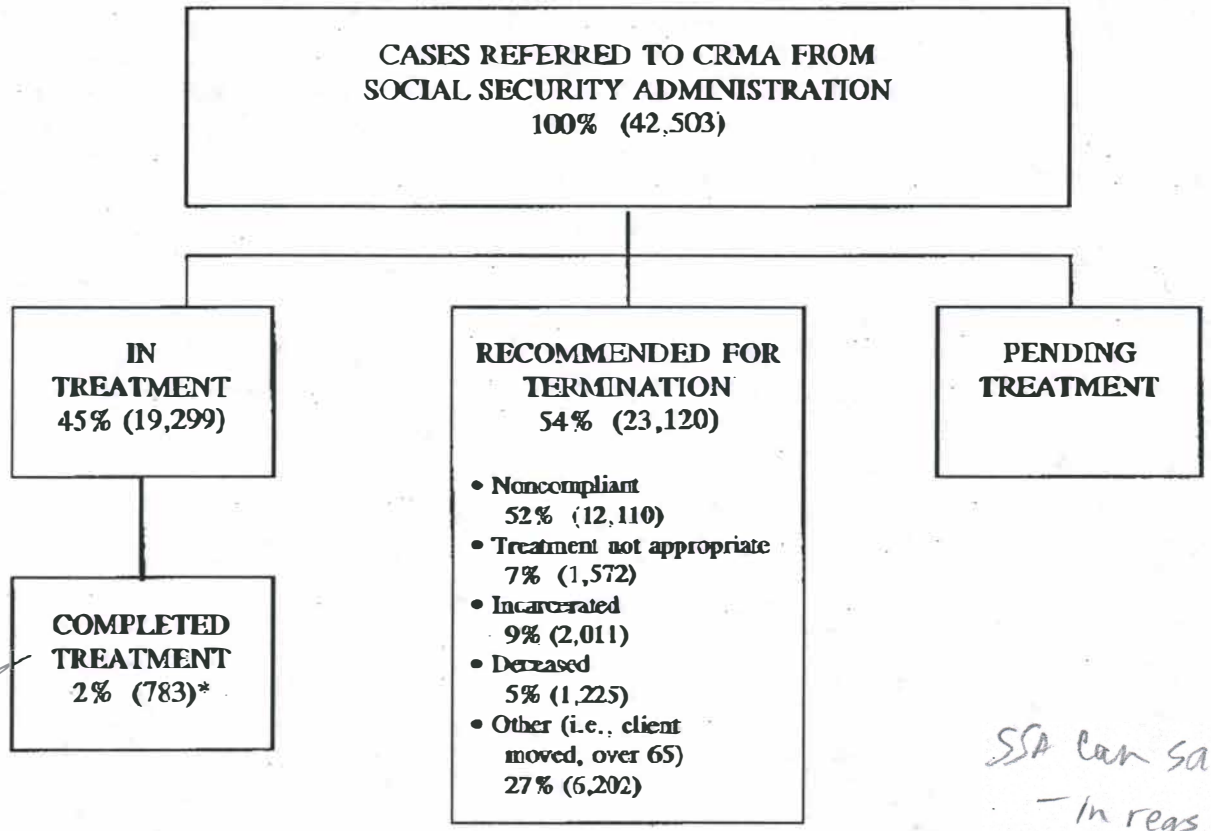
(2) The RMA program is the only proven way to reduce fraud and abuse in the SSI and SSDI programs.

- Over the past 20 months, the CRMA identified for SSA over 2,000 cases where benefit checks were improperly being sent to incarcerated individuals and over 1,200 cases where checks were being sent to deceased individuals. These individuals would not have been discovered without the CRMA's advanced tracking system.

(3) Continuation of the RMA program will result in greater savings to the federal government than if the program were to be terminated.

- Taking into account the cost of the RMA program, SSA conservatively will realize over $25 million in savings per year if the RMA program is continued. (See attached savings summary)

CENTRALIZED REFERRAL AND MONITORING AGENCY (CRMA)
DRUG ADDICTS AND ALCOHOLICS CASELOAD
(36 STATES - MAY 1, 1994 THROUGH DECEMBER 31, 1995)



Control? Guesses?

even if one wk, still on rolls, did we MA svgs

SSA can sanction even if legis. — in regs.

* The typical treatment course is 2-3 years.

* An accomplishment - RMA's?

SUMMARY OF COST SAVINGS

The total cost savings to the Federal Government for continuing to operate the RMA program for any beneficiary remaining on the disability rolls with a drug or alcohol problem is as follows.

	1996	1997
The total cost to SSA of keeping beneficiaries on the disability rolls without the RMA program	$510,764,800	$344,880,282
The cost to SSA of keeping beneficiaries on the disability rolls with the continuation of the RMA program	$434,804,221	$285,388,433
The cost of operating the RMA program	$50,164,400	$33,872,171
Total cost with the RMA program	$484,968,621	$319,260,604
TOTAL COST SAVINGS IF THE RMA PROGRAM IS CONTINUED	**$25,796,179**	**$25,619,678**

Additional savings not included in the above are as follows:

1. Nationwide studies have shown that substance abuse treatment has a major impact in reducing social program costs. Studies have shown that substance abuse treatment results in decreases in emergency room utilizations, reductions in the numbers of DWIs, levels of predatory crime, and involvement with the criminal justice system. Recent studies have found that there is a 7:1 benefit to cost ratio for placing individuals with substance abuse problems in treatment. These additional cost savings will also be realized through continuation of the RMA program.

2. In addition to reductions in social costs, continuation of the RMA will also result in reduced medical and health care costs, through the mandating of treatment for substance abuse problems. Many beneficiaries remaining on the rolls after DA&A is eliminated as a disability category may see significant improvement in their other medical or mental health conditions after they participate in required substance abuse treatment.

code of federal regulations

Employees' Benefits

20

PARTS 400 TO 499

Revised as of April 1, 1995

CONTAINING
A CODIFICATION OF DOCUMENTS
OF GENERAL APPLICABILITY
AND FUTURE EFFECT

AS OF APRIL 1, 1995

With Ancillaries

Published by
the Office of the Federal Register
National Archives and Records
Administration

as a Special Edition of
the Federal Register

...eps in our review when we con-
...hether your disability contin-
...tions 404.1579 and 404.1594 ex-
...e procedure we follow in re-
...whether your disability con-

...d *to establish a severe medically able impairment(s).* Your symp-
...ch as pain, fatigue, shortness
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...cision whether the Listing of Im-
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...However, we will not substitute
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...pact of symptoms (including pain) ...dual functional capacity. If you
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...l or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in Appendix 1 of this subpart, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity. (See §404.1545.)

[56 FR 57941, Nov. 14, 1991]

§404.1530 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g. open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994]

§404.1535 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8147, Feb. 14, 1995]

§404.1536 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in §404.1535), you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in §404.470.

[60 FR 8147, Feb. 14, 1995]

§404.1537 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility. This treatment may include (but is not limited to)—

(a) Medical examination and medical management;

(b) Detoxification;

(c) Medication management to include substitution therapy (e.g., methadone);

(d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or

y missing now becomes available
re that if it had been available at the
the prior determination, disability
t have been found.

Substantial evidence which is
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of current judgment for that
the prior favorable decision
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on.

e: You were previously found enti-
benefits on the basis of diabetes
which the prior adjudicator believed
valent to the level of severity con-
d in the Listing of Impairments.
r record shows that you had "brit-
for which you were taking insu-
urine was 3+ for sugar, and you al-
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y tion. On review, symptoms,
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ent adjudicator feels, however, that
al clearly does not equal the
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found because it would represent a
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r reopening the prior decision
.988) are met.

u *are currently engaging in sub-*
gainful activity. If you are cur-
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before we determine whether
no longer disabled because of
rk activity, we will consider
you are entitled to a trial
iod as set out in §404.1592. We
that your disability has ended
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ial gainful activity (following
on of a trial work period,
applies). This exception does
y in determining whether you
to have a disabling
impairment(s) (§404.1511) for purposes of deciding your eligibility for a reentitlement period (§404.1592a).

(c) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in §404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see §404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (d)(5) of this section).

(2) If you are not, do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of this subpart? If you do, your disability will be found to continue.

(3) If you do not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (4). If there has been no decrease in medical severity, there has been no medical improvement. (See step (5).)

(4) If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b)(1) through (4) of this section; i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is not related to your ability to do work, see step (5). If medical improvement *is* related to your ability to do work, see step (6).

(5) If we found at step (3) that there has been no medical improvement or if we found at step (4) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (6). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(6) If medical improvement is shown to be related to your ability to do work or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments in combination are severe (see §404.1521). This determination will consider all your current impairments and the impact of the combination of those impairments on your ability to function. If the residual functional capacity assessment in step (4) above shows significant limitation of your ability to do basic work activities, see step (7). When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(7) If your impairment(s) is severe, we will assess your current ability to engage in substantial gainful activity in accordance with §404.1561. That is we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(8) If you are not able to do work you have done in the past, we will consider one final step. Given the residual functional capacity assessment and considering your age, education and past work experience, can you do other work? If you can, disability will be

FEb 14, 1996

TO: Diana Fortuna

FR: Judy Chesser

RE: Meeting on RMA at 1:30 at SSA

Attached is the list of attendees from Betsy Wright. Also attached a memo that I had the staff pull together.

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington, D.C. 20004
202-638-2121
202-638-7045 Telecopy

Betsey Wright
Executive Vice President

February 13, 1995

TO: Diana Fortuna
Judy Chesser

FROM: Betsey Wright

RE: Wednesday, February 14 meeting with Maximus officials

Attending the meeting with you tomorrow will be the following persons:

David V. Mastran, CEO, Maximus

Ilene R. Baylinson, President, Health and Social Services Division, Maximus

Gwen Rubinstein, Health Policy Associate, Legal Action Council

Lee Verstandig, The Wexler Group

Cindi Berry, The Wexler Group

Many thanks for providing this meeting.

SPECIAL DCLCA D.C. TRANSMITTAL

RMAs

DELIVERED BY: FAX ☒ Shuttle ☐ Other _____

RESPONSE FROM JUDY NEEDED BY: DATE: 02/07/96 TIME: 11:45

ATTN: Paulette/Regina Jack C to give to

Please take the following action: Give to Judy.

TO: JUDY L. CHESSER

THRU: Diane B. Garro dg by KJ

FROM: Karen Jennings KJ

SUBJECT: **Your Questions Regarding Referral and Monitoring Agencies (RMAs) and DAAs**

Attached are responses to two of your questions resulting from the RMA paper we prepared. You also requested State breakdowns on the:

- 30,000 beneficiaries who are currently in treatment;
- 5 percent cases which were closed by RMAs; and
- 21 beneficiaries who were removed from the rolls.

Due to other priorities, such as the DAA Report to Congress, the Office of Disability is uncertain as to when they can provide this information to us.

Please let me know if you have any questions.

COMMENTS FROM JUDY:

_____ **APPROVE** _____ **DISAPPROVE**

cc: KJ
DG

Questions and Answers Regarding Referral and Monitoring Agencies (RMAs) and Individuals Disabled by Drug Addiction and Alcoholism (DAA)

- When were RMAs first used and what were the responsibilities then?

  -- RMAs were first used in 1974 as a result of the original SSI legislation and were primarily State agencies--with the exception of the San Francisco Region which had a local administrative contract.

  -- The agreements were general in nature and did not provide specific guidance to the States as to how RMAs should function on a day-to-day basis. For example, the agreements did not require specific case intake and interview procedures, establish timeframes for referring recipients to treatment facilities, mandate specific monitoring periods, or establish requirements for dealing with noncompliance by DAA recipients.

  -- Also, in past years, SSA found it difficult to establish agreements with RMAs covering all geographic locations in a uniform manner because of small workloads in some States and lack of funding to cover the whole country. In fact, as recent as October 1993, we had agreements in only 18 States.

- Why does Mississippi not have a new contract?

  The technical proposal submitted by the State of Mississippi was not acceptable. Since the State of Mississippi was the sole offeror, the Office of Acquisitions and Grants determined that negotiations could resume with the State of Mississippi. Currently, negotiations are being finalized and SSA anticipates awarding a contract sometime in February 1996.

ROUTING AND TRANSMITTAL SLIP

Date 1/22/96

TO: Diane Garro

	Action		For Clearance		Per Conversation
	Approval		For Correction		Prepare Reply
X	As Requested		For Your Information		See Me
	Circulate		Investigate		Signature
	Coordination		Justify		
	File		Note and Return		

REMARKS

RE: Discussion Paper on DAA Beneficiaries and RMAs

Attached is the subject paper which has been reviewed by OD and revised to incorporate your comments concerning materiality and treatment numbers.

If you have any questions, please call me or Pamela Mazerski, 52642.

	Room No.	Bldg.
Karen Jennings	3216	WHR
	Phone No. 5-2641	

RMAs
When RMAs 1st required?
What responsibilities?
stay w/ MSO.
any of by 1st
breakdown
or 30,000 #'s 1/20 21
30,000 states?

SPECIAL DCLCA D.C. TRANSMITTAL

DELIVERED BY: FAX ☑ Shuttle ☐ Other _____

RESPONSE FROM JUDY NEEDED BY: **DATE:** / / **TIME:** :

ATTN: Paulette/Regina

Please take the following action:

TO: JUDY L. CHESSER

THRU: Diane B. Garro _____

FROM: Karen Jennings

SUBJECT: Discussion Paper on Drug Addiction and Alcoholism (DAA) and Referral and Monitoring Agencies (RMAs)

As requested, attached for your approval, is a paper on RMAs for your use in responding to inquiries to proposed legislation regarding beneficiaries disabled by DAA

Please call me if you have any questions.

COMMENTS FROM JUDY:

_____ **APPROVE** _____ **DISAPPROVE**

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

Background

The Social Security Act provides for the payment of disability benefits to persons who cannot perform substantial gainful work and who have a medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of a least 12 months or to result in death.

Eligibility for disability benefits involving DAA is determined like any other medical disorder. That is, a diagnosis alone, including alcoholism or drug addiction, cannot be the sole basis for either a favorable or an adverse disability determination. Despite the presence of a condition diagnosed as DAA, if individuals do not manifest significant limitations resulting from the disorder, they cannot be considered eligible for disability benefits under current law and regulations. In addition, for individuals disabled by DAA, a determination must also be made as to whether the DAA is a factor material to the finding of disability. DAA is material when an individual would not be disabled if drug and/or alcohol use were to stop.

When the SSI program was established, 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. (Although there were no expressions by Congress as to why they did not extend these restrictions to Social Security Disability Insurance (SSDI) beneficiaries, we believe it is because payments to SSDI beneficiaries were considered an earned right.)

Legislation Enacted in 1994

In recent years, public criticism has been expressed about the appropriateness of providing cash benefits to individuals disabled by DAA and their responsibility to seek recovery. In response to these concerns, Congress enacted the *Social Security Independence and Program Improvements Act of 1994* which 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. The new restrictions generally limited benefit payments to 36 months for SSI recipients and SSDI beneficiaries (when treatment is available) and instituted

mandatory progressive sanctions (benefit suspension) for noncompliance with treatment.

RMA Responsibilities

To ensure that beneficiaries comply with the treatment requirement, SSA established agreements with States and private contractors serving as RMAs. The 1994 legislation required that SSA establish RMAs in each State. RMAs must:

- Determine if appropriate treatment is available;
- Refer beneficiaries to treatment;
- Monitor progress under treatment plans; and
- Report to SSA if a beneficiary is not in compliance with the treatment requirement.

Because the RMA contracts in place when the new law was enacted did not provide for SSDI beneficiaries, and were more limited in scope than what was required under the new legislation, Federal procurement rules required SSA to recompete and award new contracts. New RMA contracts which include SSDI beneficiaries were awarded in September 1995 (see tab A for break-out of State contractors and estimated contract costs).

RMA Referrals and Success Rates

As of September 1995, about 100,000 SSI recipients had been referred to RMAs. This figure includes cases which were pending from prior years under previous contracts and agreements as well as new referrals during the fiscal year. (Note: SSA contracts with RMAs were based on a total workload of 40,000 cases. Therefore, much of the pending would remain unprocessed until new contracts were negotiated in September 1995.) Of the contracted workload, about 30,000 beneficiaries were reported in treatment.

RMA contractors reported that nearly 5 percent of the 30,000 cases closed during fiscal year 1995 were closed because the beneficiary successfully completed treatment. In this sense, treatment is considered successful only if the beneficiary completed the plan of treatment. It does **not** mean the beneficiary left the rolls and entered the workforce. According to SSA records, since April 1995, when SSA began to collect data on the implementation of the 1994 legislation, 21 persons have successfully completed

1500

definition of "success"?

treatment and have had benefits terminated because of medical improvement. Although we do not have longitudinal data to draw a conclusion about the use of RMAs, the small number of successful treatments raises a question as to the value of using RMAs.

Proposed Legislation Regarding DAA Beneficiaries

Several bills in both the House and Senate have been introduced which would:

- Eliminate benefits to beneficiaries whose drug addiction and/or alcoholism is a contributing factor material to the finding of disability. (See tab B for number of SSI and concurrent beneficiaries receiving benefits based on DAA.)

- Apply representative payee requirements to DI or SSI beneficiaries who have a DAA "condition" that prevents them from managing benefits. 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.)

- Require SSA to refer individuals who must have a payee because of a DAA "condition" to the appropriate State agency for treatment.

- Provide appropriations for each of FYs 1997 and 1998 to carry out activities relating to the treatment of drug and alcohol abuse under the Public Health Service Act.

RMA Phase-Out

Should the above described legislation be enacted, the costs of RMA services--about $928 million through FY 2000 (see tab C)--could not be justified given that the proposed legislation eliminates the functions RMAs currently perform for SSA.

The legislation would eliminate current law requirements to:

-- impose payment sanctions against beneficiaries who refuse or fail to comply with treatment;

-- require monitoring of beneficiaries compliance with treatment;

-- mandate that beneficiaries exhibit progress in treatment; and

-- require reports to SSA regarding beneficiaries' treatment status.

In addition, beneficiaries with a DAA "condition" who would be referred to treatment under the proposed legislation, would not be removed from the rolls if their "condition" improved, because they have been determined disabled independently of DAA. Therefore, contracting with RMAs would not be a prudent use of SSA's limited administrative resources.

To phase out RMA contracts under the proposed legislation, SSA would exercise a "termination of convenience." After RMA contractors submit costs they have incurred up to the termination date of the contract, contractors and SSA would negotiate and settle on compensation due. Because SSA would be required to pay RMAs for services provided in 1996, neither CBO nor SSA estimated RMA savings in FY 1996 for proposed legislation.

928M thru FY2000

SUMMARY OF DA&A CONTRACT NEGOTIATIONS

Contracts awarded 9/25/95 and expire 9/24/98.

Vendor
Maximus, Inc. of Vienna, Va

Amount
$ 350,275,880

(42 States, D.C., and Puerto Rico)

Alabama	Hawaii	Montana	Puerto Rico
Alaska	Idaho	Nevada	Rhode Island
Arizona	Indiana	New Hampshire	South Carolina
Arkansas	Iowa	New Jersey	South Dakota
California	Kansas	New Mexico	Tennessee
Colorado	Kentucky	New York	Texas
Connecticut	Louisiana	North Carolina	Utah
Delaware	Maine	North Dakota	Vermont
D. C.	Maryland	Ohio	Virginia
Florida	Minnesota	Oklahoma	West Virginia
Georgia	Missouri	Pennsylvania	Wyoming

Independent Awards:

(6 States)

State	Vendor	Amount
Illinois	State Department of Alcoholism & Substance Abuse	$ 22,531,434
Massachusetts	Center for Addictive Behavior, Inc. (Private Vendor)	9,367,414
Michigan	State Department of Rehabilitation Services	21,669,112
Nebraska	State Department of Public Institutions	285,198
Washington	State Department of Social & Health Services	5,786,354
Wisconsin	State Division of Health & Social Services	5,600,617

No Awards Under SSA-RFP-95-2476:

(2 States)

Mississippi	Contract awarded 9/30/93 is still in effect. Does not include DI beneficiaries.
Oregon	No DA&A RMA Services. Negotiations with the State are underway for possible contract award.

1/22/96

TITLE XVI AND CONCURRENT TITLE II/TITLE XVI DRUG ADDICTS AND ALCOHOLICS IN PAY STATUS

12/92 THROUGH 09/95[1]

	12/92	12/93	12/94	09/95
NATIONAL	53,464	78,310	100,771	116,557
REGION I				
CT	149	232	347	
ME	182	336	540	
MA	1,364	1,869	2,680	
NH	22	26	75	
RI	61	112	190	
VT	70	100	128	
REGION II				
NJ	257	417	529	
NY	2,389	3,291	3,934	
REGION III				
DE	17	31	36	
DC	21	38	66	
MD	488	719	1,061	
PA	1,528	1,995	2,609	
VA	409	600	808	
WV	404	684	1,061	
REGION IV				
AL	296	455	665	
FL	357	543	820	
GA	390	566	883	
KY	517	1,226	2,349	
MS	129	228	409	
NC	276	473	744	
SC	104	217	424	
TN	929	2090	3,756	
REGION V				
IL	9,321	13,060	15,486	
IN	785	1,028	1,274	
MI	3,708	7,592	9,781	
MN	1,553	2,213	2,496	
OH	1,292	2,414	4,444	
WI	2,248	2,651	2,806	

	12/92	12/93	12/94
REGION VI			
AR	124	178	289
LA	162	210	363
NM	126	189	252
OK	122	189	309
TX	265	365	710
REGION VII			
IA	146	232	329
KS	58	154	293
MO	420	571	773
NE	87	122	197
REGION VIII			
CO	215	314	486
MT	188	236	278
ND	66	88	114
SD	94	144	191
UT	73	93	151
WY	15	21	25
REGION IX			
AZ	534	733	1,016
CA	18,572	25,651	29,706
HI	149	220	249
NV	178	341	533
REGION X			
AK	99	155	232
ID	77	110	163
OR	453	741	1,064
WA	1,600	2,110	2,647

1. Latest National data available; Title II DA&A data and State-by-State data for 1995 not available.

SOURCE OF INFORMATION: Office of Disability

C

Referral and Monitoring Savings
$ in millions

Proposed Legislation

	FY 97	FY 98	FY 99	FY 00	TOTAL
T16	-$107	-$186	-$166	-$193	-$652
T2	-$41	-$65	-$82	-$88	-$276
	-$148	-$251	-$248	-$281	-$928

04-Jan-96

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington, D.C. 20004
202-638-2121
202-638-7045 Telecopy

Cynthia E. Berry
Deputy General Counsel
& Vice President

February 20, 1996

Ms. Diana Fortuna
Senior Policy Analyst
Office of Policy Development
Domestic Policy Council 224-A
Old Executive Office Building
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Diana:

I wanted to thank you for arranging and participating in last week's meeting at the Social Security Administration.

The MAXIMUS group was excited to have the opportunity to share with you and Deputy Commissioner Chesser its data which demonstrate the successes and savings produced by the RMA program. We hope you agree that as a matter of public policy, as well as fiscal responsibility, it makes sense to continue referral and monitoring for the 75%-80% of drug addicts and alcoholics who would return to the SSI rolls despite the passage of legislation ending the DA&A disability category.

I understand your concerns about SSA's ability to sanction noncompliant beneficiaries absent clear legislative direction. I would be very interested to learn what you determine after consulting with SSA counsel. If you and counsel believe that legislative authority is necessary, I hope the Administration will work with us to make sure that the appropriate language is included in whichever legislative vehicle contains SSI and/or SSDI reform.

Again, thank you so much for taking time out of your hectic schedule to meet with us. If you have any questions or need any additional information, please do not hesitate to call me. I look forward to working with you.

Sincerely,

Cynthia E. Berry

MAXIMUS
20th
ANNIVERSARY
1975 • 1995

MAXIMUS

HELPING GOVERNMENT SERVE THE PEOPLE

February 16, 1996

Diana Fortuna, Senior Policy Analyst
Office of Policy Development
Domestic Policy Council 224-A
Old Executive Office Building
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Ms. Fortuna: Diana

Thank you for taking the time to meet with MAXIMUS, and allowing us an opportunity to provide you with more details on the success of the RMA program. The Clinton Administration can take credit for eliminating fraud and abuse, reducing the disability rolls, and providing treatment for those who want the help.

We are looking forward to working with SSA actuaries and General Counsel to determine what barriers remain to continuing the RMA. MAXIMUS recognizes that sanctioning is a key component to ensuring that individuals who are drug and alcohol dependent remain in treatment. While SSA may not have exercised its authority in the past to sanction or withhold benefits from non-DA&As, we believe that exercising its regulatory authority at this time will result in significant long-term dividends through further reductions in the disability rolls. Since DA&A would no longer be a disability category under the new legislation, sanctioning beneficiaries who do not accept treatment would be non-discriminatory.

MAXIMUS stands ready to provide you with any additional information you may require in reviewing the RMA program. If you have any specific questions about the program, please feel free to call either me at (703) 734-4200 or Ilene Baylinson at (703) 790-9515.

We believe that we are part of a program whose accomplishments will have a significant impact on the future of disability services in this country. We hope to have an opportunity to work with you to ensure the continuation of this program.

Sincerely,

David V. Mastran
Chief Executive Officer
MAXIMUS, Inc.

DVM/wpc

cc: Betsey Wright, The Wexler Group
Lee Verstandig, The Wexler Group

2/14/96

RMA's / Wexler / Maximus

Verstandig, Cindy Berry } Wexler

Mastrandrea, Baylinson } Maximus

Gwen Rubinstein - LAC

Chesser, Jasmine } SSA

THE WEXLER GROUP
1317 F Street, NW
Washington, DC 20004
(202) 638-2121

cc Jeremy
Molly

FYI

DATE: *January 3, 1996*

TOTAL NUMBER OF PAGES (INCLUDING THIS PAGE): *6*

Please deliver the following page(s) to:

NAME: **Diana Fortuna**

FAX NUMBER: 202/456-7028

SPECIAL INSTRUCTIONS:

We wanted to make sure you were aware of NASADAD's activities on the SSI and SSDI drug addiction and alcoholism issue. Would the Administration be willing to weigh in on this with Congress?

MAXIMUS is pulling together some data for you. We will contact you as soon as we receive it so we can pursue the meeting we discussed.

Thanks so much for your help.

FROM: *Betsey Wright*
Cindi Berry

If you do not receive the entire telecopy message, please call us as soon as possible at (202) 638-2121.

Operator's Name: *Shirley*

Facsimile No.: *202-638-7045*

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

MEMO TO: Gerry Kavanaugh
Senate Labor and Human Resources Committee

FROM: Kathleen Sheehan and Chris Rugaber

DATE: December 21, 1995

HOLD NEEDED ON S. 1432, "SENIOR CITIZENS' RIGHT TO WORK ACT"

Attached is our summary of the issues regarding the removal of drug addiction and alcoholism (DA&A) as a disability category for the SSI and SSDI programs, as called for in S. 1432, the "Senior Citizens' Right to Work Act." This bill has been passed by the House and the Senate Finance Committee, and its supporters are pushing for the bill to be brought to the Senate floor by tomorrow. The removal of the DA&A population would provide cost offsets for the increase in the Social Security earnings allowance that S. 1432 would provide.

NASADAD is supportive of S. 1432, but strongly believes that removal of the DA&A disability category is an inappropriate cost offset. As our summary notes, many DA&A recipients could reclassify for SSI/SSDI under another disability. If reclassified, they would continue to receive SSI/SSDI benefits and Medicaid assistance, without the incentive for treatment provided for by the Referral and Monitoring Agencies. The 20-25 percent that are not reclassified will lose everything. Attached is a State-by-State listing of the number of SSI and SSDI DA&A recipients, compiled by the General Accounting Office. Also attached is our most recent waiting list survey, which shows how overburdened the public treatment system already is.

Because of these and other factors outlined in our summary, NASADAD requests that Senator Kennedy place a hold on the bill until an alternative offset can be found. Please call Chris Rugaber at (202) 783-6868 regarding the possibility of a hold being placed. Thank you very much for your time and consideration.

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

SSI AND SSDI REFORM
(12/20/95)

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) opposes provisions in the "Senior Citizens' Right to Work Act" that would eliminate Drug Addiction and Alcoholism (DA&A) as disability categories for the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs. This paper summarizes our concerns on this issue.

1) **Over 75% of the DA&A population would be reclassified under a different disability and continue to receive an SSI or SSDI payment.** According to the Congressional Budget Office (CBO), *"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."* CBO made this estimate for the SSI program, but there is no reason to believe the SSDI population will be any different. As a result, reclassifications will require significant time, staff and paperwork to process.

2) **Those with alcohol and other drug (AOD) problems who are reclassified would no longer be subject to stringent requirements passed by Congress in 1994.** Legislation passed last year strengthens provisions requiring that DA&A recipients be closely monitored for treatment compliance by a Referral and Monitoring Agency (RMA), and that a third-party representative payee be selected to handle their payments. In addition, it provides a limit of 36 months of SSI benefits to individuals classified as DA&A recipients.

   Once these recipients are reclassified under a different disability, Referral and Monitoring Agencies will no longer ensure that recipients receive treatment and other services essential to getting these individuals back to work. Furthermore, benefits will not be time-limited. This would clearly not be an improvement over what exists now. Treatment in a supervised setting holds the best potential for long term recovery and self-sufficiency.

3. **Removing those with alcohol or other drug (AOD) problems from SSI and SSDI would result in a significant cost-shift to the States.** A letter dated February 23, 1995 from the National Governors' Association to House Ways and Means Committee Chair Bill Archer noted that proposed changes in SSI eligibility *"represent a substantial and unacceptable cost shift to states."* NGA adds, *"We also ask that Congress allow last year's amendments regarding the substance abuse population to be implemented before enacting new changes in that area. If changes in SSI are enacted that deny benefits to hundreds of thousands of families and children, the result may be a sharp increase in the need for aid from the new cash assistance block grant at a time when those funds would be capped."*

4) **RMAs have vastly improved in the past several years, and should be allowed to continue with their work.** RMAs ensure that each recipient is assessed, referred to appropriate treatment, has their treatment monitored, and is subjected to graduated periods of benefit suspension for non-compliance with treatment or failure of a drug-test. The Referral and Monitoring Agency function has been strengthened and expanded greatly in recent years as it has been carried out by State Alcohol and Drug Agencies and private companies. Washington State's Division of Alcohol and Substance Abuse runs an RMA that has shown considerable success. A recent study found that 82% of its monitored recipients stayed in treatment, versus 35% of recipients not monitored.

MAXIMUS RMA has contracted to run RMAs in 35 States, and has greatly improved monitoring capabilities through the use of computerized tracking. In the past 12 months, over 11 percent of recipients monitored by Maximus have been referred back to the Social Security Agency due to noncompliance with treatment requirements. Moreover, Maximus has implemented a standardized assessment process that has reduced the number of AOD-disabled recipients on SSI rolls. Allowing this work to continue will yield significant cost savings, from both reduced SSI rolls and increased treatment success.

5) **Removal of the DA&A population from the SSI rolls is already included in the welfare reform bill.** By including this measure as an offset in this bill as well, conflicts between the two measures could arise.

Conclusion

NASADAD understands that many policymakers support removing the DA&A population from SSI and SSDI out of concern over the occasional misuse of federal dollars. But under the "Senior Citizens' Right to Work Act," since drug addicts and alcoholics will no longer be classified and therefore monitored as such, *the potential for misuse of benefits will increase, not decrease.*

MAXIMUS RMA and State Alcohol and Drug Agencies will no longer monitor recipients and refer back to SSA those that do not comply with treatment requirements. And the 36-month limit that currently prevents long-term use of SSI or SSDI by those with AOD problems will no longer apply. *Currently, there is a guarantee that the DA&A population will be removed from the SSI/SSDI rolls; if the DA&A category is eliminated, that guarantee will disappear.*

Number of Addicts by State

		Substance Abuse Diagnoses				
			SSI Non-DA&A		DI Non-DA&A	
State	Grand Totals	SSI DA&As[a]	Primary[b]	Secondary[c]	Primary[b]	Secondary[c]
Alabama	3,953	397	284	1,847	344	1,081
Alaska	348	134	25	88	40	60
Arizona[d]	2,593	572	207	465	429	630
Arkansas	2,074	154	97	1,027	168	628
California[d]	34,935	23,561	3,884	211	3,613	3,966
Colorado	3,306	291	206	1,250	226	1,333
Connecticut	3,718	190	193	916	253	2,161
Delaware	817	26	16	109	26	640
District of Columbia	920	37	50	583	17	233
Florida	13,728	485	480	7,088	544	5,201
Georgia	8,382	464	480	3,387	463	3,618
Hawaii[e]	957	209	30	158	95	465
Idaho	386	98	47	195	64	142
Illinois[d]	27,728	11,643	3,302	2,102	3,705	6,972
Indiana	5,130	957	666	845	901	1,761
Iowa	1,839	195	84	411	116	761
Kansas	1,721	100	84	828	188	721
Kentucky	6,374	912	601	3,029	481	1,351
Louisiana	2,259	189	264	1,228	199	379
Maine	1,815	284	125	225	236	746
Maryland[d]	2,472	604	225	408	300	935
Massachusetts	9,287	1,679	1,270	2,066	1,124	3,148
Michigan[d]	14,524	6,315	662	2,018	1,853	3,675
Minnesota[e]	5,171	1,992	308	552	761	1,558
Mississippi[d]	1,547	177	192	363	188	627
Missouri	3,986	624	115	827	331	1,689
Montana[d]	885	222	46	389	82	246
Nebraska[d]	1,091	107	22	379	73	510
Nevada[e]	1,174	273	73	137	221	470
New Hampshire	719	26	37	182	64	410
New Jersey[d]	4,768	366	442	1,770	416	1,763
New Mexico	1,270	177	121	609	136	227
New York[e]	15,536	2,887	2,456	5,006	1,668	3,519
North Carolina	6,216	386	275	2,493	413	2,646
North Dakota	870	61	9	436	85	289
Ohio[e]	9,086	1,91	966	2,749	1,064	2,386

(continued)

Appendix II
Number of Addicts by State

State	Grand Totals	Substance Abuse Diagnoses				
		SSI DA&As[a]	SSI Non-DA&A		DI Non-DA&A	
			Primary[b]	Secondary[c]	Primary[b]	Secondary[c]
Oklahoma	2,359	187	117	1,372	126	557
Oregon	2,799	618	199	873	324	1,125
Pennsylvania[d]	7,857	1,849	713	2,141	742	2,212
Rhode Island	1,290	96	67	499	83	545
South Carolina	2,271	187	137	1,176	201	590
South Dakota	1,220	127	24	751	53	265
Tennessee[d]	4,962	1,593	591	616	768	1,164
Texas	6,833	319	274	3,425	402	2,413
Utah	1,250	87	74	527	89	473
Vermont	606	90	57	127	74	258
Virginia	3,054	516	177	799	882	1,210
Washington[d]	5,003	1,941	312	523	662	1,565
West Virginia	2,108	672	218	366	304	828
Wisconsin[d]	5,755	2,524	390	1,137	928	1,776
Wyoming	455	19	11	252	17	159
Total	249,199	69,419	21,268	69,799	26,065	71,708

[a]SSI DA&A recipients in current payment status as of August 2, 1993.

[b]Number of addicts in current payment status as of August 2, 1993, (SSI) and September 23, 1993 (DI).

[c]Estimated number of addicts based on claims allowed during the years 1989 to 1992 and the relationship between those with primary diagnoses of substance abuse versus those with secondary diagnoses of substance abuse.

[d]States (18) with RMAs as of December 31, 1993.

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington, D.C. 20004
202-638-2121
202-638-7045 Telecopy

Betsey Wright
Executive Vice President

February 13, 1995

OMIS?

TO: Diana Fortuna
Judy Chesser

FROM: Betsey Wright BW

RE: Wednesday, February 14 meeting with Maximus officials

Attending the meeting with you tomorrow will be the following persons:

David V. Mastran, CEO, Maximus

Ilene R. Baylinson, President, Health and Social Services Division, Maximus

Gwen Rubinstein, Health Policy Associate, Legal Action Council

Lee Verstandig, The Wexler Group

Cindi Berry, The Wexler Group

Many thanks for providing this meeting.

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington, D.C. 20004
202-638-2121
202-638-7045 Telecopy

Betsey Wright
Executive Vice President

FAX COVER SHEET

NAME: Diana Fortuna FAX NUMBER: (---) --- - ---- 202/456-7028

FROM: BETSEY WRIGHT/Shirley Watson

PAGES: 2

DATE: 2/13/96

MESSAGE:

ANY PROBLEMS WITH THIS TRANSMISSION PLEASE CALL (Shirley) 202-662-3753

TO
Diana
Fortuna

FYI

THE WEXLER GRO

1317 F Street, N.W.
Suite 600
Washington, D.C. 20004
202-638-2121
202-638-7045 Telecopy

Betsey Wright
Executive Vice President

: HR departure
on F when
[redacted]

ER SHEET
: CHR tomorrow

NAME: Carol Rasco **FAX NUMBER:** (202) 456-2878

FROM: BETSEY WRIGHT/Shirley Watson

PAGES: 3 (Including cover)

DATE: December 21, 1995

MESSAGE:

ANY PROBLEMS WITH THIS TRANSMISSION PLEASE CALL (Shirley) 202-662-3753

dually diagnosed - refer to state age

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington D.C. 20004
202 638 3131
202-638-7045 Telecopy

MEMORANDUM

TO: Carol Rasco

FROM: Betsey Wright

DATE: December 21, 1995

RE: Referral and Monitoring requirement for all SSI beneficiaries with an alcoholism or drug addiction condition

To counter the problems with ineligible beneficiaries, the Social Security Administration put out RFP's for referral and monitoring in the fall of 1993.

The contracts were awarded and began May 1, 1994.

You will see from the attached chart that in the 36 states which have this monitoring process, and in the period from May 1, 1994 through November 30, 1995, the system has recommended for termination 48% of the referred caseload. Folks were recommended for termination based on failure to participate in treatment, inappropriate treatment, incarceration, death, and other ineligibilities. THE PROCESS WORKS. IT HAS KICKED OFF THE FRAUDULENT RECIPIENTS.

Being unaware of this program, the Congress (apparently with White House blessings) is eliminating eligibility of people with a drug addiction or alcoholism.

75% - 80% (estimate of SSA, CBO, and CRS) of the drug addicts and alcoholics who will now be dumped from SSI or SSDI because of this new legislation will requalify based on another disability category -- and they will still have a drug addiction or alcoholism problem. Without the treatment referral and monitoring for this population, these people will never be "cured," will stay on the federal rolls forever, and some will abuse the system; there will be another disastrous "60 Minutes" story highlighting the abuse.

THERE IS NOTHING WHICH PROHIBITS THE COMMISSIONER FROM CONTINUING WITH THE MONITORING PROGRAMS. The White House should instruct her to do so. The current monitoring contracts go through January of 1997. The Commissioner should be urged by you to use her authority to continue them through the entire three years of their program life in order to really get a good record of the effects of monitoring fraud and abuse in the DA&A program.

Please call me about the feasibility of this.

NOTE: The contracts from SSA are with Maximus, a client of the Wexler Group.

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 505 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

h 588-1040

cc Carol
Jeremy
Bruce
Dennis
Ken
Richard

November 9, 1995

Diana Fortuna
Domestic Policy Council
Old Executive Office Building
Room 224
Washington, D.C. 20500

Dear Diana:

As welfare reform legislation makes its way to the President's desk, I wanted to share with you the collective opinion of leading drug and alcohol organizations about language affecting SSI benefits for individuals disabled by drug dependence and alcoholism, an issue we had met about last July. I have attached a sign-on letter we sent to welfare conferees and Senate and House leaders. I hope it helps inform the President's decision making about whether to sign or veto the legislation.

If you have any questions, please don't hesitate to call me at (202) 544-5478.

Sincerely,

Gwen Rubinstein

Gwen Rubinstein
Health Policy Associate

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

Rebecca Holland – TASC

Elim of RMA's scored as svgs

Gwen R: RMA's in law

Cindy Berry Wexler 682-3714

October 30, 1995

Dear Welfare Conferee:

The undersigned organizations urge you to adopt the following legislative provisions and report language regarding Supplemental Security Income (SSI) benefits for individuals whose drug dependence and alcoholism is a factor material to the Commissioner's determination that they are disabled.

Request House to accept Senate provisions regarding the SSI program for individuals whose drug dependence or alcoholism is a factor material to the Social Security Commissioner's determination of disability.

Conf: compromise = OMB

Both the House and Senate bills deny SSI benefits to individuals whose drug dependence or alcoholism is a factor material to the Social Security Commissioner's determination that they are disabled. According to the Congressional Budget Office (CBO), 75 to 80 percent of these individuals will re-qualify for benefits under another disability category. The following provisions of the Senate bill are critical to preventing abuse in the program:

prevents mgg benefits

- Benefits for an individual eligible for SSI must be paid to a representative payee if the individual also has been diagnosed as drug dependent or alcoholic.

This will prevent drug dependent and alcoholic individuals who qualify for SSI based on another disability from receiving direct cash payments and using them inappropriately.

- The Social Security Commissioner must refer requalified individuals for drug or alcohol treatment. Under current law, these individuals must enter and complete treatment, are not eligible for SSI benefits if they do not accept referred treatment services, and are limited to 36 months of benefits.

SSI recipients with drug and alcohol problems will never leave the Federal rolls if they do not receive treatment. In most cases, their drug or alcohol problem contributes to their other qualifying disability.

not on a positive — refer to state agencies

Request conferees to adopt report language to clarify the role of Referral and Monitoring Agencies (RMAs).

haven't accommodated

When the House drafted and passed welfare reform legislation, it was unaware of the success of RMAs, which provide a noteworthy example of how the private sector has been able to manage a government program effectively. By applying private sector techniques and efficiencies, the RMA program weeds out fraud and abuse; places SSI beneficiaries with drug and alcohol problems into treatment, monitors their progress, and ensures that they comply with treatment; and provides SSA with a comprehensive, state-of-the-art database on SSI recipients, all of which the government had never been able to accomplish on its own. RMAs have also saved the government millions of dollars.

only DI

By requiring the SSA Commissioner to refer SSI recipients with drug and alcohol problems into treatment, the Senate bill recognizes the importance of treatment for this population. But the Senate language would have SSI recipients referred to the State agency that administers the Substance Abuse Block Grant. These agencies, however, do not provide direct treatment services or treatment referrals. The report language below is needed to clarify that the Commissioner may execute his or her referral duties under the Act by using an RMA where appropriate and cost-effective.

Suggested language:

> One of the principal goals of welfare reform is to help individuals end their dependency on government cash benefits and become self-sufficient members of society. Congress is aware of the significant progress that has been made in that regard through the requirement that every State have a Referral and Monitoring Agency (RMA) program. All across the country, RMAs have demonstrated success in referring federal disability beneficiaries with drug and alcohol problems into treatment, monitoring their progress and compliance, ensuring that they complete treatment, and appropriately removing them from Federal disability rolls. These efforts have produced millions of dollars in direct savings to the Federal government. The Congress, therefore, strongly encourages the Commissioner of Social Security to continue the RMA program, where cost-effective, in executing the Commissioner's duty under this Act to refer SSI beneficiaries with drug and alcohol problems into treatment.

Request Senate to accept House language on appropriations for drug and alcohol treatment but distribute the money through the Substance Abuse Block Grant.

$100 m

The House bill provides $400 million in direct appropriations for drug and alcohol treatment ~~each year~~ for FYs 97-2000, while the Senate bill provides only $50 million in FY 97 and 98. The House bill would have the funding flow through the Capacity Expansion Program (CEP), while the Senate bill would have it flow through the Substance Abuse Block Grant.

House

The public treatment system cannot currently meet the need in the community for services, and treatment slots will become even scarcer as these SSI recipients also lose their Medicaid, which supports some of their treatment. The ~~Senate~~ appropriation will come closer to the amount lost from Federal Medicaid, which paid an estimated $325 million for drug and alcohol treatment in FY 93.

Funding should be distributed through the Block Grant because it gives States the greatest flexibility to respond to local treatment needs. CEP, which is targeted for elimination in the FY 96 appropriations and reauthorization processes, sets a priority on treatment for pregnant women, which does correspond to the SSI population.

Conf - $50 for 2 yrs (Senate)

Request House to accept Senate language on effective date. Senate won

The House bill ends benefits immediately, while the Senate bill closes the rolls to newcomers immediately and ends benefits for current recipients on January 1, 1997. The Senate language gives current recipients a 12-month interval in which to complete treatment, thereby recognizing that ending SSI benefits in the middle of treatment serves no useful purpose for the Federal government or recipients.

American Methadone Treatment Association, Inc.
American Public Health Association
Bazelon Center for Mental Health Law
Legal Action Center
National Association of Addiction Treatment Providers
National Association of Alcohol and Drug Abuse Counselors
National Association of Protection & Advocacy Systems
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Black Police Association
National Coalition of State Alcohol and Drug Treatment and Prevention Associations
National Council on Alcoholism and Drug Dependence
National Community Mental Healthcare Council
National Mental Health Association
National Treatment Consortium for Alcohol and other Drugs
Phase: Piggy Back, Inc.
TASC, Inc., of Illinois

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

06-Feb-1996 05:42pm

TO: Kenneth S. Apfel

FROM: Keith J. Fontenot
Office of Mgmt and Budget, HRD

CC: Jack A. Smalligan

SUBJECT: Thoughts on Referral and Monitoring

This is big business. Used to be a guy named Jack Svahn -- former Reagan SSA commisioner and CA welfare guy -- who was involved in setting these things up. They've done very well at selling on the hill, but bluntly, I've never thought they added a lot of value.

I'll ask Jack or Richard to call Diana and sit in. Several hundred million dollars as a recall -- over the budget period.

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

06-Feb-1996 04:35pm

TO: Kenneth S. Apfel

FROM: Diana M. Fortuna
Domestic Policy Council

SUBJECT: Referral and monitoring agency meeting

The referral and monitoring agencies that were fairly recently set up under the restrictions put on drug addicts/alcoholics receiving SSI (to ensure they are in treatment) are arguing that they should continue to exist even assuming that the legislation passes that would eliminate DA&A as a reason for SSI. One of the agencies that has a lot of these contracts is Maximus, and Maximus is represented by a lobbyist (Betsey Wright), who wants to meet on this subject. I tentatively have a meeting scheduled with her this Friday at 1:30, and Judy Chesser will attend also. But I wanted to bring it to your attention in case you thought it would be appropriate for anyone from OMB to attend.