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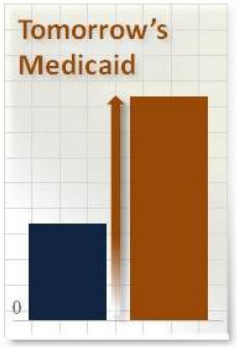

Disability Caseload Trends and Mental Illness:

Incentives under Health Care Reform to Invest in Mental Health Treatment for Non-Disabled Adults

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Report prepared for the Washington State Department of Social and Health Services, Aging and Disability Services Administration, Division of Behavioral Health and Recovery, David Dickinson, Director and Alice Huber, Chief, Evaluation and Quality Assurance

THE SUPPLEMENTAL SECURITY INCOME (SSI) program provides low-income individuals who are aged or disabled with cash assistance through the federal Social Security Administration (SSA) and with medical coverage through the Medicaid program. This policy brief shows that SSI caseload growth in Washington State has been driven by growth in the number of persons identified by the SSA as having a primary disability of mental illness. With the expansion of Medicaid under federal health care reform to more non-disabled low-income adults, and with an enhanced federal share of costs for the Medicaid Expansion population, states have an incentive to invest in mental health treatment for Medicaid adults who have not yet been determined to meet federal disability criteria.

Disability Trends and Policy Implications

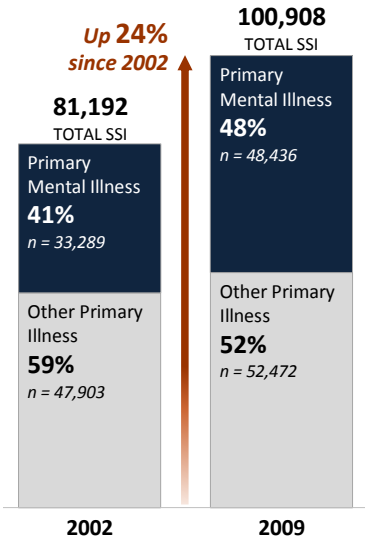
1. **Mental illness is the key driver of Washington State's SSI caseload growth.** Washington State's under-65 SSI caseload increased by 24 percent from 2002 to 2009.[1] Among working-age SSI recipients, mental illness is by far the most prevalent primary disabling condition, accounting for almost half of the caseload in 2009 and more than three-fourths of the caseload *growth* from 2002 to 2009. Washington State has the eighth highest proportion of working-age SSI clients with a primary disability of mental illness, according to SSA records.
2. **Health care reform will expand Medicaid to more low-income adults.** Starting in January 2014, federal health care reform legislation will expand Medicaid to all adults under age 65 with adjusted gross income at or below 133 percent of the federal poverty level, more than doubling Medicaid enrollment for working-age adults in Washington State.
3. **Under health care reform, there is a financial incentive to invest in mental health treatment for non-disabled adults prior to persons becoming functionally impaired to the point of disability.**[2] The enhanced federal match for the Medicaid Expansion population will be a "game changer" that shifts state financial incentives away from facilitating enrollment in the SSI program and towards improving the health status of Medicaid enrollees who have not yet become disabled. From a state budgetary perspective, the low state share of costs for the new Medicaid Expansion population creates significant incentives to adequately treat mental illness and prevent disability. Given that SSI caseload growth has been driven largely by growth in the number of individuals with mental illness, reducing growth in disability rates is likely to require investments in mental health treatment for Medicaid adults who have not yet been determined to meet federal disability criteria.

1 Social Security Administration, SSI Annual Statistical Report, 2002 and 2009.

2 See Mancuso, David and Barbara Felver, "Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention," Research and Data Analysis Division, Olympia.

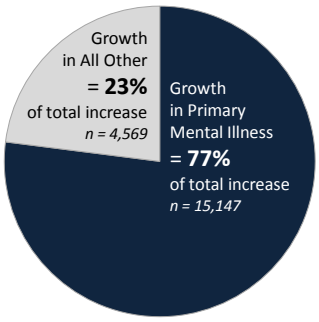
Washington's SSI Caseload Growth

Clients age 0 to 64



SSI Caseload Growth Due to Primary Mental Illness, 2002-2009

Clients age 0 to 64



TOTAL SSI CASELOAD INCREASE = 19,716

SOURCE: Social Security Administration, SSI Annual Statistical Report, 2002, 2009

Mental illness is the key driver of growth in Washington State's non elderly SSI caseload.

In 2009, 48 percent of Washington State non elderly SSI recipients had mental illness as their primary disabling condition, up from 41 percent in 2002. Moreover, 77 percent of that SSI caseload growth from 2002 to 2009 was due to an increase in the number of clients in the "primary mental illness" group. *See charts left.*

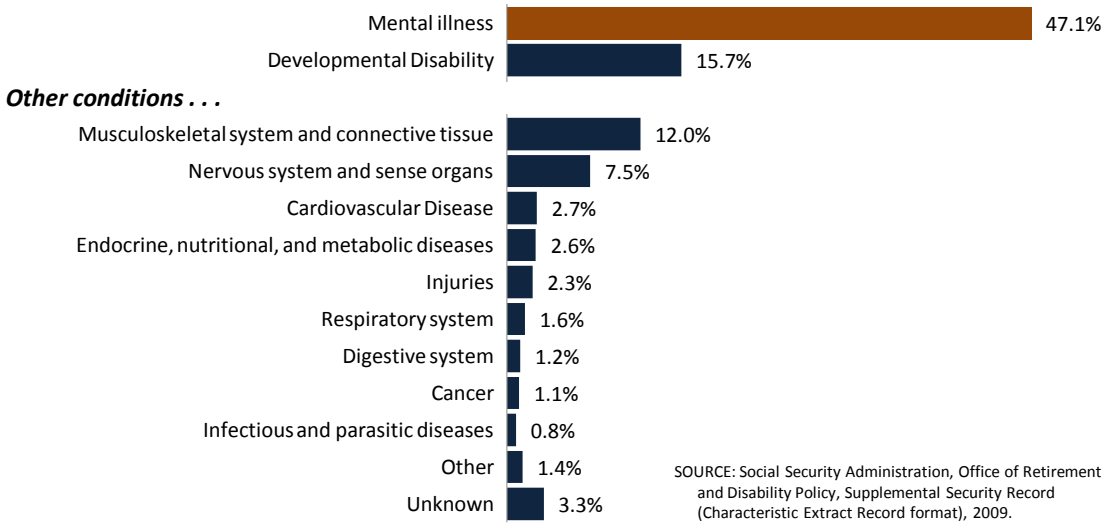
The Washington State experience is a reflection of a national trend dating back to changes in federal disability rules that were implemented in the mid 1980s. The federal rule changes made it easier for persons to qualify for disability due to mental illness, chronic pain, and multiple disease co-morbidities.

Mental Illness is by far the most prevalent primary disabling condition among working-age SSI recipients in Washington State.

In 2009, 47 percent of Washington State SSI recipients age 18-64 were identified with a primary disabling condition of mental illness in SSA data. The next most prevalent condition was developmental disability, with one-third as many recipients in that category. In contrast, diabetes and cardiovascular disease conditions together account for only five percent of the *primary disabling conditions* among the state's working age SSI population. *See chart below.*

It is important to note that diabetes and heart disease have a much higher *overall prevalence* than indicated by the data on primary disabling conditions, because diabetes and heart disease are often present as co-morbidities in combination with other primary disabling conditions. Nevertheless, the chart below shows the importance of mental illness, and to a lesser extent developmental disabilities and musculoskeletal conditions associated with chronic pain, in accounting for the largest share of primary disabling conditions as identified in the SSA disability determination process.

Primary Disabling Conditions among Washington State's SSI Recipients *(Clients age 18 to 64, n = 84,189)*

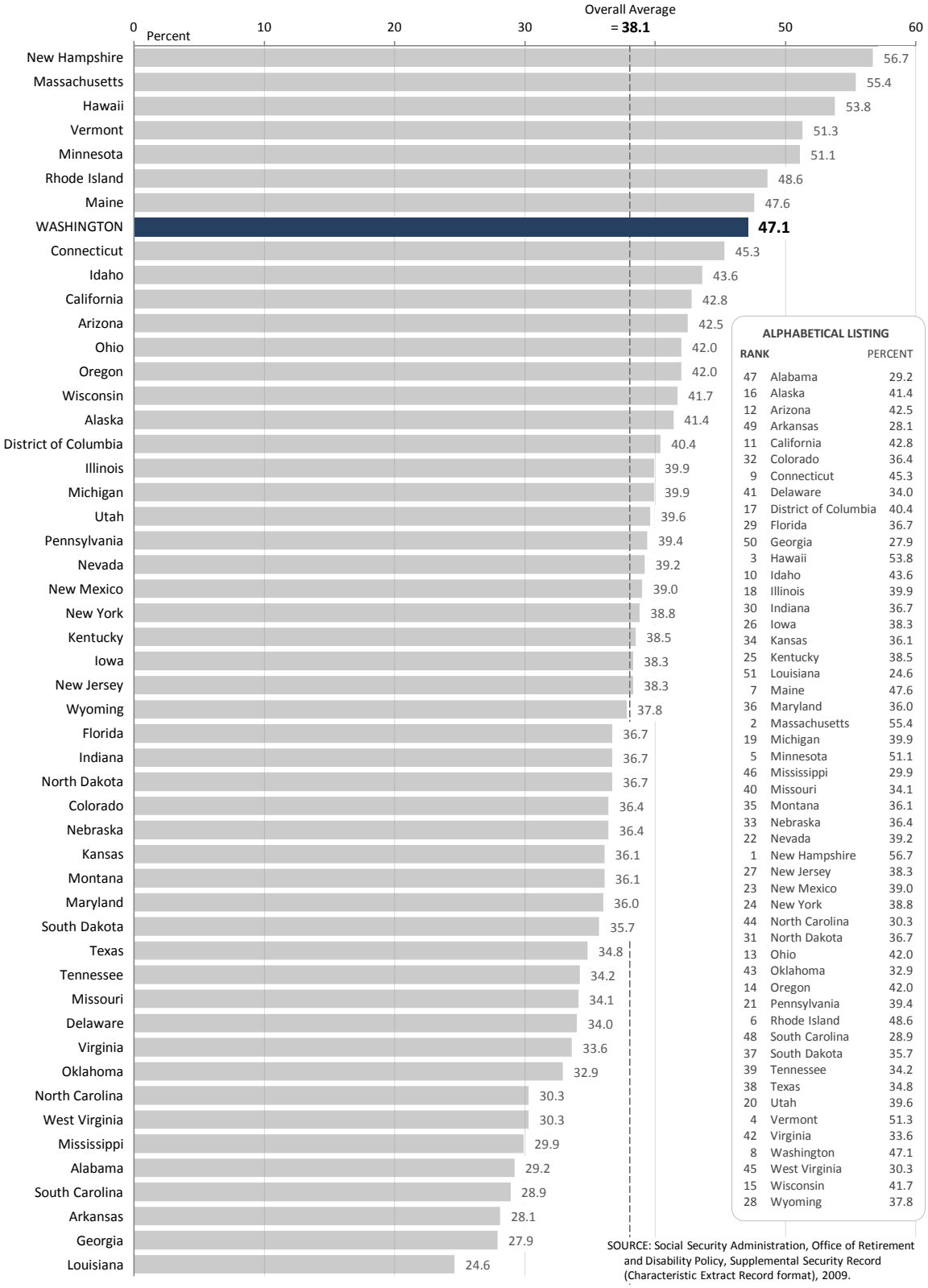


SOURCE: Social Security Administration, Office of Retirement and Disability Policy, Supplemental Security Record (Characteristic Extract Record format), 2009.

KEY TRENDS | Washington's SSI Caseload Ranks High on Primary Mental Illness

Washington ranks 8th out of 50 states and the District of Columbia in the proportion of SSI clients ages 18 to 64 with mental illness as their primary disabling condition.

Proportion of Working-Age SSI Clients with Primary Mental Illness



ALPHABETICAL LISTING

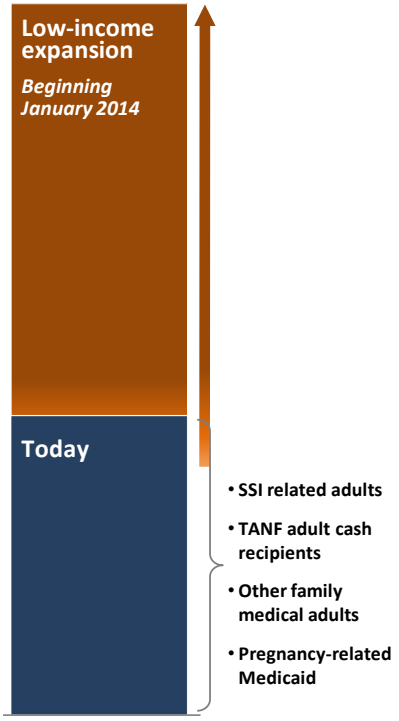
RANK		PERCENT
47	Alabama	29.2
16	Alaska	41.4
12	Arizona	42.5
49	Arkansas	28.1
11	California	42.8
32	Colorado	36.4
9	Connecticut	45.3
41	Delaware	34.0
17	District of Columbia	40.4
29	Florida	36.7
50	Georgia	27.9
3	Hawaii	53.8
10	Idaho	43.6
18	Illinois	39.9
30	Indiana	36.7
26	Iowa	38.3
34	Kansas	36.1
25	Kentucky	38.5
51	Louisiana	24.6
7	Maine	47.6
36	Maryland	36.0
2	Massachusetts	55.4
19	Michigan	39.9
5	Minnesota	51.1
46	Mississippi	29.9
40	Missouri	34.1
35	Montana	36.1
33	Nebraska	36.4
22	Nevada	39.2
1	New Hampshire	56.7
27	New Jersey	38.3
23	New Mexico	39.0
24	New York	38.8
44	North Carolina	30.3
31	North Dakota	36.7
13	Ohio	42.0
43	Oklahoma	32.9
14	Oregon	42.0
21	Pennsylvania	39.4
6	Rhode Island	48.6
48	South Carolina	28.9
37	South Dakota	35.7
39	Tennessee	34.2
38	Texas	34.8
20	Utah	39.6
4	Vermont	51.3
42	Virginia	33.6
8	Washington	47.1
45	West Virginia	30.3
15	Wisconsin	41.7
28	Wyoming	37.8

SOURCE: Social Security Administration, Office of Retirement and Disability Policy, Supplemental Security Record (Characteristic Extract Record format), 2009.

POLICY CONTEXT | Medicaid Expansion and the Enhanced Federal Match

With the passage of federal health care reform legislation—the Patient Protection and Affordable Care Act (ACA)—Medicaid coverage will be expanded to all adults under the age of 65 with income at or below 133 percent of the federal poverty level, starting in January 2014. This will result in a dramatic increase in Medicaid enrollment for working age adults without dependents by making Medicaid coverage more universally available to low income adults without regard to disability status or the presence of children in the household.

Tomorrow's Medicaid



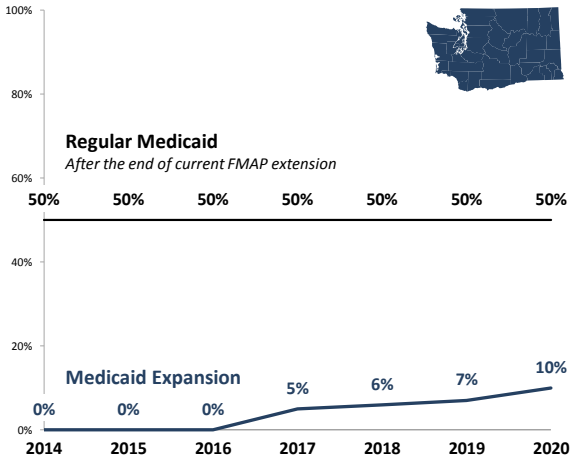
Health Care Reform will dramatically expand Medicaid coverage. The size of the Medicaid Expansion population will depend on a variety of factors including trends in economic conditions, trends in the availability of employer-based insurance for low-wage workers, and the participation rate among uninsured adults. Although there is uncertainty about the exact size of the expansion population, it is clear that it will be large in relation to working-age adult populations currently enrolled in Medicaid, which numbered approximately 280,000 adults as of June 2009. Initial estimates indicate that the low-income Medicaid Expansion will more than double the population of working age adults covered by Medicaid.

A review of early research into the likely health status of new Medicaid enrollees under health care reform shows that there are somewhat different views regarding this population. A recent Urban Institute report argues that new Medicaid enrollees are likely to be similar to current non-disabled Medicaid clients "since the new enrollees will be drawn from a population that is healthier than the adults currently covered by Medicaid."[3] An alternative review developed by the Center for Health Care Strategies (CHCS) and Mathematica Policy Research argues that new Medicaid enrollees are likely to have levels of chronic disease and behavioral health problems that are significantly greater than those experienced in the current non-disabled Medicaid population.[4]

Health Care Reform creates incentives for funding mental health treatment to prevent disability. The low state match for the new Medicaid Expansion population will create a financial incentive to provide adequate mental health treatment to prevent individuals from becoming functionally impaired to the point of disability. The state share of costs will be 0 percent from 2014 to 2016, increasing to 7 percent by 2019, and settling at 10 percent in 2020 and thereafter. By contrast, the regular state Medicaid match rate for SSI-related coverage is expected to be 50 percent over this time period. The differential match rate means that preventing disability will produce significant General Fund-State (GF-S) savings. In addition, the state share of costs for mental health services provided to the low-income population will be very low due to the enhanced federal match.

Fiscal Incentives to Prevent Disability

Washington's GF-S Share of Medicaid Costs



3 Holohan, J., G. Kenney, and J. Pelletier. August 2010. "The Health Status of New Medicaid Enrollees Under Health Reform." Urban Institute.

4 Somers, S., A. Hamblin, J. Verdier, and V. Byrd. August 2010 "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." Center for Health Care Strategies, Inc. and Mathematica Policy Research, Inc.

POLICY CONTEXT | Disability Lifeline, Mental Illness, and Transitions to SSI

An examination of the Disability Lifeline Unemployable (DL-U, formerly known as GA-U) program provides further insight into the importance of mental illness in driving SSI caseload trends. The DL-U program provides cash and medical benefits for adults without dependents who are physically or mentally incapacitated and expected to be unemployable for more than 90 days. Effective November 1, 2011, the cash grant portion of the program was eliminated and replaced with a Housing and Essential Needs program. Medical coverage through the DL-U program was brought under Medicaid through a federal waiver effective January 1, 2011.

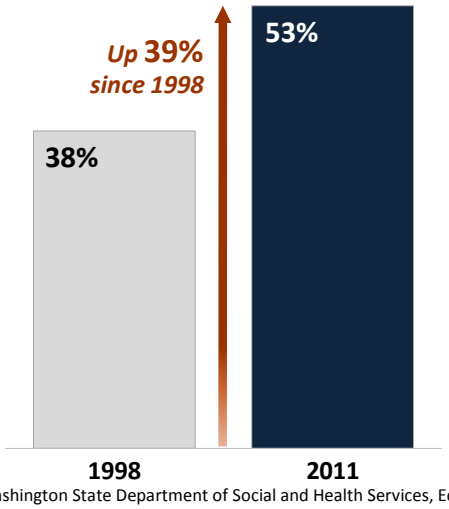
Whether or not DL-U medical coverage continues to exist in the interim, DL-U clients will be part of the Medicaid Expansion population created by the ACA. This population offers a perspective on the highest need subset of the Medicaid Expansion population who are at greatest risk of being determined to be disabled and subsequently enrolled in the SSI program. DL-U clients must meet state incapacity criteria that are similar to the criteria used by SSA to determine eligibility for federal disability benefits. The incapacity review process administered by the DSHS Economic Services Administration provides information on the primary incapacity for each DL-U client.

Between State Fiscal Year (SFY) 1998 and 2011, the proportion of individuals qualifying for DL-U with a primary incapacity of mental illness climbed from 38 percent to 53 percent. This mirrors the proportion of SSI recipients in Washington State who are identified in SSA data with a primary disability of mental illness (47 percent among working-age SSI recipients).

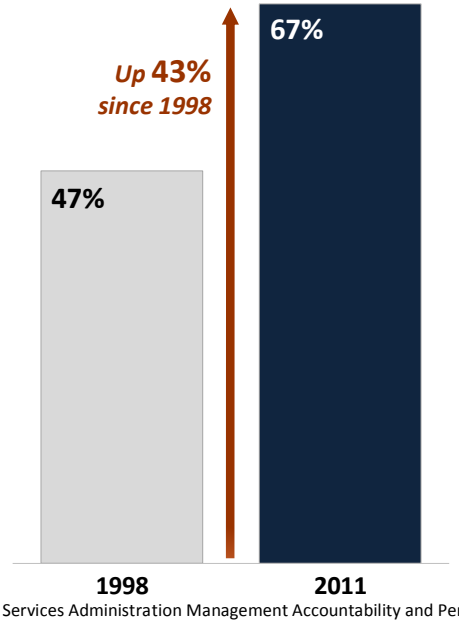
Furthermore, among DL-U clients deemed likely to qualify for federal disability (i.e., those transitioning from DL-U to the DL-Expedited program), the proportion with mental illness identified as their primary incapacity increased from 47 percent in SFY 1998 to 67 percent in SFY 2011. In other words, mental illness will be highly prevalent among the clients in the Medicaid Expansion population who are at greatest risk of being determined to be disabled and subsequently enrolled in the SSI program.

Increase in Mental Illness as Primary Incapacity for Disability Lifeline Clients

Percent of DL-U Clients with Mental Illness as Primary Incapacity
SFY 1998 to 2011



Percent of Clients Transitioning from DL-U to DL-X with Mental Illness as Primary Incapacity
SFY 1998 to 2011



SOURCE: Washington State Department of Social and Health Services, Economic Services Administration Management Accountability and Performance Statistics (E-MAPS).

DISCUSSION | Policy Implications

The enhanced federal match for the Medicaid Expansion population will be a "game changer" that shifts financial incentives away from facilitating enrollment in federal disability programs like SSI and towards improving the health status of Medicaid enrollees who have not yet become disabled. An effective state response to the incentives for disability prevention holds the promise of saving General Fund-State expenditures in an era of continuing revenue shortfalls. Given the role of mental illness in driving disability caseload growth, effective mental health treatment for persons who do not yet meet Federal disability criteria will be a high-opportunity intervention area in the Medicaid Expansion population.

This paper has documented the role of mental illness in driving disability caseload growth and hence health care costs. But mental illness also impacts outcomes and costs in other human service arenas. Low-income parents with mental health needs are more likely to have longer stays on family cash assistance due to difficulties getting or keeping employment. They are more likely to be involved in child abuse and neglect investigations and to have children in foster care. Persons with disabilities living in community residential settings or receiving assistance with functional limitations through in-home personal care have a relatively high prevalence of mental health needs, placing them at increased risk of requiring more restrictive and costly institutional care. And frail elderly persons with mental illness are more likely than other groups to have difficulties continuing to live at home as they age.

From a clinical perspective, the Mental Health Integration Program (MHIP) is a promising approach to providing mental health care for the Medicaid Expansion population. MHIP was used by the Community Health Plan of Washington to implement the mental health benefit that was added to the DL-U medical managed care benefit in January 2008. MHIP is based on a model of primary and behavioral health care integration developed and tested at the University of Washington Department of Psychiatry and Behavioral Sciences.[5] Including DL-U and other client populations, the MHIP program served 22,600 individuals between January 2008 and October 2011. Through MHIP, mental health treatment is provided within primary care settings, with care coordinators conducting regular assessments for mental health conditions and working with consulting psychiatrists to support primary care providers in caring for a patient's mental health needs. A recent evaluation of the MHIP program showed promising results.[6]

From a financing perspective, given that the Medicaid Expansion population is likely to be enrolled primarily in managed care, it is important for achieving State General Fund savings that the state's approach to managed care create incentives for health plans to focus on improving patient health status and reducing disability risk in the Medicaid Expansion population. There are multiple ways that this could be achieved, including through contractual performance requirements, thoughtful capitation rate setting, or financial incentives tied to performance metrics based on rates of transition to disability.

Copies of this paper may be obtained at www.dshs.wa.gov/rda/
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Please request REPORT NUMBER 3.36
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5 Unützer, J., Katon, W., Callahan, C.M., Williams, J.W., Hunkeler, E., et. al. (2002). Collaborative care management of late-life depression in the primary care setting. A randomized controlled trial. Journal of the American Medical Association, 288 (22), 2836-2845.

6 Joesch, Jutta, et al. (2011). "Evaluation of the General Assistance Managed Care Pilot in King and Pierce Counties for the Period January 2008 through September 2009," Seattle, WA: Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP), Department of Psychiatry and Behavioral Sciences, University of Washington (UW) at Harborview Medical Center.