Medicaid Coverage for Persons With Severe Disabilities:

Caseload Composition and Growth

Steve Lerch, Ph.D.

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Document No. 03-03-3402

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We would like to thank staff members from the following agencies for their valuable comments and assistance in producing this report: DSHS Medical Assistance Administration, DSHS Aging and Adult Services Administration, Caseload Forecast Council, and Social Security Administration's Office of Policy.

EXECUTIVE SUMMARY

The caseload for the Medicaid program providing health care services to persons with severe disabilities has been growing faster than the overall population in Washington State. Factors that may contribute to caseload growth in this program are analyzed in this report. In addition, characteristics of individuals who qualify for Medicaid on the basis of a severe disability are examined, and comparisons to similar Medicaid programs in other states are provided.

The 2001 Legislature directed the Washington State Institute for Public Policy (Institute) "to research and evaluate strategies for constraining the growth in state health expenditures."[1] In consultation with legislative fiscal committee staff, the composition and growth of the Medicaid program for persons with a severe disability was identified as a useful area of research.

Key Findings

Caseload Growth and Composition in Washington State

- Recent caseload growth is above the levels expected based on growth in either the general population or among persons in poverty.
- The fastest growing segment of the Washington State Categorically Needy Blind and Disabled Medicaid program is clients qualifying through the General Assistance Expedited Medical Disability (GA-X) pathway for persons presumed to be eligible for federal Supplemental Security Income (SSI).
- The number of individuals qualifying for SSI due to mental disorders is growing faster than the overall SSI caseload.
- Caseload growth has occurred despite changes in federal rules intended to make SSI eligibility more restrictive.
- Factors that are likely contributors to above-average caseload growth include changes in the mix of occupations and industries in Washington, the rising value of Medicaid benefits, declining numbers of nursing home beds, and rising caseloads in the state's medically indigent program.
- Washington has a smaller fraction of its population under age 65 enrolled in Medicaid programs for persons with severe disabilities when compared with California or the United States as a whole, but it has a higher fraction when compared with Oregon.

[1] ESSB 6153, Section 608(8), Chapter 7, Laws of 2001.

Policy Options

- Potential state policy responses to the rapid growth of the Categorically Needy Blind and Disabled program are limited because several of the factors contributing to program growth reflect national trends not readily addressed at the state level. Federal requirements concerning program eligibility and benefits also limit state policy options.
- Attempts to limit the size of the Categorically Needy Blind and Disabled program may result in increases in state spending in other programs, such as long-term care, TANF, and General Assistance Unemployable (GA-U).
- Current efforts to reduce program expenditures are intended to minimize unnecessary use of prescription drugs and other services. It is also possible to eliminate certain health care services to address overall program costs, but federal rules would also require the elimination of those same services for other Medicaid recipients, such as low-income families, children, and pregnant women.

INTRODUCTION

The Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS) provides health care to low-income individuals who qualify on the basis of age, family composition, pregnancy, or disability. This report focuses on a subset of these individuals: those who are eligible for full-scope health care coverage through the Medicaid program due to a severe disability. Care is provided under the Categorically Needy Blind and Disabled program. The caseload for this portion of the state's Medicaid program has been growing faster than the overall population in Washington State.

The 2001 Legislature directed the Washington State Institute for Public Policy (Institute) "to research and evaluate strategies for constraining the growth in state health expenditures."[2] In consultation with legislative fiscal committee staff, the composition and growth of the Medicaid program for persons with a severe disability was identified as a useful area of research.

This report examines Washington's caseload composition and provides comparisons with other states. Factors that may contribute to caseload growth in this program are also analyzed.

Section I briefly describes the "categorically needy" Medicaid program available to persons with a severe disability. Section II looks at the size of this program in Washington State and the characteristics of recipients. Section III then examines factors that may contribute to the growth in caseloads. Section IV compares Washington caseloads with those in Oregon, California, and the United States as a whole. Section V follows with a comparison of differences in program operation between Washington, Oregon, and California. State policy options related to funding the program are discussed in Section VI.

[2] ESSB 6153, Section 608(8), Chapter 7, Laws of 2001.

I. MEDICAID ELIGIBILITY FOR PERSONS WITH SEVERE DISABILITIES

Medicaid is a joint state and federal program that provides health care services to specific groups of low-income persons. Individuals may be eligible for Medicaid coverage of health care services under a number of different categories, one of which comprises persons under age 65 with a disability: the Categorically Needy Blind and Disabled program.[3] In general, categorical eligibility based on disability requires that an individual meet the definition of disability used under the federal Supplemental Security Income (SSI) program. This definition requires a severe, medically determined physical or mental impairment. For adults, a second condition is added: the impairment must be sufficiently severe that they are unable to engage in "substantial gainful activity."

Medicaid assistance is limited to persons in financial need. Therefore, besides meeting the SSI definition of disability, it is also necessary to meet limitations on income and assets to qualify for Medicaid. These limitations (referred to as tests) differ across programs and from state to state. For example, to qualify for Medicaid on the basis of SSI eligibility, an individual must have income at or below the monthly federal benefit of $545.[4] However, if that person needs the level of care that requires admission to a nursing facility, states may set a qualifying income limit as high as 300 percent of the monthly SSI benefit.

To further complicate the discussion, some types of income are partially or completely ignored ("disregarded") when determining if an individual's income meets the program's income test. For example, the SSI test disregards the first $20 of monthly unearned income (such as social security disability payments). The home and community-based services program for children with disabilities disregards all parental income if a child would otherwise meet program eligibility requirements.

In Washington State, individuals who are eligible for Medicaid on the basis of blindness or disability and meet the relevant income and asset tests are referred to as being eligible for the Categorically Needy Blind and Disabled program. Individuals qualify for this program through the following eligibility pathways:

- SSI blind and disabled cash grant recipients (children and adults under age 65);
- Children and adults under age 65 qualifying for home and community-based services provided by DSHS's Division of Developmental Disabilities (CAP program) and the Aging and Adult Services Administration (COPES program);[5]
- Individuals receiving cash grants through the state disability program but who have also applied and are presumed eligible for SSI due to blindness or disability.

[3] This summary provides a greatly simplified version of Medicaid eligibility rules for persons with disabilities. An excellent discussion of Medicaid eligibility requirements can be found in A. Schneider, V. Strohmeyer, and R. Ellberger, "Medicaid Eligibility for Individuals with Disabilities," Issue Paper (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, updated May 2000).
[4] This is the federal SSI benefit for 2002; the amount is increased annually to account for inflation.
[5] Individuals are eligible for home and community-based services through a Medicaid 1915(c) waiver if they require the level of care provided in nursing facilities or in intermediate care facilities for persons with mental retardation and would be eligible for Medicaid if they were institutionalized.

Individuals in this group are referred to as being in the General Assistance Expedited Medical Disability (GA-X) program, which is part of the General Assistance Unemployable (GA-U) program;

- Adult blind and disabled SSI recipients who return to work but whose earnings are too low to purchase health insurance;[6] and
- Individuals with a severe disability who do not qualify for any of the above pathways. These are generally categories for which Medicaid coverage is at state option, such as (1) adults receiving institutional long-term care services (nursing homes or intermediate care facilities for the mentally retarded) who are not eligible for SSI but have incomes up to 300 percent of the SSI benefit level, and (2) low-income undocumented aliens.

Individuals with disabilities who qualify for Medicaid *except* that they have income or assets above program limitations may, at state option, qualify for the *Medically* Needy Blind and Disabled program. Under this program, individuals may deduct medical expenses from their income in determining eligibility. Therefore, once their medical costs are large enough to reduce their income to that of the Medicaid eligibility level, all further health care is covered by Medicaid.[7] Given the Medically Needy program's unique eligibility rules and smaller size, this report will focus only on issues related to the Categorically Needy Blind and Disabled program.[8]

[6] "Qualified severely impaired individuals" are eligible for Medicaid under the federal section 1619 program. Such individuals must be eligible for SSI but subsequently are able to work at a level beyond the substantial gainful activity threshold of $760 per month but less than the combined value of SSI cash benefits and Medicaid health care benefits.

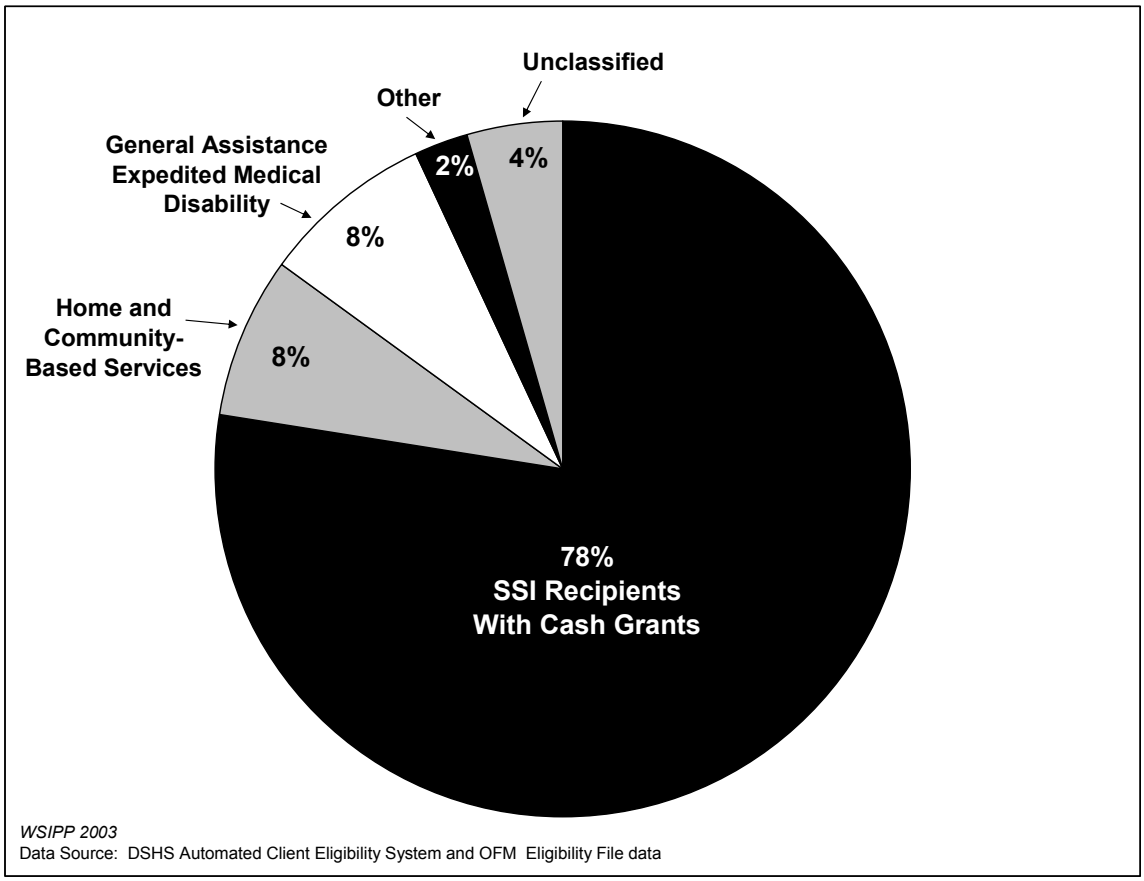
[7] Medically Needy eligibility is based on medical expenditures, referred to as "spend down," during a three- or six-month base period. Depending upon when the spend down occurs, the individual may receive health care coverage for part or all of the base period. The Medically Needy program does not necessarily provide the same scope of health care services as the categorical Medicaid programs. For example, in Washington State, personal care services and speech therapy are covered under the categorical Medicaid programs but are not available to adults who qualify for the Medically Needy program.

[8] An additional Medicaid program for persons with severe disabilities, the Healthcare for Workers with Disabilities program, started in January 2002 and had only 144 enrollees as of December 2002. Therefore, it is not considered in this report. For more information on this program, see <http://fortress.wa.gov/dshs/maa/Eligibility/HWD.htm> (Accessed January 23, 2003).

II. CASELOAD SIZE AND COMPOSITION IN WASHINGTON STATE

In September 2001, over 112,000 persons were enrolled in the Categorically Needy Blind and Disabled program,[9] accounting for approximately 15 percent of all Categorically Needy Medicaid recipients in Washington.[10] Exhibit 1 displays the groups, as defined in the Automated Client Eligibility System (ACES), making up the Categorically Needy Blind and Disabled caseload as of September 2001.

Exhibit 1
Composition of Categorically Needy Blind and Disabled Program Participants



WSIPP 2003
Data Source: DSHS Automated Client Eligibility System and OFM Eligibility File data

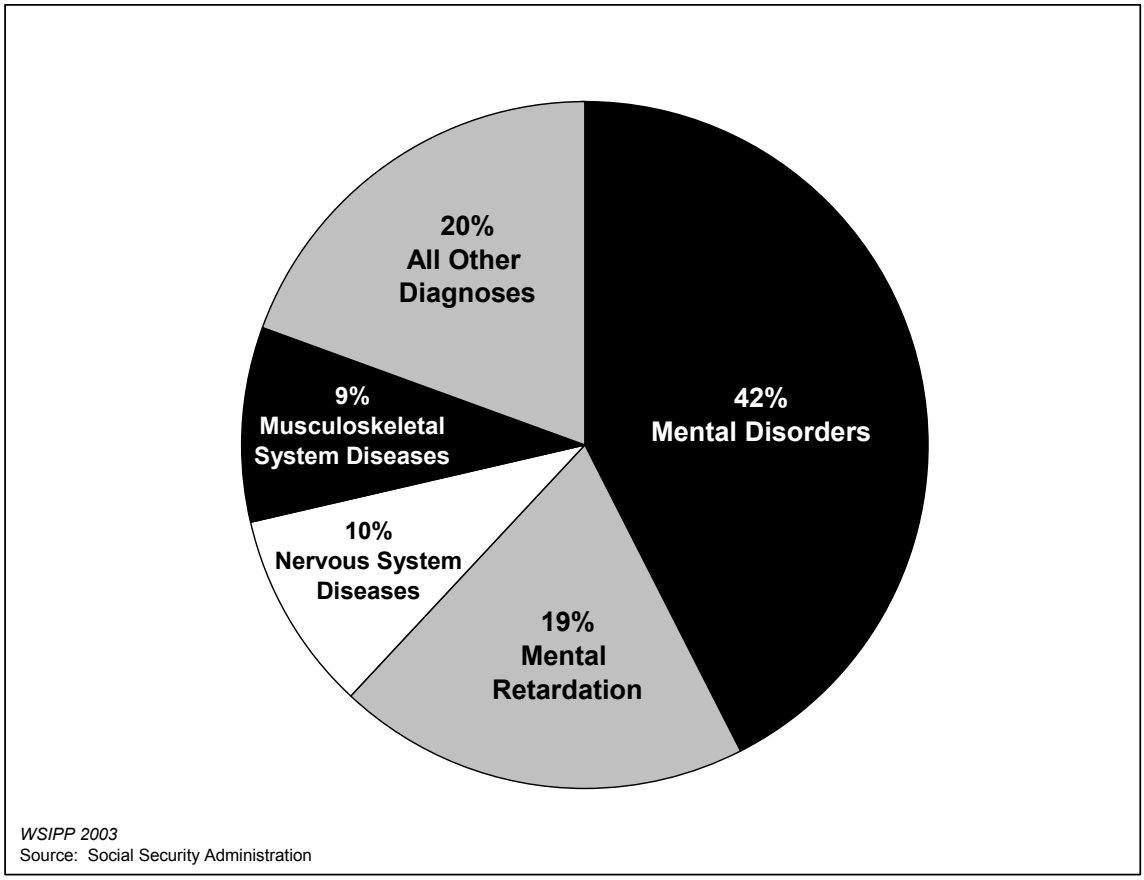
[9] See the Monitoring Reports section of the Washington State Caseload Forecast Council at http://www.wa.gov/cfc/mon_rpts.html (Accessed January 23, 2003). Actual data are available through November 2002 for the entire caseload but not at the more detailed level displayed in Exhibit 1.
[10] Other Categorically Needy groups include families eligible for the Temporary Assistance for Needy Families (TANF) welfare program, children in households with income under 200 percent of the federal poverty level, pregnant women in households with income under 185 percent of the federal poverty level, and persons aged 65 and over who meet SSI income and asset tests.

Detailed information on some groups composing the Categorically Needy Blind and Disabled program is not readily available. However, a substantial amount of data can be obtained that describe blind and disabled SSI cash grant recipients who constitute the majority (74 percent) of the Categorically Needy Blind and Disabled program in Washington. This section uses the most recent data available from the Social Security Administration (SSA) to describe the SSI portion of Washington's Categorically Needy Blind and Disabled program.

Diagnoses of SSI Blind and Disabled Recipients

As noted earlier, individuals who meet SSI eligibility standards must have a severe physical or mental impairment. As indicated in Exhibit 2, the most frequent impairment diagnosis among SSI Blind and Disabled recipients (using December 2001 data) is mental disorder, followed by mental retardation.

Exhibit 2
Washington State SSI Blind and Disabled Caseload by Diagnosis Group

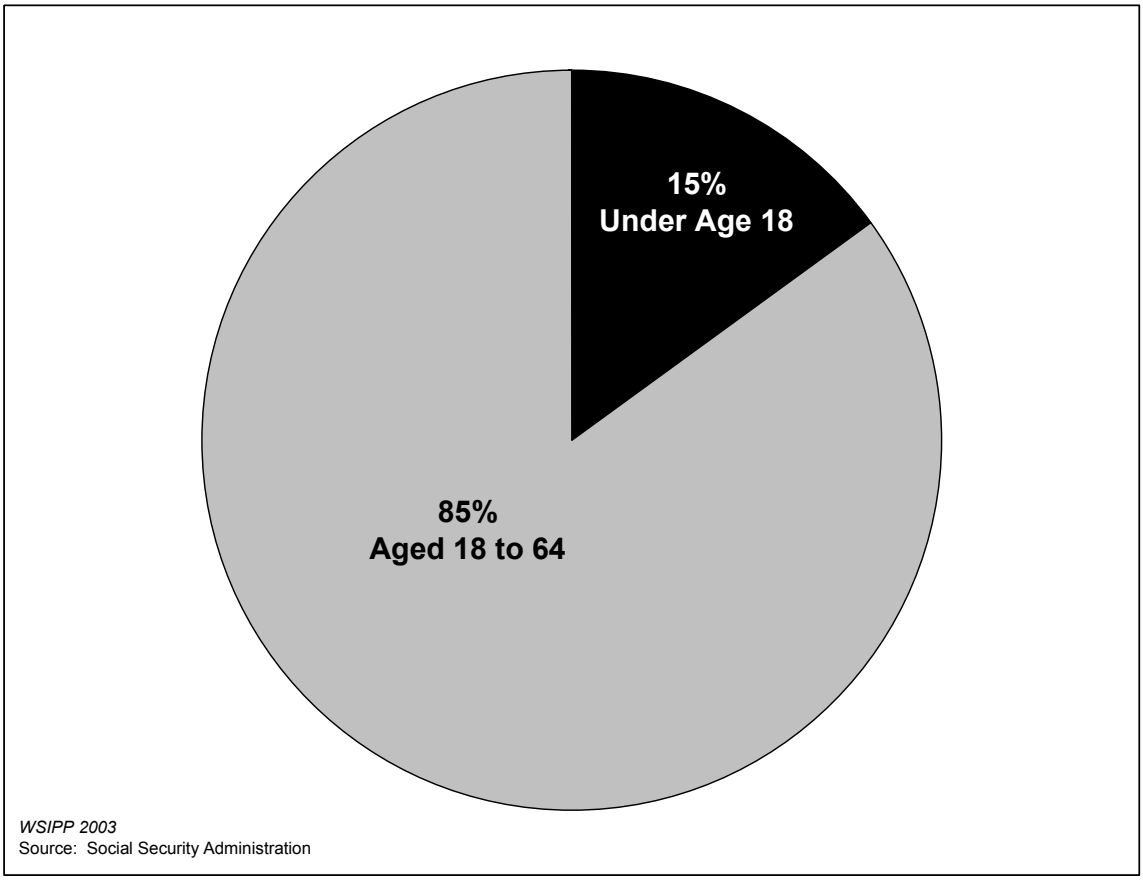


WSIPP 2003
Source: Social Security Administration

Children With Blindness or a Disability Receiving SSI

Children with a severe physical or mental impairment may also qualify for SSI and Medicaid. In December 2001, 15 percent of blind and disabled SSI recipients were children.

Exhibit 3
Percentage of Blind or Disabled SSI Recipients in Washington State



WSIPP 2003
Source: Social Security Administration

Non-Citizens With Blindness or a Disability Receiving SSI

Certain persons who meet SSI eligibility criteria and are U.S. residents but not citizens are eligible for SSI and Medicaid.[11] In December 2001, 9.5 percent of blind and disabled SSI recipients were non-citizens.[12]

[11] For a definition of "qualified alien," see *Annual Report of the Supplemental Security Income Program* (Baltimore, MD: Social Security Administration, May 2002), 52–53.
[12] Calculation based on data from *SSI Annual Statistical Report, 2001* (Baltimore, MD: Office of Policy, Social Security Administration).

III. CASELOAD TRENDS

Over the last five years (1996 through 2001), Washington's Categorically Needy Blind and Disabled Medicaid caseload grew at an annual average rate of 4 percent to over 115,000 persons.[13] During the same time period, the state's population under age 65 (i.e., the age group potentially eligible for the Categorically Needy Blind and Disabled program) grew at approximately 1 percent.[14] Some age groups, such as persons 18 to 21, did grow much more quickly—nearly 4 percent per year in Washington—over the last five years. Nationally, growth in newly eligible SSI recipients aged 18 to 21 was higher than among other age groups, so SSI enrollment growth is not unrelated to population changes. However, the 18 to 21 age group only accounted for 8 percent of newly eligible SSI recipients in 2001, so clearly factors other than increasing population are *also* contributing to the enrollment growth in the Categorically Needy Blind and Disabled program. This section describes several factors that may be contributing to this high growth rate.

Growth in Groups Eligible for the Categorically Needy Blind and Disabled Program

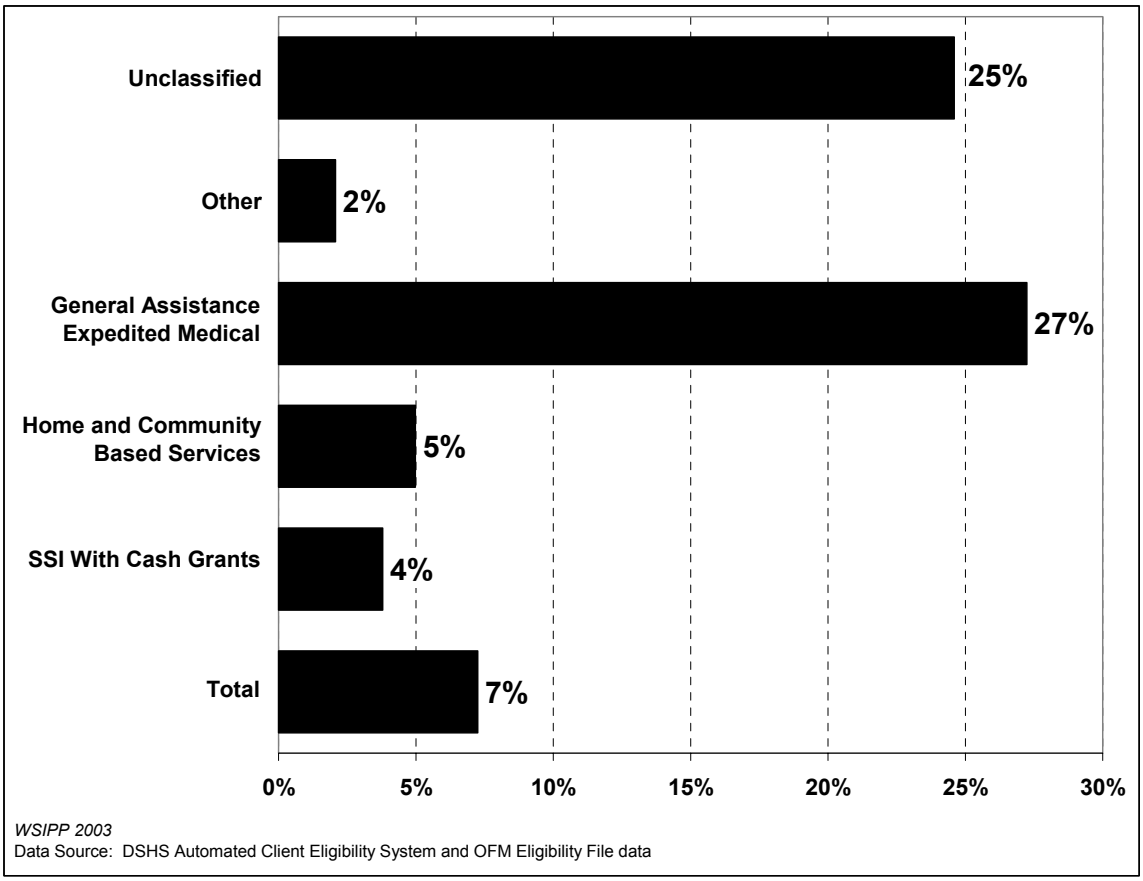
Exhibit 4 displays the growth between 2000 and 2001 in the Categorically Needy Blind and Disabled program and for its major subgroups. The total caseload grew much faster in 2001 than the average annual growth rate for the 1996 to 2001 period (7 percent compared with 4 percent). This higher rate of growth is largely explained by two subgroups, General Assistance Expedited Medical Disability (GA-X)and an unclassified group of recipients, that both grew by more than 20 percent between 2000 and 2001.

The "Unclassified" group includes individuals found to be eligible for disability-related Medicaid in the Medicaid eligibility system but not in the broader social service data system (the Automated Client Eligibility System, or ACES) and persons eligible for multiple disability or age-related Medicaid programs during the year. However, most of this group consists of persons who are *not* receiving SSI grants but have sufficiently low income that they appear to qualify for SSI. It is unclear how these individuals qualify for the Categorically Needy Blind and Disabled program, although it is possible that data lags or errors result in some of the misclassification.

[13] The 4 percent annual average growth rate is calculated from December 1996 through December 2001. In the most recent month enrollment data are available, November 2002, the Categorically Needy Blind and Disabled program covered 118,640 individuals. See the Washington State Caseload Forecast Council website at <http://www.wa.gov/cfc/Monitoring/MAA-CN-Blind-Disabled.html> (Accessed March 4, 2003).

[14] Office of Financial Management, "Forecast State Population by Age and Sex: 1990–2030 November 2002 Forecast" <http://www.ofm.wa.gov/pop/stfc/index.htm> (Accessed March 4, 2003).

Exhibit 4
Average Annual Growth Rates for Categorically Needy Blind and Disabled Groups, 2001



WSIPP 2003
Data Source: DSHS Automated Client Eligibility System and OFM Eligibility File data

Changing Economic Conditions

Recent research indicates that, while short-term economic changes have little if any impact on the SSI program, longer-term declines in employment and earnings do increase participation in the SSI program.[15] This conclusion appears to be especially valid when the declining industries are those that require on-the-job training or work experience rather than formal education.

One possible explanation for this pattern is that when individuals with disabilities have the opportunity to work, some will be able to do so and will become employed. As job opportunities disappear, especially for workers with lower levels of education or skills and fewer employment alternatives, applying for SSI (or Social Security Disability Insurance for workers with a sufficient work history) becomes a more feasible option.

[15] D. Black, K. Daniel, and S. Sanders, "The Impact of Economic Conditions on Participation in Disability Programs: Evidence from the Coal Boom and Bust," *American Economic Review* 92, no. 1 (March 2002). The research examined the impacts of long-term changes in coal-mining employment in Kentucky, Ohio, and Pennsylvania and in primary metals employment in Alabama, California, Illinois, Indiana, Michigan, and New York.

In Washington State, a number of indicators suggest a decline in occupations and industries that require lower levels of education and skills obtained through work experience.[16] For example, of the 25 occupations expected to have the largest employment declines between 1998 and 2008, 23 require work experience or on-the-job training but not post-secondary education.[17] A comparison of employment data between 1990 and 2000 indicate 15 industries where employment declined by 200 workers or more over the decade (see Exhibit 5).[18] While some of these industries, such as transportation equipment (largely the aerospace industry in Washington) and the federal government, employ workers at a variety of skill and education levels, many have substantial numbers of workers with lower levels of education.

Exhibit 5
Washington Industries With Largest Employment Decline, 1990–2000

Industry	Employment Change 1990–2000
Transportation Equipment	(29,715)
Chemicals and Allied Products	(7,172)
Lumber and Wood Products	(6,968)
Federal Government	(3,850)
Paper and Allied Products	(2,701)
Fishing, Hunting, and Trapping	(2,376)
Primary Metal Industries	(2,196)
Miscellaneous Repair Services	(1,842)
Water Transportation	(644)
Metal Mining	(638)
Textile Mill Products	(302)
Coal Mining	(289)
Forestry	(267)
Leather and Leather Products	(248)
Oil and Gas Extraction	(206)

Source: Employment Security Department

This decline in employment for workers with lower skill and education levels suggests that the growth in SSI and the Categorically Needy Blind and Disabled caseload reflects, in part, changes in the mix of occupations and industries in Washington and the nation as a whole.

[16] A decline in job opportunities for less educated workers has occurred throughout the U.S. For example, see Chinhui Juhn, "Decline of Male Labor Market Participation: The Role of Declining Market Opportunities," *Quarterly Journal of Economics* (February 1992).
[17] See the Washington State portion of America's Career InfoNet website, developed through a partnership between the U.S. Department of Labor and state employment security agencies: <http://www.acinet.org/acinet/state1.asp?soccode=&from=&Level=&keyword=&stfips=53&x=22&y=6> (Accessed January 23, 2003).
[18] Based on Washington State covered employment and payroll data available at <http://www.wa.gov/esd/lmea/download/download.htm> (Accessed January 23, 2003).

Increasing Value of Medicaid Benefits

As health care costs rise over time, the value of having health insurance or Medicaid coverage rises as well. The value of health insurance is especially high for individuals with disabilities who are likely to require a greater level of services than healthier individuals. Because qualifying for SSI entitles an individual to Medicaid coverage through the Categorically Needy Blind and Disabled program, rising Medicaid expenditures (which reflect, in part, rising overall health care costs) mean that the value of SSI eligibility has been rising over time as well.

An analysis of the participation determinants in the national SSI program found that 20 percent of caseload growth between 1987 and 1993 was explained by the rising level of Medicaid expenditures.[19] This research suggests that the rising value of Medicaid benefits is especially important in explaining SSI participation among adults with low expected levels of lifetime earnings.

The declining employment opportunities for lower-skill workers noted earlier are related to the impact of Medicaid on SSI participation as well. To the extent that low-wage workers with a disability lose employment or have greater difficulty finding jobs that offer health insurance benefits, the greater value they will attach to Medicaid coverage.

Factors Related to Home and Community-Based Services Caseload

Washington State has a long-term care industry with a below-average level of nursing home beds and above-average levels of certified home health providers and non-medical residential care beds. The number of nursing home beds in the state has declined continuously between 1995 and 2001.[20] A recent attempt to predict state caseloads and expenditures for Medicaid home and community-based services identified these factors (among others) as having a significant impact on increasing the number of clients, expenditures, or both for home and community-based service programs.[21] Therefore, the growth in the home and community-based services portion of the Categorically Needy Blind and Disabled program is at least partly explained by the characteristics of Washington's long-term care market.

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[19] A. S. Yelowitz, "Why Did the SSI-Disabled Program Grow So Much? Disentangling the Effect of Medicaid," *Journal of Health Economics* 17, no. 3 (June 1998).

[20] J. M. Wiener and S. M. Lutzky, "Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Washington," prepared for U.S. Department of Health and Human Services, Health Care Financing Administration, June 5, 2001; available at <http://urban.org/url.cfm?ID=410355> (Accessed January 24, 2003); also, see C. Harrington, H. Carrillo, V. Wellin, and B. B. Shemirani, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995 Through 2001* (San Francisco: University of California, Department of Social and Behavioral Sciences, August 2002), 11, Table 2.

[21] C. Harrington, H. Carrillo, V. Wellin, N. Miller, and A. LeBlanc, "Predicting State Medicaid Home and Community Based Waiver Participants and Expenditures, 1992–1997," *The Gerontologist* 40, no. 6 (2000).

Relationship to Medically Indigent Caseload

The state-funded Medically Indigent program provides up to three months of medical services for persons with emergency health conditions that require hospitalization and who are also ineligible for any other medical assistance program. As the result of an emergency health condition, individuals who could become too impaired to work may qualify for Medicaid coverage under the Categorically Needy Blind and Disabled program.[22] If so, some persons in the Medically Indigent program might eventually become eligible for the Categorically Needy Blind and Disabled program.

An analysis of all persons eligible for the Medically Indigent program in 1999 found approximately 8 percent subsequently received health care services through the Categorically Needy Blind and Disabled program in 1999 or 2000.[23] Further analysis is required to determine if this finding is typical of the rate of transition between these programs. Since the Medically Indigent caseload has been rising at an average rate of 9 percent per year since 1997, a consistent relationship between these two programs could help to explain a portion of the growth in the Categorically Needy Blind and Disabled program.

Growth in Disability Due to Mental Disorders

Individuals with impairments due to mental disorders are the largest category of SSI recipients nationally and in Washington State. This subset of SSI recipients has also been growing much faster than the overall SSI caseload, both nationally and in Washington, despite program changes designed to make eligibility for some mental health and substance abuse impairments more difficult.[24]

It is unclear if the actual frequency of mental disorders is increasing in the general population.[25] However, these trends are consistent with the rising use of mental health

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[22] This would be consistent with recent research suggesting that hospitalization increases the probability of applying for SSI or Social Security Disability Insurance; see D. Dwyer, J. Hu, D. R. Vaughan, and B. Wixon, "Counting the Disabled: Using Survey Self-Reports to Estimate Medical Eligibility for Social Security's Disability Programs," ORES Working Paper Series No. 90 (Washington, D.C.: Social Security Administration, Office of Policy, Office of Research, Evaluation and Statistics, January 2001).

[23] Details of analysis available from author upon request. For purposes of this brief analysis, eligibility is defined as anyone having one or more health care services paid for through the Medically Indigent program during 1999. During 1999, a total of 10,767 individuals were eligible for the medically indigent program; 868 of these persons subsequently received health care services under the Categorically Needy Blind and Disabled program during 1999 or 2000.

[24] Between 1999 and 2001, the national SSI caseload under age 65 increased by 3 percent, but the number of SSI recipients under age 65 with a mental disorder increased by 18 percent. For Washington State, the SSI caseload under age 65 increased by 7 percent between 1999 and 2001, but SSI recipients under age 65 with a mental disorder increased by 21 percent. See *SSI Annual Statistical Supplement* (Baltimore, MD: Office of Policy, Social Security Administration, various years).

[25] Using the National Co-morbidity Survey data covering 1990–1992, an estimated 6 percent of adults aged 18 to 54 meet the criteria for serious mental illness; see R. C. Kessler et al., "The Prevalence and Correlates of Untreated Serious Mental Illness," *Health Services Research* 36, no. 6, part 1 (December 2001). Data from the 2001 National Household Survey on Drug Abuse indicate that 7 percent of all adults aged 18 or older and 9 percent of adults aged 18 to 49 meet the criteria for serious mental illness; see <http://www.samhsa.gov/publications/publications.html> (Accessed January 24, 2003). Although this suggests a possible increase in serious mental illness, at least part of this difference could be explained by different sample sizes and survey techniques.

services in recent years. Between 1987 and 1996, a national study found a 23 percent increase in the proportion of the population using mental health or substance abuse services and a 63 percent increase in the use of psychotropic drugs (antidepressants, antipsychotics, stimulants such as Ritalin, and sedative hypnotics).[26] One explanation for this increased use of services is an apparent reduction in the stigma associated with some types of mental illness.[27] Other factors which may contribute to a rising number of persons receiving SSI benefits on the basis of mental illness are downsizing and closure of facilities for the mentally ill and increased efforts to educate and train SSI adjudicators concerning mental illnesses. Unfortunately, it is impossible to know to what extent, if any, reduced stigma or other factors explain the growing proportion of the SSI caseload whose eligibility is linked to a mental disorder.

Changes in the Number of Persons in Poverty

Because most persons qualifying for the Categorically Needy Blind and Disabled program must have income below the federal poverty level ($9,214 for a single person under age 65 in 2001), it is reasonable to expect that the state's caseload growth could be related to changes in the number of persons in poverty. Relatively accurate state poverty data are available from the U.S. Census every ten years. For years between censuses, state poverty data are estimates based on samples and, especially for smaller states, have a considerable degree of uncertainty.

Based on census data, Washington's population aged 64 or younger with income below the federal poverty level grew from 468,424 in 1989 to 564,403 in 1999. This is an overall increase of 21 percent, or an average growth rate of 2 percent per year. While this exceeds the average population growth, it is well below the recent annual growth in the Categorically Needy Blind and Disabled program. Therefore, increases in the number of persons in poverty can provide, at most, only a partial explanation for the growth in this program.

Changes in SSI Eligibility for Children

In late 1990, the rules governing a child's eligibility for SSI based on mental impairment were expanded. New categories of impairment, such as attention deficit hyperactivity disorder, were added as well as changes to medical standards that emphasized limitations to a child's ability to act in age-appropriate ways.[28] Combined with expanded outreach efforts, the result

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[26] S. H. Zuvekas, "Trends in Mental Health Services Use and Spending, 1987–1996," *Health Affairs* 20, no. 2 (March/April 2001). The number of individuals in Washington receiving publicly funded mental health services through the DSHS Mental Health Division has also increased considerably (from 94,356 persons receiving community treatment in fiscal year 1996 to 118,844 persons in fiscal year 2001). However, since this includes SSI recipients, among others, it is not an entirely independent reflection of the use of mental health services among low-income persons. See <http://www1.dshs.wa.gov/budget/020830/pdf/030Fall2002.pdf> (Accessed January 23, 2003).

[27] J. C. Phelan, B. G. Link, A. Stueve, and B. A. Pescosolido, "Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to Be Feared?" *Journal of Health and Social Behavior* 41, no. 2 (June 2000).

[28] U.S. General Accounting Office, "Rapid Rise in Children on SSI Disability Rolls Follows New Regulations," Report No. HEHS-94-225 (Washington, D.C.: U.S. General Accounting Office, September 1994).

was a tripling in the number of children receiving SSI disability benefits and related Medicaid coverage nationally between 1989 and 1996.[29]

However, welfare reform legislation that took effect in 1997 made SSI eligibility criteria for children more restrictive.[30] Even with some lags in issuing the new regulations to disability reviewers, the number of children receiving SSI nationally has dropped from over 955,000 in 1996 to less than 847,000 by the end of 2000.[31] Washington's SSI caseload for children has not followed this trend as strongly but has still declined from 11,446 in 1997 to 11,244 in 2000.[32] Therefore, at least since 1997, eligibility of children for SSI and Medicaid does not explain the growth in the Categorically Needy Blind and Disabled caseload.

Changes in SSI Eligibility for Drug and Alcohol Dependence

Prior to 1994, impairment related to alcoholism or drug addiction that prevented employment qualified as a disability for determining SSI or Social Security Disability Insurance (SSDI) eligibility.[33] Due to concerns that cash benefits were being used to support some recipients' drug and alcohol habits, Congress passed legislation in 1994 limiting SSI and SSDI eligibility for drug- or alcohol-related disabilities to 36 months and requiring recipients to enter treatment.

In 1996, new legislation denied eligibility for SSI or SSDI if drugs or alcohol were contributing factors to disability. This change resulted in the termination of benefits for nearly 125,000 individuals nationally, most of whom were SSI recipients. These individuals also lost eligibility for Medicaid.

In Washington State, the Categorically Needy Blind and Disabled caseload decreased by 2 percent between December 1996 and December 1997. It is likely that most of this decline was related to changes in SSI eligibility for alcoholics and drug addicts.

Changes in SSI Eligibility for Non-Citizens

Federal welfare reform legislation passed in 1997 also made changes to SSI eligibility rules for non-citizens. Prior to this legislation, legal immigrants in the United States were eligible

[29] U.S. General Accounting Office, "Regulations on SSI Eligibility for Children," Report No. HEHS-97-220R (Washington, D.C.: U.S. General Accounting Office, September 1997).
[30] U.S. General Accounting Office, "Supplemental Security Income: SSA Needs a Uniform Standard for Assessing Childhood Disability," Report No. HEHS-98-123 (Washington, D.C.: U.S. General Accounting Office, May 1998).
[31] Office of Policy, *Children Receiving SSI–December 2000* (Baltimore, MD: Social Security Administration).
[32] Social Security Administration, *Annual Statistical Supplements* (Baltimore, MD, 1998 and 2001). Comments from the Washington State agency responsible for SSI eligibility (Division of Disability Determination Services, Medical Assistance Administration) indicate that recent rates of eligibility among child applicants do not appear to reflect any impact of the 1997 welfare reform legislation.
[33] For a discussion of legislative history on this subject, see U.S. Congress, Committee on Ways and Means, "Section 3: Supplemental Security Income," *2000 Green Book (106th Congress)*, Committee Print WMCP: 106-14 (Washington, D.C.: U.S. Government Printing Office, October 6, 2000).

for most public benefit programs on essentially the same terms as citizens.[34] However, welfare reform restricts SSI eligibility to blind or disabled non-citizens who also meet the definition of "qualified alien," which includes certain persons legally residing in the U.S. as of August 22, 1996, individuals granted refugee or asylum status, and other specified non-citizens.[35]

After decreasing in 1996 and 1997, the number of non-citizens receiving SSI grants on the basis of disability has been growing (both in the U.S. and in Washington State). However, the fraction of legal non-citizen families with one or more members receiving an SSI grant declined from 6 percent in 1994 to 4 percent in 1999 for the U.S. as a whole.[36] The declining share of immigrant families receiving SSI grants suggests that the number of non-citizens on the SSI caseload, and therefore the Medicaid Categorically Needy Blind and Disabled caseload, would be even larger in the absence of the 1997 eligibility rule changes.

Other Factors Impacting SSI

Eligibility System Changes. Beginning in September 2001, the data system used to determine eligibility for Medicaid and other social service programs (ACES) was modified to assure that clients eligible for SSI receive Medicaid benefits in a timely manner. This change also facilitates updates to client records and termination of benefits based on SSA data. This process is referred to as SSI-Auto Open. As part of its February 2003 forecast, the Caseload Forecast Council estimates that SSI-Auto Open will result in an increase of approximately 3,400 Categorically Needy Blind and Disabled recipients by the end of fiscal year 2003.

Federal Outreach Activities. During the past several years the federal government has increased efforts to identify low-income Medicare recipients who qualify for Medicaid assistance with out-of-pocket health care expenses. The Medical Assistance Administration (MAA) estimates that these measures resulted in an increase of fewer than 1,000 new recipients in the Categorically Needy programs for the Aged, Blind, and Disabled.

Advocacy Group Activities. A number of advocacy groups within the community provide assistance to individuals with disabilities, including help applying for SSI. According to the MAA, over time many of these groups have gained a greater understanding of the disability determination process and are assisting applicants to obtain more and better medical and non-medical evidence for their disability applications. In turn, this may have some impact on increasing the number of successful SSI applicants.

[34] M. Fix and J. Passel, "The Scope and Impact of Welfare Reform's Immigrant Provisions," Discussion Paper 02-03 (Washington, D.C.: Urban Institute, January 2002).
[35] For a more detailed definition of "qualified alien," see Social Security Administration, "SSI Annual Statistical Report 2001," 3.
[36] Fix and Passel, "The Scope and Impact."

IV. CASELOAD SIZE AND COMPOSITION: WASHINGTON COMPARED WITH OTHER STATES

Relative Size of the Caseload

The fraction of persons with a severe disability who participate in Medicaid may vary among states for several reasons. Eligibility for Medicaid through the Supplemental Security Income (SSI) pathway is based both on disability and low income. As a result, poorer states may have a greater share of individuals with a disability who meet SSI income eligibility tests. States have a great deal of discretion in setting eligibility criteria for individuals who qualify for Medicaid through the home and community-based services pathway. Therefore, state policy choices also affect the percentage of persons with a disability who qualify for Medicaid.

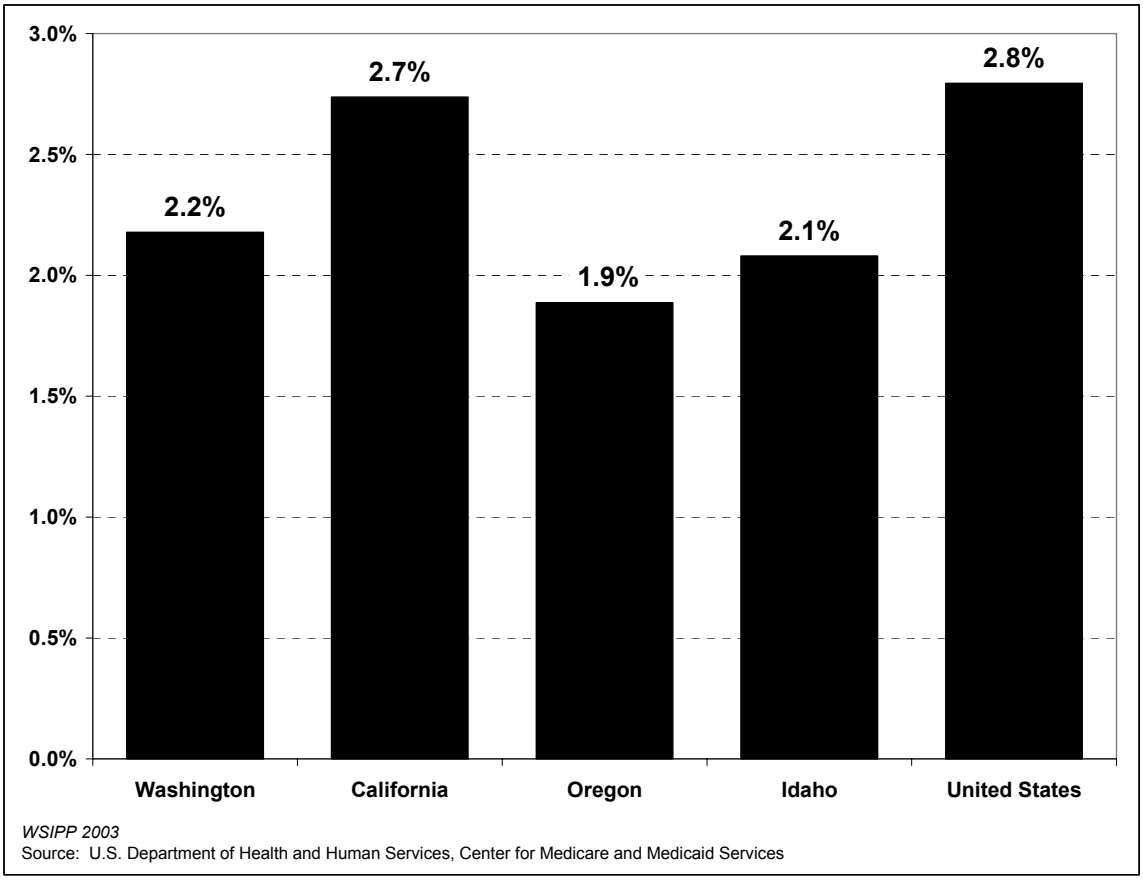
One way to gauge the comprehensiveness of Washington's Medicaid coverage for persons with severe disabilities is to compare the percentage of the state's population covered under the Categorically Needy Blind and Disabled program with similarly calculated percentages for other states. Because of different enrollment categories used across state Medicaid programs, it is very difficult to obtain information from other states that is directly comparable to Washington's Categorically Needy Blind and Disabled program. However, the federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) has defined three categories of individuals categorically eligible for Medicaid on the basis of blindness or disability: those receiving cash assistance, those with poverty-related eligibility, and those with other eligibility. CMS collects annual caseload data from all states using these definitions.[37]

Combining the three CMS disability categories creates a Medicaid group that overlaps extensively with the Washington Categorically Needy Blind and Disabled program. Because of differences in CMS and Washington State definitions, the sum of the three CMS disability related groups is similar, but not identical, to Washington's caseload. While the CMS data are not an exact match to Washington's Categorically Needy Blind and Disabled program, they do provide a reasonable way to compare the relative size of Medicaid caseloads across states for persons with disabilities.

Exhibit 6 compares the percentage of the population under age 65 covered under one of the Medicaid categories for persons with blindness or a disability for Washington, neighboring states, and the U.S. as a whole. As the exhibit indicates, Washington is below both the U.S as a whole and California but above Oregon and Idaho in the fraction of the under-65 population covered.

[37] These data are available at both the state and national level at the CMS website: <http://www.cms.hhs.gov/medicaid/datasources.asp> (Accessed January 23, 2003).

Exhibit 6
Percentage of Population Under 65 With Medicaid Coverage Based on Disability, 2000

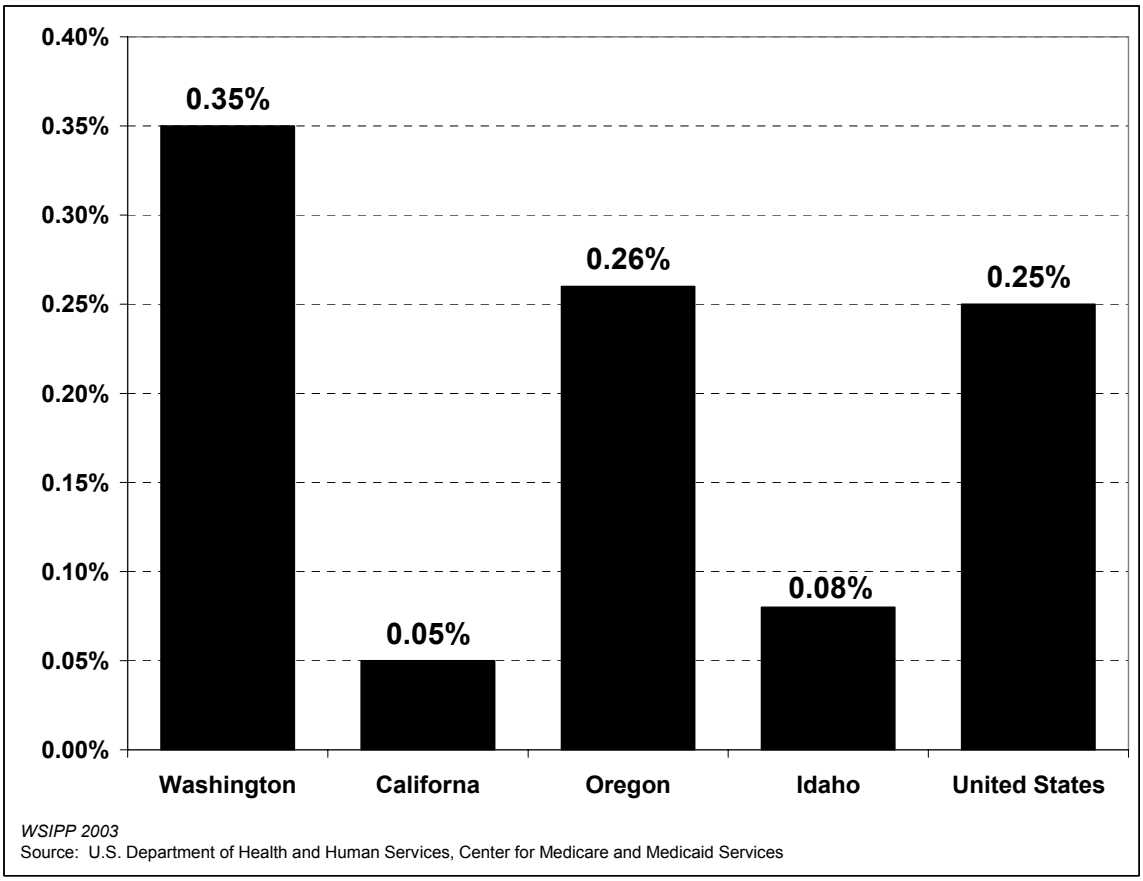


WSIPP 2003
Source: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services

Focusing only on the "other" category of persons eligible for Medicaid on the basis of blindness or disability provides another useful cross-state comparison. Although not strictly comparable across states, this category contains many groups for which states have received Medicaid "waivers" to modify eligibility or other program rules, such as the home and community-based services program. Exhibit 7 compares the percentage of the population under age 65 covered under the "other" category for persons with blindness or a disability for Washington, neighboring states, and the U.S. as a whole. Although the fraction of the under age 65 population enrolled in "other" programs is quite small, the exhibit indicates that Washington does provide above-average coverage in this area.

As noted earlier, more detailed information on some groups that compose the Categorically Needy Blind and Disabled program is not readily available. Therefore, the remainder of this section uses the most recent Social Security Administration data sources to compare the SSI portion of Washington's Categorically Needy Blind and Disabled program with the SSI caseload in other states.

Exhibit 7
Percentage of Population Under 65 With "Other" Medicaid Coverage Based on Disability, 2000

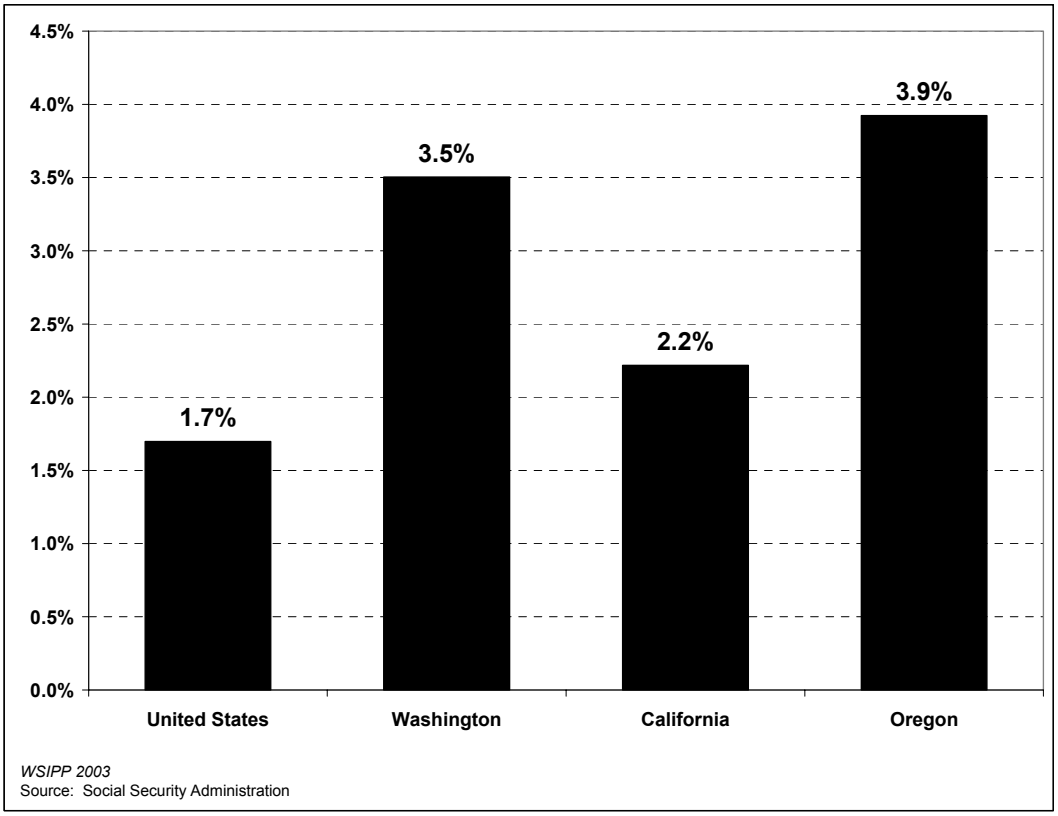


WSIPP 2003
Source: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services

Relative Growth in the SSI Caseload

Exhibit 8 shows average annual growth rates for the SSI blind and disabled portion of the Medicaid caseload for the 1999 to 2001 period. At an average rate of 3.5 percent, Washington's SSI caseload has grown twice as fast as the national caseload during the last two years. California and Oregon also have growth rates exceeding the national rate, with Oregon's caseload growth exceeding Washington's rate.

Exhibit 8
Annual Average Growth of SSI Blind and Disabled Caseload, 1999–2001



WSIPP 2003
Source: Social Security Administration

Diagnosis Group of SSI Recipients

Exhibit 9 compares the percentage of SSI recipients in the four most common diagnosis groups in Washington, Oregon, Idaho, California, and the U.S. for December 2001. For Washington, the surrounding states, and the U.S. as a whole, mental disorders and mental retardation were the identified impairment for nearly 60 percent of SSI recipients. While there is some variation, Exhibit 9 suggests that the basis of eligibility for SSI and associated Medicaid benefits is fairly similar across states.

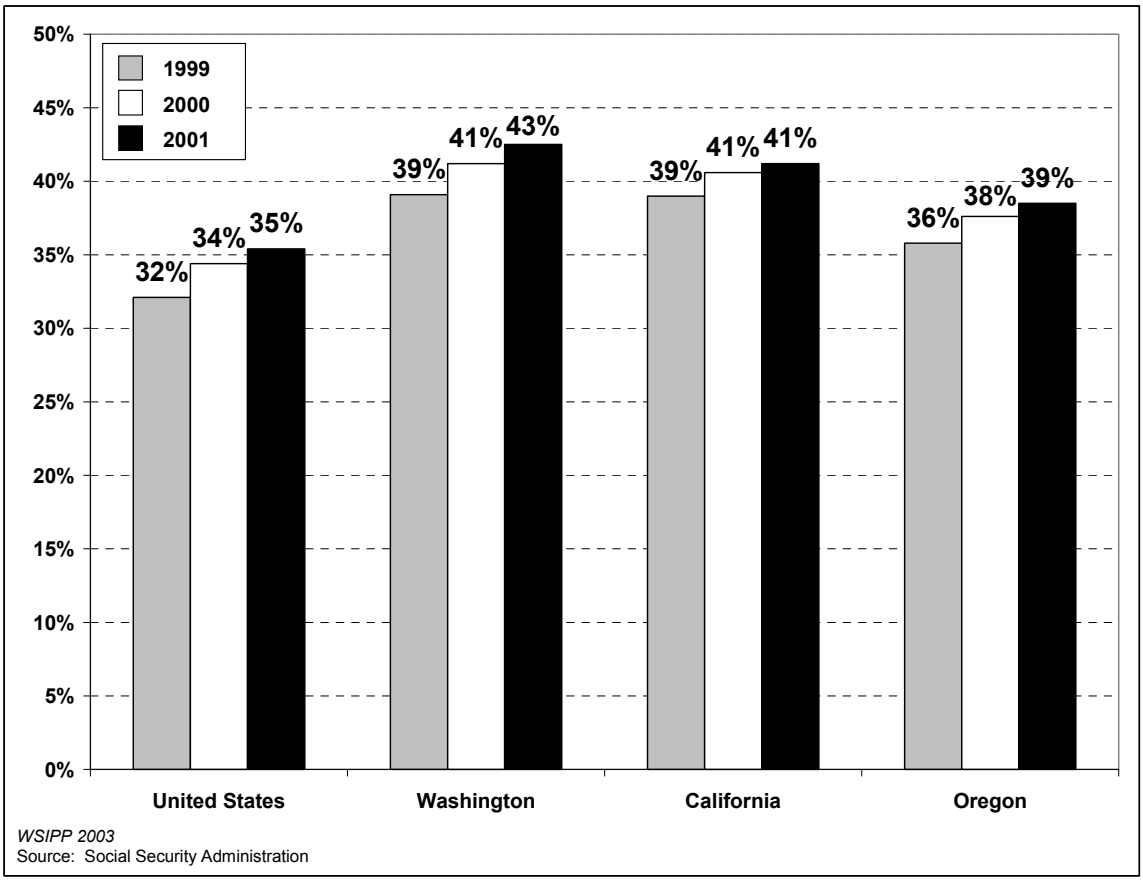
Exhibit 9
Four Most Common Diagnosis Groups Among SSI Recipients, December 2001
Percentage of SSI Blind and Disabled Caseload

	United States	California	Idaho	Oregon	Washington
Mental Disorders Other Than Retardation	35%	41%	38%	39%	43%
Mental Retardation	25%	17%	25%	21%	19%
Diseases of Nervous System and Sense Organs	9%	10%	11%	11%	10%
Diseases of Musculoskeletal System and Connective Tissue	8%	10%	8%	10%	9%

Source: Social Security Administration

Exhibit 10 focuses specifically on the share of SSI recipients with mental disorders. Nationally, and for each of the states displayed, individuals with mental disorders account for a growing fraction of the SSI caseload from 1999 through 2001. However, Washington had a consistently higher share of SSI recipients with mental disorders than did nearby states or the U.S. as a whole.

Exhibit 10
Percentage of SSI Blind and Disabled Caseload With Mental Disorder Diagnosis, 1999–2001

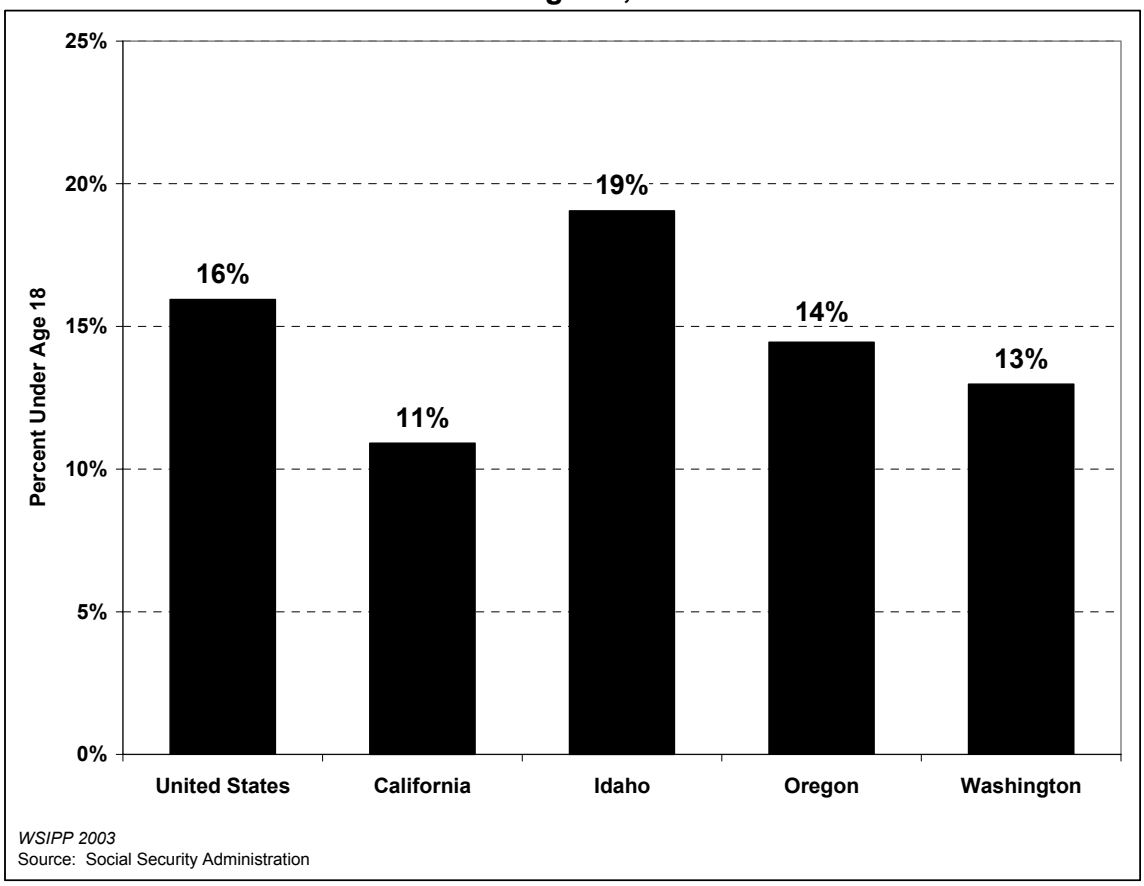


WSIPP 2003
Source: Social Security Administration

Children Receiving SSI

Exhibit 11 displays the fraction of individuals receiving SSI benefits on the basis of blindness or disability who were under age 18 in December 2001. Washington, Oregon, and California had a smaller share of SSI recipients under age 18 than the national average, while Idaho had an above-average fraction of SSI recipients under age 18.

Exhibit 11
Percentage of SSI Blind and Disabled Caseload Under Age 18, December 2001

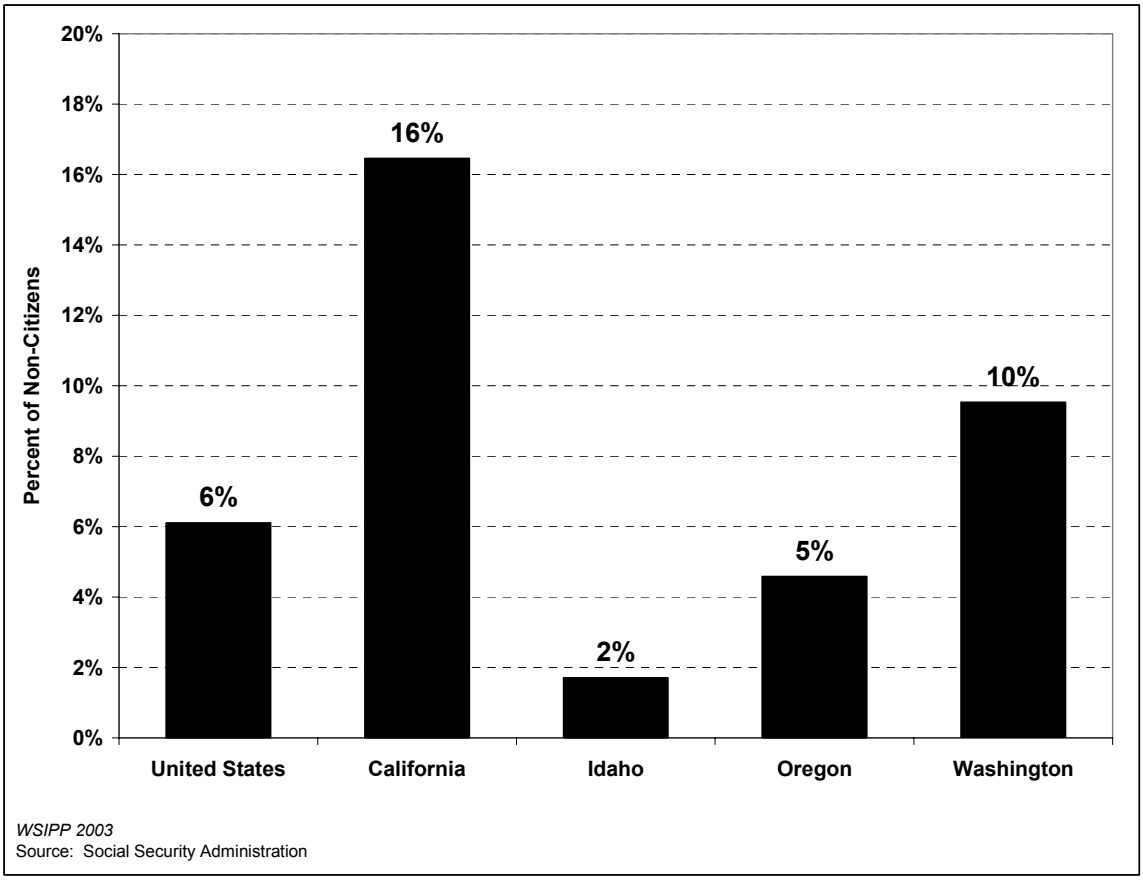


WSIPP 2003
Source: Social Security Administration

Non-Citizens Receiving SSI

Exhibit 12 displays the fraction of individuals receiving SSI benefits on the basis of blindness or disability who were non-citizens in December 2001. Washington had a higher fraction of non-citizens than neighboring states and the U.S. as a whole but a lower fraction than California.

Exhibit 12
Non-Citizens as a Percentage of SSI Blind and Disabled Caseload, December 2001



WSIPP 2003
Source: Social Security Administration

V. PROGRAM OPERATION DIFFERENCES: WASHINGTON COMPARED WITH OTHER STATES

Besides differences in the number and characteristics of persons with disabilities covered by Medicaid, states differ in the determination of eligibility for Medicaid programs. Due to a recent Social Security Advisory Board study, data have been made available that allow for some comparisons of the SSI portion of the eligibility process across states.[38]

SSI Applications

In 1999, adult SSI applications as a percentage of state population aged 18 to 64 ranged from a low of 0.3 percent to a high of 1.5 percent. Washington's adult application rate, at approximately 0.6 percent, was lower than the rate for 31 states (including California, Oregon, and Idaho) and higher than 14 states.

In 1999, child SSI application rates, as a percentage of state population under age 18, ranged from 0.2 percent to 1.8 percent. Washington's child application rate was one of the lowest of the states.

SSI Allowance Rates

Although most state Medicaid agencies are responsible for assessing eligibility for the SSI program, the eligibility process is determined at the federal level through the Social Security Act and associated regulations. In other words, state agencies review applications and determine if applicants are eligible for SSI by applying federal rules that define mental and physical impairments and allowable levels of income and assets. While this process implies that a consistent set of standards is applied across all states, the Social Security Advisory Board concluded in 2001 that "there are wide variations in decision making between different regions of the country…."[39]

One aspect of these regional variations is the difference, across states and over time, in the rate at which SSI applications are initially approved. Referred to as the initial SSI allowance rate, in recent years it has ranged from as low as 19 percent (Arkansas and West Virginia in 1997) to as high as 55 percent (New Hampshire in 1999) of *adult* SSI applicants. Washington's allowance rate for adults was fairly stable between 1997 and 1999, ranging from 36 percent to 39 percent. However, relative to other states, Washington's allowance rate has declined, going from fifth highest in 1997 to sixteenth highest in 1999.[40]

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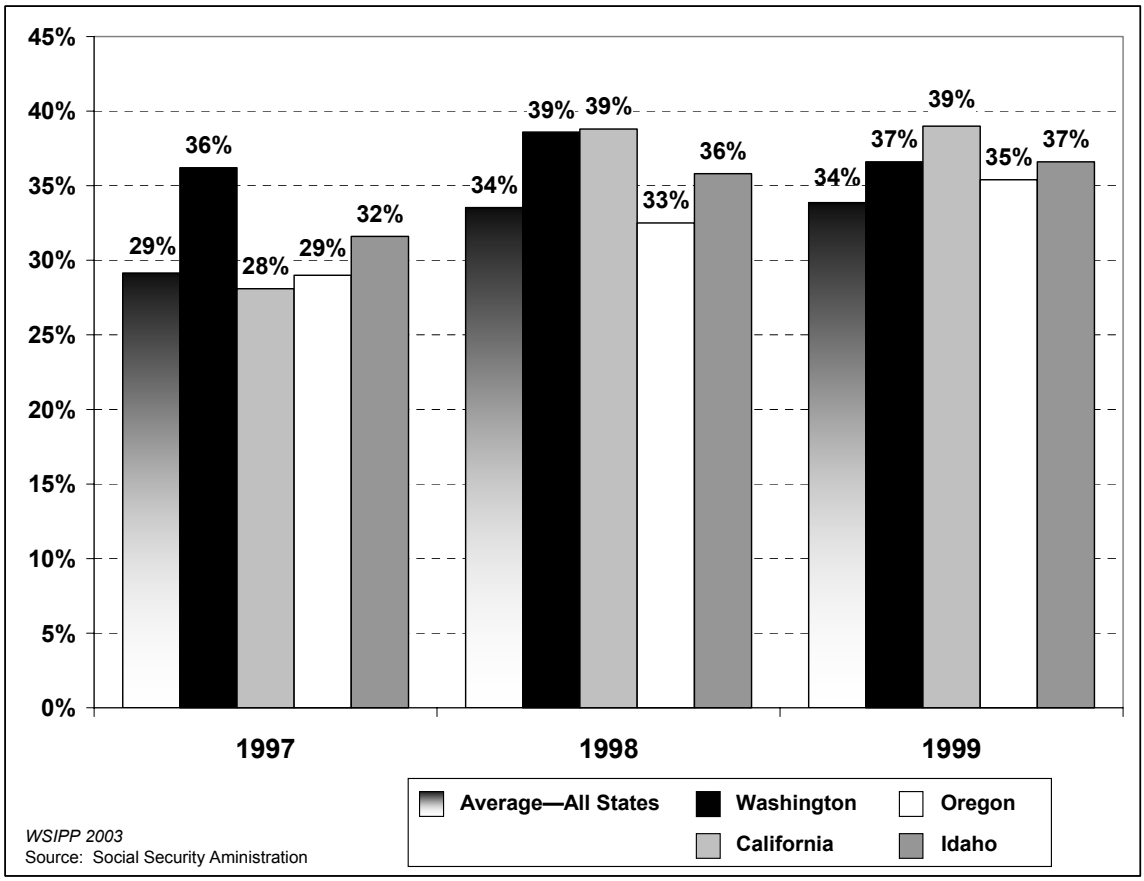
[38] This section makes use of research and analysis from *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change* (Washington, D.C.: Social Security Advisory Board, January 2001).

[39] Ibid.

[40] Data are from Alexander Strand, "Social Security Disability Programs: Assessing the Variation in Allowance Rates," ORES Working Paper Series No. 98 (Washington, D.C.: Social Security Administration, Office of Policy, Office of Research, Evaluation and Statistics, August 2002). Note that these data exclude SSI applicants under age 18.

Recent research indicates that a substantial fraction of the variance in allowance rates across states is attributable to differences in economic factors (poverty rates, percentage of workers with health insurance) and demographic factors (median age, percentage of population that completed high school). Therefore, while the Washington allowance rate is above the national average (see Exhibit 13), it is likely that much of that difference is explained by factors related specifically to the state and its population rather than to its SSI adjudication process.[41]

Exhibit 13
Initial SSI Allowance Rates



However, there are some factors specific to the Washington adjudication process that may have affected allowance rates relative to other states. A U.S District Court for Western Washington case settled in 1989, *Morrison, Doe and Decker*, required readjudication of a substantial number of cases and altered the ongoing adjudication process in Washington

[41] Strand, "Social Security"; D. Stapleton, K. Coleman, K. Dietrich, and G. Livermore, "Empirical Analyses of DI and SSI Application and Award Growth" in *Growth in Disability Benefits: Explanations and Policy Implications*, ed. K. Rupp and D. Stapleton (Kalamazoo, MI: W. E. Upjohn Institute for Employment Research, 1998).

State.[42] A national study of the adjudication process between 1989 and 1993 found that this case increased the probability of favorable treatment of SSI and SSDI applicants in the northwestern U.S.[43] compared to other parts of the country.[44] The northwest allowance rate for SSI and SSDI applications jumped from 38 percent before the court settlement to over 50 percent by mid-1990, after implementation of the settlement.[45]

Two administrative changes by the Social Security Administration may have resulted in higher allowance rates in Washington. In 1996, "process unification" regulations were implemented with the goal of reducing the workload for the SSI appeals process and minimizing the number of cases with lengthy appeals. These regulations resulted in a greater number of applications receiving initial approval and fewer cases being approved at the appeals level.

Prior to process unification, some applicants who were initially denied SSI eligibility did not pursue an appeal. Therefore, it is likely that the increase in initial application approvals due to process unification has increased the overall allowance rate and thus the size of the SSI caseload. To avoid further court decisions such as *Morrison, Doe and Decker*, Washington State fully implemented the process unification regulations. However, it is not clear that all states were as vigorous in implementing the regulations. As a result, process unification may have had a larger impact on Washington's allowance rate than in other states.

Twenty states, including Washington, are involved in a Social Security pilot project, referred to as "Single Decision Maker," which enables adjudicators to make medical assessments without the review of a medical consultant. The pilot states have had consistently higher allowance rates than states not using the Single Decision Maker adjudication model.[46]

[42] See Social Security Administration, Office of Hearings and Appeals, *Hearings, Appeals and Litigation Law (HALLEX) Manual*, Volume I, Chapter I-5-4 (Court Cases), sections I-5-5-1 and I-5-4-1-A, available at <http://www.ssa.gov/OP_Home/hallex/hallex.html> (Accessed March 5, 2003).
[43] The Social Security Administration administers its programs through ten regional offices. The Seattle regional office covers the northwest states of Washington, Oregon, Idaho, and Alaska.
[44] J. Hu, K. Lahiri, D. R. Vaughan, and B. Wixon, "A Structural Model of Social Security's Disability Determination Process," Working Paper No. 72 (Baltimore, MD: Office of Research, Evaluation and Statistics, Social Security Administration), 1997.
[45] Hu et al.
[46] E-mail to author from staff of the Department of Social and Health Services, Medical Assistance Administration, Division of Disability Determination Services, March 5, 2003.

VI. STATE POLICY OPTIONS IN FUNDING THE CATEGORICALLY NEEDY BLIND AND DISABLED PROGRAM

A state's expenditures for the Categorically Needy Blind and Disabled program depend on two major components: the number of persons eligible for and receiving services and the average cost of health care services received. State governments face several limitations in their ability to influence either of these components.

Eligibility

In general, federal rules govern eligibility for the Categorically Needy Blind and Disabled program. One important exception relates to individuals who qualify for the program on the basis of receiving home and community-based services. For this group, states have flexibility in setting maximum income levels and may limit the number of persons allowed to receive home and community-based services.[47] By changing the number of persons eligible for home and community-based services, states can in turn affect the number of persons qualifying for the Categorically Needy Blind and Disabled program. The data in Exhibit 7 suggest that Washington provides more extensive coverage through home and community-based services and other Medicaid waivers relative to neighboring states and the U.S. as a whole.

State policy can also indirectly influence two groups potentially eligible for the Categorically Needy Blind and Disabled program: individuals with severe disabilities receiving welfare payments through the Temporary Assistance for Needy Families (TANF) and General Assistance Unemployable (GA-U) programs. In either case, these persons are eligible for the Categorically Needy Blind and Disabled program if they meet SSI disability criteria. Because SSI cash benefits are generally higher than those in the TANF or GA-U programs, eligible individuals are better off shifting to the SSI program. However, this eligibility cannot be determined until an SSI application is made. In Washington State, there are active programs to identify TANF and GA-U recipients who appear to be eligible for SSI and to assist them with the SSI application process.

Slowing Caseload Growth. The above discussion suggests that it is possible to redesign state policies and slow the growth or even reduce the Categorically Needy Blind and Disabled caseload. However, current state policies regarding home and community-based services, TANF, and GA-U recipients were designed to create offsetting savings in other programs. This means that efforts to reduce the Categorically Needy Blind and Disabled caseload may increase state spending in long-term care, TANF, and GA-U programs.

For example, the home and community-based services program was intended to enable individuals who would otherwise require nursing home care to remain in their homes or in

[47] Schneider et al., "Medicaid Eligibility for Individuals with Disabilities." The Americans with Disabilities Act places some restrictions on the extent states are able to limit access to home and community-based services; see S. Rosenbaum, "The Olmstead Decision: Implications for Medicaid," prepared for the Kaiser Commission on Medicaid and the Uninsured (Washington, D.C., March 2000).

other residential settings. Concerns have been expressed that the desirability of these home and community services would attract individuals who would not have made use of nursing home services. However, research conducted during the early 1990s on home and community-based programs in several states, including Washington, indicates that these programs have been successful in replacing more expensive nursing home care with less expensive services.[48] Since that time, Washington has expanded its use of home and community-based services.

To the extent that reduced eligibility for Medicaid home and community-based services results in greater use of Medicaid nursing home services, it is likely that overall state expenditures would be increased.[49] Therefore, for a reduction in home and community-based service eligibility to be successful in reducing the Categorically Needy Blind and Disabled caseload and overall state expenditures, it must target those individuals with a low probability of requiring (or using) nursing home services.

Exhibit 14
Reducing Eligibility for Home and Community-Based Services

Reducing ↓ eligibility for *home and community-based services*
Increases ↑ the number of persons eligible for *nursing home services*
Impact on *Categorically Needy Blind and Disabled program* is ***unclear***

Individuals who shift from home and community-based services to nursing homes would remain eligible for Medicaid through the Categorically Needy Blind and Disabled program. *The Medicaid caseload would decline only if individuals who lost home and community-based service eligibility did not need, or chose not to use, nursing home services*.

State policies to identify individuals with severe disabilities in the GA-U and TANF programs and assist them in applying for SSI and the Categorically Needy Blind and Disabled program have a straightforward link to reducing total state expenditures. The GA-U program provides cash and medical assistance, from state-only funds, to individuals unable to work due to a temporary disability. Identifying GA-U recipients with longer-term

[48] Two studies using data from the early 1990s concluded that several states, including Washington, had reduced long-term care costs by providing home and community-based services to aged and disabled persons who might otherwise have received more expensive nursing home care. See L. M. B. Alecxih, S. Lutzky, and J. Corea, *The Efficacy of Using Home and Community-Based Care as an Alternative to Nursing Facility Care in Three States* (Washington, D.C.: American Association of Retired Persons, 1996); U. S. General Accounting Office, "Medicaid and Long-term Care: Successful State Efforts to Expand Home Services While Limiting Costs," Report No. HEHS-94-167 (Washington, D.C.: U. S. Government Printing Office, August 1994). A study of Arizona's home and community-based service program during 1989 and 1990 estimated that it reduced total long-term care costs; see W. G. Weissert, T. Lesnick, M. Musliner, and K. A. Foley, "Cost Savings From Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program," *Journal of Health Politics, Policy and Law* 22, no. 6 (December 1997).

[49] If an individual qualified for the Medicaid Categorically Needy Blind and Disabled program on the basis of eligibility for home and community-based services, he or she would continue to be Medicaid-eligible if placed in a nursing home. Therefore, shifting an individual from home and community-based services to nursing home services has no impact on the Categorically Needy Blind and Disabled caseload.

disabilities who qualify for SSI does result in a larger Categorically Needy Blind and Disabled caseload, but it also results in the replacement of state income assistance funds by federal SSI grant dollars and the replacement of state-only health care funding with the state and federally funded Medicaid program.

Exhibit 15
Reducing Efforts to Identify GA-U Recipients Eligible for SSI and Categorically Needy Blind and Disabled Programs

Reducing ↓ efforts to identify GA-U recipients with severe disabilities and assisting them in applying for SSI

Increases ↑ GA-U grants
and
Reductions ↓ in the Categorically Needy Blind and Disabled program
would be
Offset by increases ↑ in the Medical Care Services program, which is funded completely with state dollars.

For TANF recipients with severe disabilities, a shift to SSI eligibility replaces state and federal income assistance funds with federal SSI grant dollars. Because TANF recipients qualify for the Medicaid Family Medical program, the increase in the Categorically Needy Blind and Disabled caseload is offset by a reduction in the Family Medical caseload.

Exhibit 16
Reducing Efforts to Identify TANF Recipients Eligible for SSI and Categorically Needy Blind and Disabled Programs

Reducing ↓ efforts to identify TANF recipients with severe disabilities and assisting them in applying for SSI

Increases ↑ TANF grants
and
Reductions ↓ in the Categorically Needy Blind and Disabled program
would be
Offset by increases ↑ in the Family Medical program

Per Person Costs

Currently, the Medical Assistance Administration (MAA) has several efforts intended to reduce Medicaid expenditures, including those in the Categorically Needy Blind and Disabled program. These include a prescription drug program designed to reduce the unnecessary use of high-cost prescription drugs and a case management program to better coordinate the care of high-cost patients.

In addition to cost containment efforts, it is possible for Medicaid programs to scale back the types of health services they cover. To receive matching federal funding, state Medicaid programs must provide a specified minimum set of benefits, such as hospital and physician services.[50] However, states also receive matching federal funding for a set of optional health care services if they choose to provide them. Optional services provided to Medicaid recipients in Washington State include prescription drugs, eyeglasses, dentists, and podiatrists, among others. One method of reducing costs is to eliminate the coverage of optional Medicaid services for the Categorically Needy Blind and Disabled program, although this change would also require that the same service or services be eliminated for other Medicaid groups, such as low-income families, children, and pregnant women.

[50] For a list of required and optional Medicaid services, see *2000 Green Book*, WMCP: 106-14 (Washington, D.C.: U.S. House of Representatives, Committee on Ways and Means), 906, 924.

CONCLUSIONS

An examination of Washington State's Medicaid program for persons with severe disabilities indicates the following:

- Recent caseload growth is above the levels expected based on growth in either the general population or among persons in poverty.
- The fastest growing segment of the Categorically Needy Blind and Disabled program is clients qualifying through the General Assistance Expedited Medical Disability (GA-X) pathway for persons presumed to be eligible for Supplemental Security Income (SSI).
- The number of individuals qualifying for SSI due to mental disorders is growing faster than the overall SSI caseload.
- Caseload growth has occurred despite changes in federal rules intended to make SSI eligibility more restrictive.
- Factors that are likely contributors to above-average caseload growth include changes in the mix of occupations and industries in Washington, the rising value of Medicaid benefits, declining numbers of nursing home beds, and rising caseloads in the state's medically indigent program.
- Washington has a smaller fraction of its population under age 65 enrolled in Medicaid programs for persons with severe disabilities when compared with California or the U.S. as a whole but a higher fraction when compared with Oregon.
- Potential state policy responses to the rapid growth of this program are limited because several of the factors contributing to program growth reflect national trends not readily addressed at the state level. Federal requirements concerning program eligibility and benefits also limit state policy options.

In those areas where state policy may be able to affect program size or growth, the net fiscal benefits of such actions may be small or even negative. That is, attempts to limit the size of the Categorically Needy Blind and Disabled program may result in overall increases in state spending in other programs, such as long-term care, Temporary Assistance for Needy Families (TANF) and General Assistance Unemployable (GA-U). Additionally, while it is possible to eliminate some "optional" services to address overall program costs, federal rules would also require the elimination of those same services for other Medicaid recipients, such as low-income families, children, and pregnant women.