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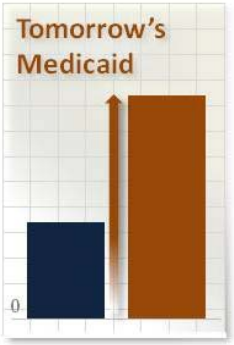

Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention

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Key Findings

1. **Health care reform will dramatically increase Medicaid enrollment for working age adults by making Medicaid coverage available universally to low-income adults without regard to pregnancy, disability status or the presence of children in the household.** The expansion population is likely to more than double the population of working-age adults receiving Medicaid.
2. **The Medicaid expansion population will have relatively high rates of alcohol/drug problems.** The Medicaid expansion population will include most Disability Lifeline and ADATSA clients, along with many persons who have been involved in the criminal justice system. These populations are known to have high rates of alcohol/drug problems.
3. **The likely demand for alcohol/drug treatment services from the Medicaid Expansion population will overwhelm the existing publicly funded alcohol/drug treatment provider network.** Based on the level of alcohol/drug treatment penetration currently observed in the SSI and Disability Lifeline populations, we estimate that more than 40,000 clients in the Medicaid expansion population would engage in alcohol/drug treatment in a typical fiscal year, if treatment were available.
4. **Untreated substance abuse is a key driver of chronic physical disease progression that results in qualification for disability related Medicaid coverage.** Providing alcohol/drug treatment to those who need it slows disease progression.
5. **The low state share of costs for the Medicaid expansion population creates a financial incentive to provide alcohol/drug treatment to slow the progression of diseases that result in disability.** The long-run state share of costs for the expansion population will be 10 percent, compared to 50 percent for SSI-related Medicaid coverage. Keeping clients healthy enough to remain enrolled in expansion coverage rather than SSI-related Medicaid will produce large State General Fund savings.
6. **Several steps could be taken to better position the state to have adequate alcohol/drug treatment capacity to serve the Medicaid expansion population**:
   - Preserve current alcohol/drug treatment funding for the low-income adults who will become a significant part of the Medicaid expansion population.
   - Finance alcohol/drug treatment for Medicaid populations through a forecast process that will ensure that funding adjusts based on caseload growth.
   - Implement workforce development strategies to build treatment provider capacity.
   - Consider expanding the use of brief intervention strategies for substance abusing clients who are not yet chemically dependent.

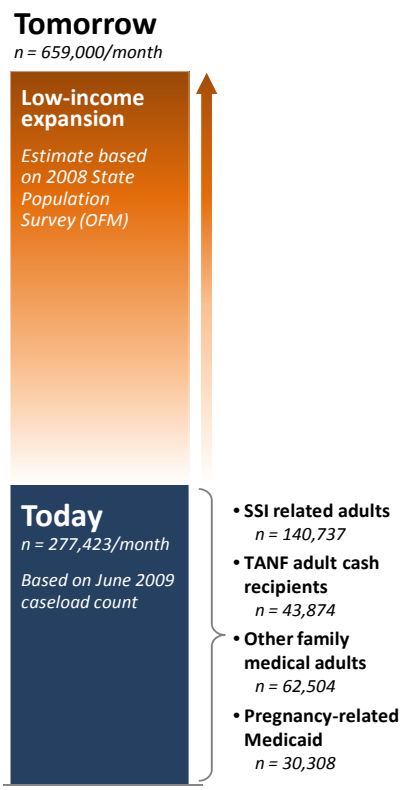
Health Care Reform will dramatically expand Medicaid coverage

The passage of federal health care reform legislation—the Patient Protection and Affordable Care Act (ACA)—will have profound impacts on the delivery of health care in Washington State. One of the major provisions of the ACA is the expansion of Medicaid to all adults under the age of 65 with income at or below 133 percent of the federal poverty level, starting in January 2014. Although some low income parents with children will be newly eligible for Medicaid, the ACA 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.[1]

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 are that the low-income Medicaid expansion could add 380,000 clients to the monthly caseload—more than doubling the population of working age adults covered by Medicaid (figure 1).[2]

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]

FIGURE 1.
Medicaid working-age adults



It is important to understand the likely health care needs of the population that will be newly qualified for Medicaid to inform benefit design, forecast service utilization and expenditures, and to identify areas where provider network capacity is likely to be particularly constrained. This paper focuses on what we know about the likely level of substance abuse treatment need in the Medicaid expansion population in Washington State, based in part on information about jail populations and clients currently receiving state-funded medical assistance who likely will be a key subset of the Medicaid expansion population.

In addition, this report describes how health care reform creates strong financial incentives for states to focus on providing services that slow the progression of chronic disease conditions that result in disability, and the important role of substance abuse treatment in this area. 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 (for states with state funded general assistance programs), and towards improving the health status of Medicaid enrollees who have not yet become disabled. **An effective response to the incentives for disability prevention holds the promise both of saving General Fund-State expenditures in an era of continuing revenue shortfalls, and of bending the aggregate cost curve for disability related Medicaid coverage towards a more sustainable rate of growth.**

The Medicaid expansion population will have high rates of substance abuse

There are reasons to expect the Medicaid expansion population will have high rates of substance abuse compared to existing working-age adult populations enrolled in Medicaid. For example, most individuals meeting current eligibility criteria for state-funded Disability Lifeline and ADATSA[5] medical coverage will now qualify for Medicaid coverage, and these populations are known to have high rates of alcohol/drug treatment need. ADATSA clients qualify for medical coverage because they are unable to work due to a substance use disorder and are participating in chemical dependency treatment (or waiting for treatment to become available). With regard to the Disability Lifeline program, although clients must have a primary physical or mental illness incapacity other than a substance use disorder to qualify for the program, many have co-occurring alcohol/drug problems. Overall, more than half of the 45,000 adults who were enrolled in Disability Lifeline or ADATSA coverage for at least one month in SFY 2009 had an identified alcohol/drug treatment need indicated in administrative data (Figure 2).[6]

In estimating the contribution of Disability Lifeline and ADATSA clients to the Medicaid expansion caseload, it is important to note that the average coverage duration for these programs is much shorter than for Medicaid.[7] Consequently, the average monthly caseloads for the Disability Lifeline and ADATSA programs significantly understate the likely monthly Medicaid expansion caseload contribution from clients who currently qualify for these state-funded programs. This is because the Medicaid expansion will provide clients with more sustained coverage that is not tied to the duration of incapacity or participation in alcohol/drug treatment. Therefore, although the average monthly caseloads associated with Disability Lifeline and ADATSA coverage are relatively low (approximately 25,000 in June 2009), the contribution to the monthly Medicaid expansion caseload is likely to be closer to the unduplicated population of clients who currently would enroll in Disability Lifeline or ADATSA coverage over the course of a fiscal year (45,000 clients in FY 2009).

Based on the size of the Disability Lifeline and ADATSA populations in SFY 2009 (approximately 45,000), relative to the estimated size of the Medicaid expansion population (approximately 380,000), in the long run we would expect clients meeting current Disability Lifeline and ADATSA eligibility criteria to comprise at least 10 percent of the Medicaid expansion population. However, these clients are likely to be early enrollees in the Medicaid expansion because they have significant health care needs and are already connected to publicly funded health insurance coverage.

FIGURE 2.

Future Medicaid expansion clients who currently receive state-funded medical coverage have high rates of alcohol/drug problems

Disability Lifeline and ADATSA Clients
SFY 2009 POPULATIONS

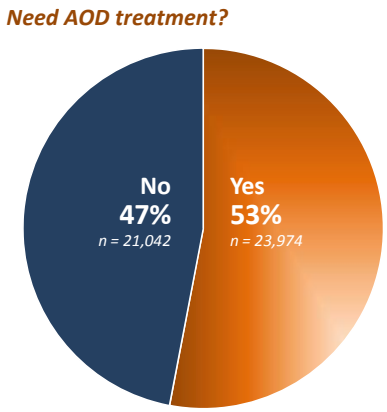
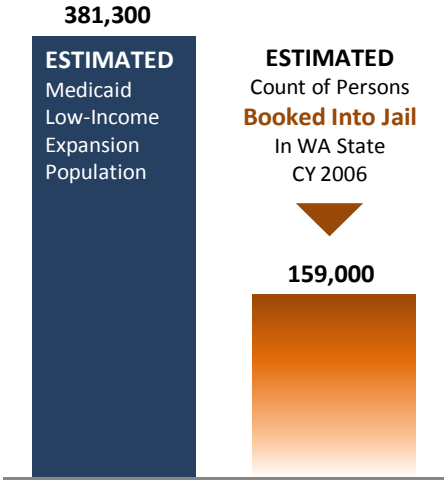


FIGURE 3.

Persons involved in the criminal justice system will be a large component of the Medicaid expansion population

Medicaid Low Income Expansion Population
ESTIMATE BASED ON 2008 STATE POP. SURVEY



Persons involved in the criminal justice system will be a large component of the Medicaid expansion population

In addition to persons on existing Disability Lifeline and ADATSA coverage, persons with a history of involvement in the criminal justice system are likely to be an important part of the Medicaid expansion population.[8] The unduplicated annual population of persons booked into jail in Washington State is significant in relation to the expected size of the Medicaid expansion population (Figure 3). In calendar year 2006, we estimate that there were 159,000 unique individual adults booked into a county or city jail in Washington State.[9] Of these 159,000 persons:

- 32,000 had Medicaid coverage at some time in the year
- 15,000 had Disability Lifeline or ADATSA coverage at some time in the year, but never enrolled in Medicaid
- 112,000 had no DSHS-funded medical coverage in the year

We should expect the vast majority of persons involved in the criminal justice system who are not currently enrolled in Medicaid or other state-funded insurance to meet Medicaid expansion income eligibility requirements. A key question is the extent to which will they enroll in Medicaid expansion coverage. Participation rates for persons involved in the criminal justice system will depend on the extent to which local jails and the State Department of Corrections facilitate enrollment. Even assuming a relatively modest Medicaid participation rate from among the jail-involved population with no prior DSHS coverage would imply that a significant component of the Medicaid expansion population will have recent involvement with local jails. The business case for these agencies to facilitate Medicaid enrollment following release is supported by the potential for shifting health service costs to Medicaid and the evidence that timely access to behavioral health treatment services reduces criminal recidivism.[10]

Demand for alcohol/drug treatment is likely to overwhelm provider capacity

The table below provides an estimate of need for alcohol/drug treatment in the Medicaid expansion population. We assume a relatively modest rate of Medicaid engagement from the population involved in the criminal justice system (approximately 50 percent), along with nearly universal enrollment in Medicaid among persons currently enrolled in the Disability Lifeline and ADATSA programs. Estimates place the rate of alcohol/drug treatment need among persons booked into jail at approximately 65 percent,[11] and at 53 percent for persons enrolled in Disability Lifeline or ADATSA coverage. Combining these two groups produces an estimate of approximately 100,000 persons in the Medicaid expansion population, with 60 percent estimated to need alcohol/drug treatment.[12]

Assuming a modest rate of alcohol/drug treatment need (15 percent) for the balance of the Medicaid expansion population, the likely demand for alcohol/drug treatment from the expansion population will overwhelm the existing provider network.[13] Based on treatment penetration rates observed in the SSI-related and Disability Lifeline client populations, we estimate that approximately 40,000 clients in the Medicaid expansion population would engage in alcohol/drug treatment in a typical fiscal year, if adequate treatment funding were available.

TABLE 1.
Estimating alcohol/drug treatment need in the Medicaid expansion population

Estimated Medicaid expansion population by source		Need for Alcohol and/or Drug Treatment	
	NUMBER	PERCENT	NUMBER
Disability Lifeline/ADATSA/Criminal Justice populations	100,000	60%	60,000
Balance of Medicaid Low Income Expansion population	281,300	15%	42,195
TOTAL Medicaid Low Income Expansion population	**381,300**	**27%**	**102,195**
Estimated demand for treatment based on penetration rate of 40 percent:			***40,878***

Untreated substance abuse is a key driver of chronic disease progression

Failing to build adequate alcohol/drug treatment capacity for the Medicaid expansion population will have a profound impact on General Fund State expenditures for the Medicaid program long into the future. It is well understood that untreated substance abuse increases the risk of catastrophic injuries and the incidence of infectious diseases that increase medical service utilization and cause individuals to qualify for disability-related Medicaid coverage. As illustrated in Figure 4 below, substance abuse also accelerates the progression of chronic physical disease conditions that result in disability.

Figure 4 illustrates the impact of substance abuse on the risk of deterioration of cardiovascular disease conditions among persons who were enrolled in SSI-related Medicaid, Disability Lifeline, or ADATSA coverage in FY 2002 who were diagnosed with hypertension in that year but did not have a more serious cardiovascular disease condition. The chart shows how the likelihood that a client subsequently experiences a heart attack, congestive heart failure, or other serious cardiovascular condition depends on whether the client has co-occurring substance use problems. Persons with substance use disorders were much more likely to die during the follow-up period, and this analysis excludes clients who died during the period. Accounting for differential mortality would show an even stronger relationship between substance abuse and the risk of cardiovascular disease progression.

The evaluation of the chemical dependency treatment expansion that occurred in the FY 2005-07 and FY 2007-09 Biennia indicates that providing alcohol/drug treatment to Medicaid and Disability Lifeline clients who need it slows disease progression and growth in medical costs.[14] The chemical dependency treatment expansion increased alcohol/drug treatment penetration rates (Figure 5), causing a significant relative reduction in the rate of growth in medical expenditures for persons with alcohol/drug treatment needs in the targeted medical coverage groups (Figure 6).

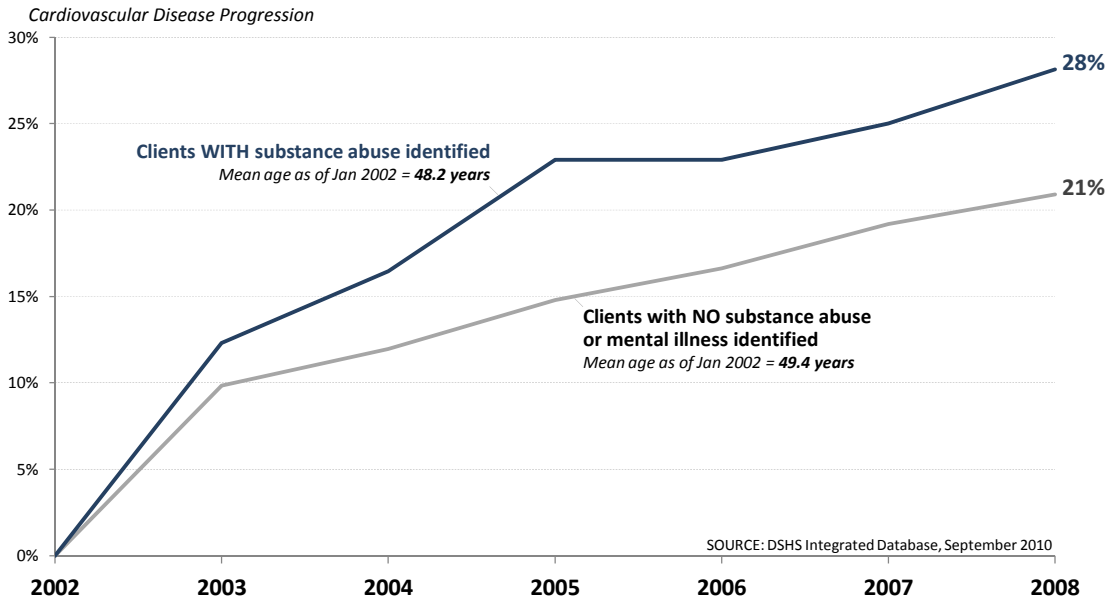
Together with prior research, these findings imply that providing alcohol/drug treatment to the Medicaid expansion population will reduce the risk of catastrophic injuries, the spread of infectious disease, and the progression of chronic disease conditions. This in turn will reduce the rate of transition from the Medicaid expansion coverage to existing SSI-related medical coverage. As we discuss in the next section, slowing rates of transition to SSI-related Medicaid coverage will have profound budgetary implications.

FIGURE 4.

Percent diagnosed with major cardiovascular disease condition (myocardial infarction, CHF, etc.)

Among Medicaid Disabled, Disability Lifeline, or ADATSA clients with hypertension but without a more serious cardiovascular condition diagnosed in SFY 2002

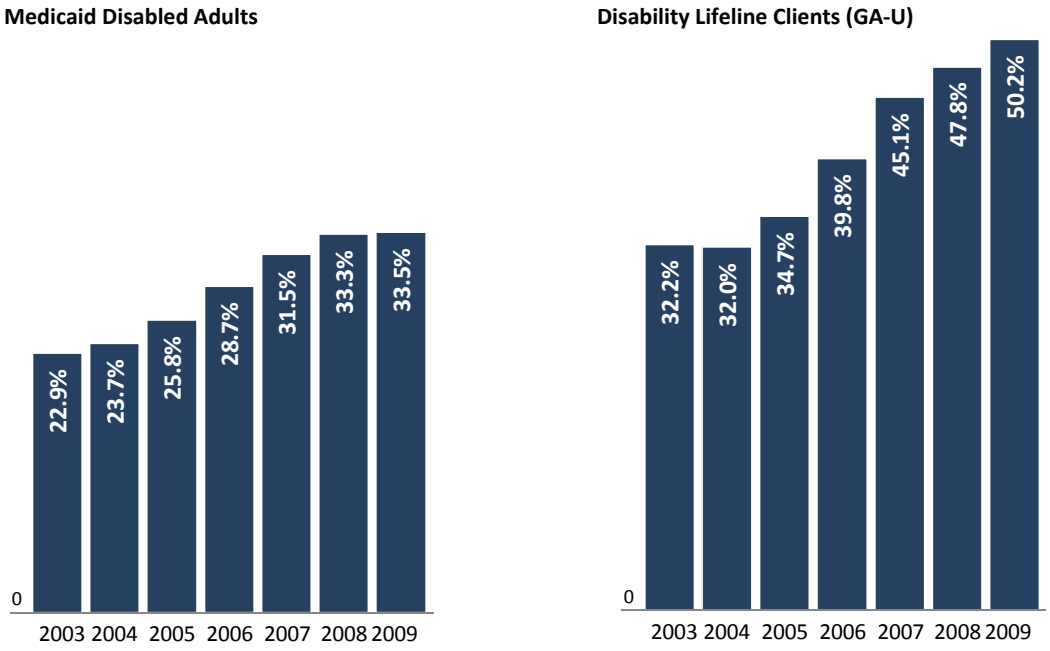
EXCLUDES MEDICARE DUAL ELIGIBLES



Alcohol/drug treatment expansion increased treatment penetration in 2005-07 and 2007-09 Biennia

FIGURE 5.

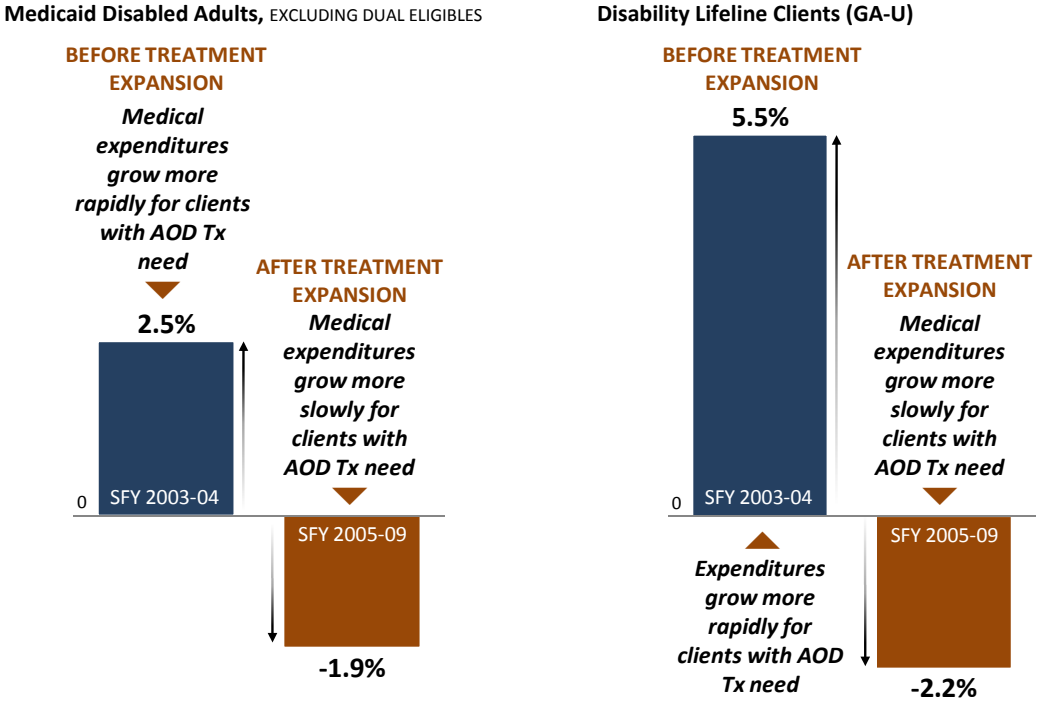
Alcohol/drug treatment utilization among clients with identified treatment need, SFY 2003 - SFY 2009



Increased access to alcohol/drug treatment slows growth in medical costs

FIGURE 6.

Annual percent change in medical expenditures before and after alcohol/drug treatment expansion
Clients with alcohol/drug treatment (AOD Tx) need relative to balance of medical coverage group



Health Care Reform creates incentives for funding alcohol/drug treatment to prevent disability

The low state match for the new Medicaid expansion population will create significant financial incentives to provide adequate alcohol/drug treatment to slow the progression of disease conditions that result in disability. The state share will be 0 percent for the Medicaid expansion population from 2014 to 2016, then increase from 5 percent to 7 percent from 2017 to 2019, before settling at 10 percent in 2020 and thereafter. The regular state Medicaid match rate for SSI-related coverage, family medical, and pregnancy related coverage is expected to be 50 percent over this time period (Figure 7).

The differential match rate means that slowing the progression of chronic diseases that result in disability will produce significant General Fund-State savings. Table 2 illustrates the potential impact on General Fund-State expenditures for two hypothetical individuals who need alcohol/drug treatment – one who receives treatment and one who does not. Both start with annual Medicaid medical costs of approximately $5,000, but the client who remains untreated experiences accelerated progression of chronic disease conditions and medical expenditures, and ultimately deteriorates physically to the point where he qualifies for SSI-related Medicaid coverage. At this point (in the year 2017 in this hypothetical case), the General Fund-State share of medical costs for the client jumps to 50 percent. From that point until the person loses Medicaid coverage (for example, due to death or incarceration) or becomes eligible for Medicare, he will continue to have significant General Fund-State Medicaid expenditures.

Meanwhile, General Fund-State costs remain very low for the client who remains healthy enough to continue in the Medicaid expansion coverage category. In addition, alcohol/drug treatment has been shown to have significant positive impacts on employment for low-income adults, which would increase the likelihood of a subsequent exit from Medicaid coverage through employment.[15]

Every Medicaid expansion client who transitions to SSI-related Medicaid coverage due to the lack of access to alcohol/drug treatment services represents a large financial loss to the State. If 1,000 additional clients were to experience the "no treatment" cost trajectory outlined below due to lack of alcohol/drug treatment funding, the additional State General Fund cost for these clients would be $20 million over the time period.

FIGURE 7.

State share of Medicaid costs: ***Comparing those who remain non-disabled (Low-Income) versus those who transition to Disability (regular Medicaid)***

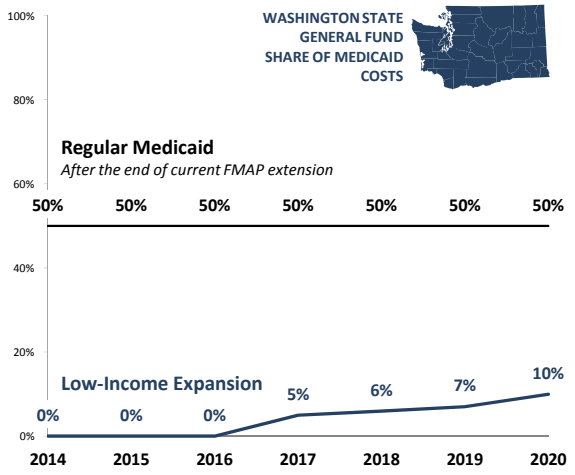


TABLE 2.

Illustration of potential General Fund-State savings from preventing transition to disability coverage

	YES. Receives Alcohol/Drug Treatment			NO. Does Not Receive Alcohol/Drug Treatment		
	Total Annual CD Treatment Cost	Total Annual Medical Cost	Total GF-S Expenditure	Total Annual CD Treatment Cost	Total Annual Medical Cost	Total GF-S Expenditure
2014	$2,500	$5,250	$0	$0	$5,750	$0
2015	$2,500	$5,513	$0	$0	$6,613	$0
2016	$0	$5,788	$0	$0	$7,604	$0
2017	$0	$6,078	$304	$0	$8,745	$4,373
2018	$0	$6,381	$383	$0	$10,057	$5,028
2019	$0	$6,700	$469	$0	$11,565	$5,783
2020	$0	$7,036	$704	$0	$13,300	$6,650
		Cumulative GF-S expenditure	**$1,859**		***Cumulative GF-S expenditure***	**$21,834**

Policy Implications

The enhanced federal match for the Medicaid expansion population is a "game changer" that shifts financial incentives away from facilitating enrollment in federal disability programs, and in favor of improving or maintaining the health status of persons enrolled in Medicaid who have not yet become disabled. Access to alcohol/drug treatment will be critical in achieving this objective. One of the lessons learned from the alcohol/drug treatment expansion that occurred in the 2005-07 and 2007-09 Biennia is that it will take a significant amount of time to increase provider network capacity to meet the underlying demand for alcohol/drug treatment. Waiting until January 2014 to add new federal Medicaid dollars to the alcohol/drug treatment system will not allow time for provider network development to ensure that adequate alcohol/drug treatment resources will be available for the Medicaid expansion population. Further cuts to alcohol/drug treatment funding for non-Medicaid low-income populations in the 2011-13 Biennium would leave the alcohol/drug treatment system with even less capacity to serve the influx of new Medicaid clients that will begin in 2014.

There are several steps that could be taken to better position the state to have adequate alcohol/drug treatment capacity for the Medicaid expansion population:

- **Preserve current alcohol/drug treatment funding for non-Medicaid low-income adults** who will become a significant part of the Medicaid expansion population.
- **Finance alcohol/drug treatment for Medicaid populations through a forecast process** that will ensure that funding adjusts with caseload growth and create a stable funding platform for provider network expansion.
- **Design and implement workforce development strategies** to build alcohol/drug treatment provider capacity.
- **Expand the use of brief intervention strategies.** The Medicaid expansion population is likely to include many clients whose substance abuse has not yet developed into chemical dependency. For these clients, brief intervention strategies may provide a cost effective early intervention.

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[1] Based on the 2008 State Population Survey there were 313,582 uninsured childless adults at or below 200 percent of the federal poverty level (FPL) in 2008, compared to only uninsured 57,860 parents with incomes between 75 percent and 200 percent of the FPL. Source: Washington State 1115 Demonstration Waiver Proposal, Transitional Bridge for Low-Income Adults, Exhibit 21, Washington State Medicaid Purchasing Administration.

[2] The estimate of 381,300 Medicaid expansion clients used here is a rough approximation based on data from the Medicaid Purchasing Administration.

[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.

[5] ADATSA stands for the Alcohol and Drug Abuse Treatment and Support Act.

[6] Alcohol/drug treatment need was identified by the presence of the following in FY 2008 or FY 2009 records: a substance use disorder diagnosis in medical claims; an alcohol/drug treatment or detox encounter; or an arrest for substance-related offenses.

[7] For example, in SFY 2009 the average coverage durations were 4 months for ADATSA, 5 months for Disability Lifeline (GA-U), and 10 months for Categorically Needy Disabled Medicaid coverage.

[8] For a broader discussion of this issue from a national perspective, see "Medicaid and Criminal Justice: The Need for Cross System Collaboration Post Health Care Reform", a forthcoming report by the Center for Health Care Strategies, Inc.

[9] Jail population estimates are based on identified data for King, Kitsap, Snohomish, Spokane, Whatcom and Yakima counties, adjusted to form a statewide estimate based on the share of the state's average daily jail population.

[10] Drake, E., S Aos, and M Miller. 2009. "Evidence-Based Public Policy Options to Reduce Crime and Criminal Justice Costs: Implications in Washington State." Washington State Institute for Public Policy, Olympia, Washington.

[11] National Center on Addiction and Substance Abuse at Columbia University. February 2010. "Behind Bars II: Substance Abuse and America's Prison Population."

[12] This estimate is based on the unduplicated SFY 2009 Disability Lifeline and ADATSA population of approximately 45,000, combined with 55,000 jailed persons (roughly 49 percent of the 112,000 persons jailed in 2006 who had no DSHS coverage).

[13] Based on supplementary analysis of 2003 Washington State Needs Assessment Household Survey (WANAHS) data, the rate of need for alcohol/drug treatment is 17.6 percent for uninsured adults at or below 200 percent of the federal poverty level. For the calculations on page 4 of this report we used a more conservative estimate of 15 percent.

[14] Mancuso, D. and B. Felver. June 2010. "Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment." WA State DSHS, Research and Data Analysis Division.

[15] Mancuso, D. and B. Felver. November 2009. "The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults." WA State DSHS, Research and Data Analysis Division. Available at http://publications.rda.dshs.wa.gov/1397/.