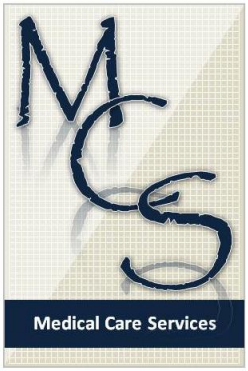
January 2013 | Number 11.187
Olympia, Washington



The Impact of Recent Policy Changes on Outcomes for Medical Care Services Clients

Health, Mortality, Housing, Food Assistance, and Criminal Justice

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OVER THE PAST THREE YEARS, in response to ongoing budget shortfalls, the Washington State cash assistance program formerly known as General Assistance experienced significant changes. In March 2010, the General Assistance program was renamed Disability Lifeline. The value of the Disability Lifeline cash grant was reduced in January 2011 and again in April 2011. In November 2011, the Disability Lifeline program was eliminated and replaced with three programs: 1) the Aged, Blind or Disabled (ABD) program, 2) the Pregnant Women Assistance (PWA) program, and 3) the Housing and Essential Needs (HEN) program. While ABD and PWA clients still receive cash assistance, HEN clients do not. To qualify for HEN, a person must be receiving Medical Care Services (MCS). Through the HEN program, MCS clients may receive housing support such as rent and utility assistance if they are currently homeless or at imminent risk of becoming homeless. This report examines how recent policy changes have impacted caseload trends and measures of well-being among individuals enrolled in the Medical Care Services program who were eligible for the Disability Lifeline (DL) program in October 2011, prior to its elimination.[1]

Key Findings

We compare the experiences of a cohort of individuals enrolled in MCS/DL in October 2011 with outcomes for cohorts enrolled in MCS/DL in October 2009 and October 2010. Over an eight month follow-up period, we find that the October 2011 cohort experienced:

1. Increased migration off MCS coverage, primarily through transitions to Categorically Needy Medicaid coverage associated with ABD cash assistance rather than through exits from medical assistance;
2. Lower mortality rates and emergency department utilization;
3. Higher rates of receipt of housing assistance among those with an identified housing need; and
4. Similar arrest rates and lower rates of incarceration in State Department of Corrections facilities.

Given the generally positive findings for clients on MCS coverage in October 2011, the elimination of the DL cash grant did not appear to have major negative impacts. The HEN program—in combination with outreach and coordination efforts on the part of ESA, Commerce, and local HEN grantees—appears to have mitigated potential negative impacts on housing stability. In addition, changes in ESA's eligibility determination process allowed more clients to continue accessing cash assistance than would have otherwise been the case. In particular, caseworkers screen new applicants for ABD *first*, gathering the necessary medical evidence earlier in the process than was done under the former GA-X/DL-X program. New applicants are only screened for MCS eligibility when they have been denied for ABD.

[1] This report examines outcomes over an eight-month follow-up period for a cohort of 15,544 individuals enrolled in MCS/DL in October 2011 compared to cohorts enrolled in October 2009 and October 2010. RDA report number 11.186, *Washington State's Housing and Essential Needs Program*, compares outcomes for 661 MCS enrollees who received HEN in the initial months of implementation to two comparison groups.

SUMMARY

1. **Increased migration off MCS coverage—primarily through transitions to Categorically Needy Medicaid coverage associated with the ABD program—and a significant reduction in new enrollment**

   The decline in the MCS caseload following the elimination of the DL-U cash grant in November 2011 was associated with an increase in the rate of exits, an increase in the rate of transitions to other medical coverage, and a steep drop in the rate of new entries. The drop in new entries onto the MCS caseload coincided with an increase in new entries onto the ABD program, due to changes in ESA's eligibility determination process. Caseworkers now screen new applicants for ABD *first*, and screen for MCS eligibility only if the applicant is denied for ABD. Clients on MCS in October 2011 were about half as likely to still be on MCS coverage 8 months later relative to the two earlier cohorts. However, relative to those cohorts, the decline in the proportion of clients in the October 2011 cohort who remained on MCS coverage was primarily due to an increase in transitions to the ABD program.

2. **Decreased mortality rates and emergency department utilization**

   Medical and housing need levels had already risen in the MCS caseload prior to the elimination of the DL-U cash grant in November 2011. This reflects, at least in part, the impact of the earlier cash grant reductions in January and April 2011, which reduced the rate of new entries and increased the rate of exits. Given the intrinsic economic incentives associated with program participation, it is to be expected that the earlier cash grant reductions would tend to increase the medical and housing need risk in the ongoing caseload. However, despite the trend towards higher levels of medical risk in the MCS caseload that preceded the elimination of the cash grant, outpatient ED utilization and mortality outcomes for the October 2011 cohort are favorable relative to the earlier cohorts of MCS clients. The decline in ED utilization may be driven by broader efforts by the Health Care Authority, the Community Health Plan of Washington, and the Washington State Hospital Association to reduce ED utilization.

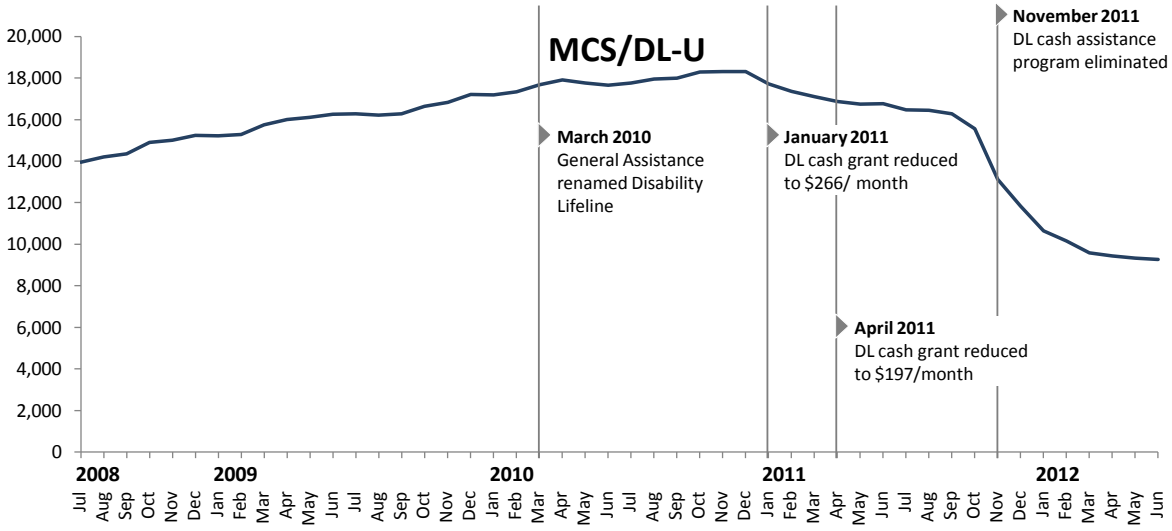
3. **Increased rates of housing assistance receipt among those with identified housing need**

   The replacement of the DL-U cash grant with the HEN program increased access to housing assistance provided by local housing providers for MCS clients who could demonstrate homelessness or imminent risk of homelessness. This resulted in a three-fold increase in the monthly proportion of MCS clients with housing needs who received housing assistance reported through the state's Homeless Management Information System (HMIS).

4. **Stable arrest rates and lower incarceration rates**

   Arrest rates for the 2011 cohort of MCS clients were essentially unchanged from the levels observed in earlier cohorts of MCS clients. However, we found a substantial reduction in the October 2011 cohort in the proportion of clients who were incarcerated in a State Department of Corrections facility in the follow-up period compared to the two earlier cohorts.

The MCS/DL-U caseload has declined following recent policy changes

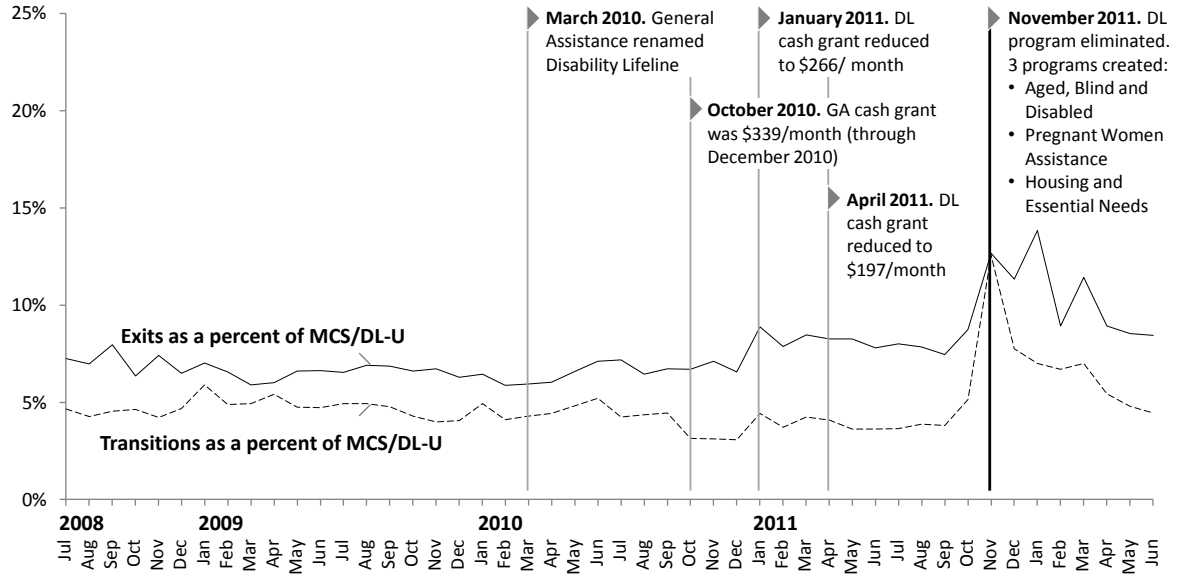


Q1. *What are the caseload trends among MCS enrollees?*

CASELOAD TRENDS | Exits, Transitions, and New Arrivals

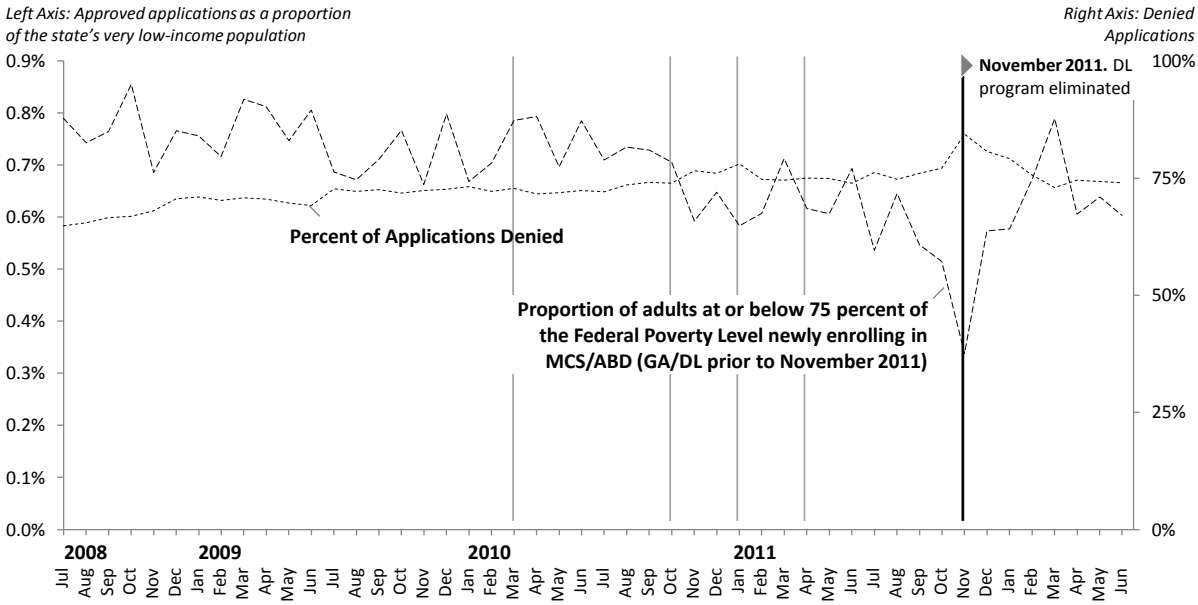
There was a sharp increase in the proportion of MCS enrollees who left the program in November 2011 when the DL cash grant was eliminated, primarily due to transitions to other medical coverage (most notably coverage associated with the ABD program). From October to November 2011, exits increased from 9 to 13 percent of the MCS caseload and transitions to other coverage increased from 5 to 13 percent. "Exits" as reported here exclude transitions to other forms of medical assistance.

Exits and Transitions as a Proportion of the Overall MCS Caseload



In November 2011, there was a decline in the proportion of the state's adult low-income population that newly enrolled in MCS or ABD. However, this rate started to return to previous levels in December 2011, reflecting a change in ESA's process whereby new applicants are concurrently screened for ABD and MCS.

New Arrivals and Denied Applications*



* Data is based on applications for GA/DL through October 2011 and applications for MCS and ABD from November 2011 to June 2012.
SOURCE: DSHS Economic Services Administration Management Accountability and Performance Statistics (E-MAPS).

STUDY DESIGN | Three Cohorts of MCS Enrollees

To understand how recent policy changes may have impacted low-income adults who are unable to work due to physical or mental health incapacities, we looked at measures of well-being over an 8-month follow-up period for three cohorts of MCS enrollees. We identified a 2009, 2010, and 2011 cohort, each selected based on MCS enrollment in October of the respective calendar year. The October 2009 cohort did not experience major programmatic changes in the course of their November 2009 to June 2010 follow-up period. The October 2010 cohort experienced two reductions to the cash grant in their follow-up period, down to $266 per month in January 2011 and $197 per month in April 2011. The focal cohort—individuals enrolled in October 2011—experienced the elimination of the Disability Lifeline cash assistance program in November 2011, the first month of their follow-up period.

By comparing the October 2011 cohort to the two earlier cohorts, we are able to observe how MCS enrollees may have been impacted by the elimination of the DL cash assistance program (see study timeline in Technical Notes on p. 9.). We also remove some of the bias that would be introduced by *only* comparing the experience of individuals in the same time period. This is because individuals who left MCS coverage or transitioned to other medical coverage when the cash grant was eliminated are likely to be different from those who remained in ways that make it difficult to say whether exposure to the policy change itself led to observed differences in outcomes.

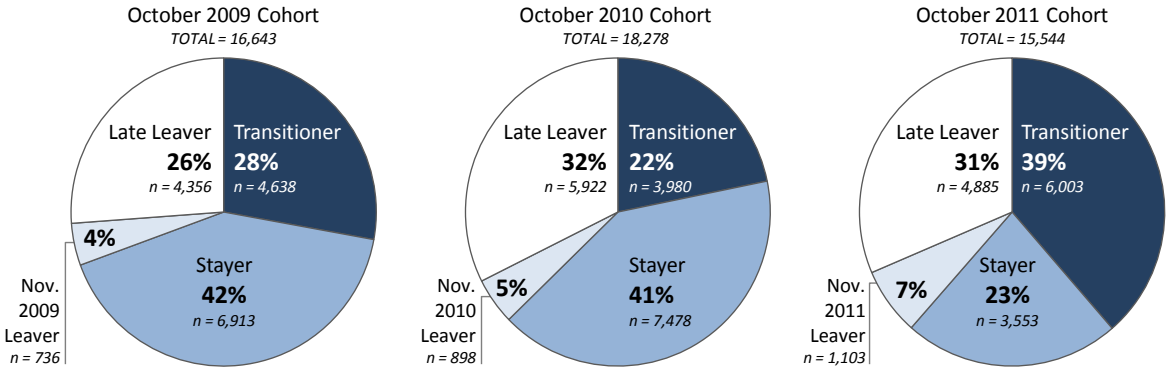
CASELOAD DYNAMICS | Transitioners, Stayers, November Leavers, and Later Leavers

We looked at caseload dynamics within each of the three October cohorts to gain insight into how changes in enrollment patterns have corresponded with changes in policy. We looked at four subgroups: stayers, transitioners, November leavers, and late leavers. These groups were mutually exclusive, so if an enrollee fell into more than one group, they were assigned to a single group in the order listed below:

- **Stayers:** Individuals who had MCS coverage in October and were still enrolled in the program at 8-months follow-up. They were not necessarily continuously enrolled in the program.
- **Transitioners:** Individuals who had MCS coverage in October and transitioned to other medical coverage in the follow-up period.
- **Late Leavers:** Individuals who had MCS coverage in October, were not on MCS in June but *were* on in at least one month between November and May.
- **November Leavers:** Individuals who had MCS coverage in October, left in November, and did not return to MCS or transition to other medical coverage in the follow-up period.

As the chart below demonstrates, about half as many individuals in the October 2011 cohort were still enrolled in MCS by June compared to the other two cohorts (23 percent were "stayers" compared to 42 percent of the October 2009 cohort and 41 percent of the October 2010 cohort). A greater share of both the October 2010 and 2011 cohorts left MCS coverage in the follow-up period compared to the October 2009 cohort (37 and 38 percent, respectively, compared to 30 percent), so it is not necessarily patterns of exit that distinguishes the October 2011 cohort. Rather, a greater share of this cohort transitioned to other medical coverage relative to the two earlier cohorts (39 percent compared to 28 percent of the October 2009 cohort and 22 percent of the October 2010 cohort).

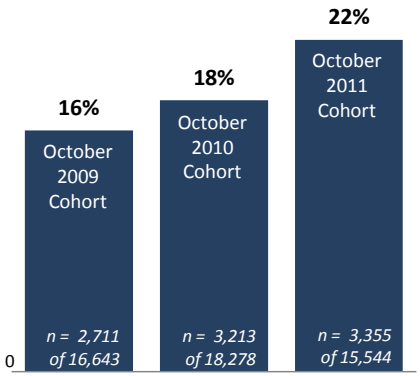
Caseload Dynamics by Cohort



Q2. *How have health outcomes changed as programs have changed?*

HEALTH STATUS

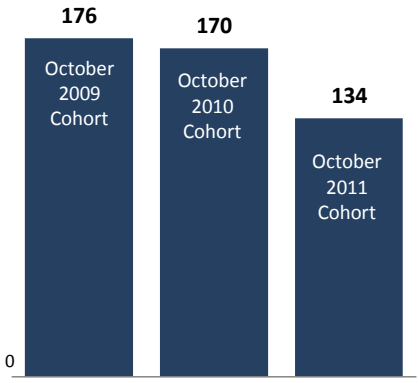
Percent of clients with health risk comparable to or worse than average SSI recipient



To assess health status at baseline, we used a chronic illness risk score based on health service diagnoses and pharmacy claim information.[2] The score is calibrated to equal one for the average person in Washington State meeting Social Security Insurance (SSI) disability criteria. Compared to prior cohorts, a greater share of the October 2011 cohort had a chronic illness risk score greater than one, meaning their medical risk was above the average for a disabled SSI recipient in Washington State. This is consistent with the prior grant reductions resulting in "adverse selection" of program participants from a medical risk perspective.

EMERGENCY DEPARTMENT USE

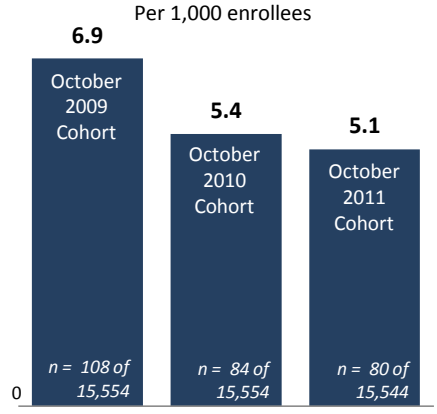
Outpatient Emergency Department Visits
Per 1,000 member months



Despite the finding that the October 2011 cohort experienced greater baseline medical risk, we observe a lower number of outpatient emergency department (ED) visits relative to the two earlier cohorts. While the October 2009 and October 2010 cohorts experienced 176 and 170 outpatient ED visits per 1,000 member months, the October 2011 cohort had only 134 visits per 1,000 member months. This finding may reflect broader efforts by the Health Care Authority, the Community Health Plan of Washington, and the Washington State Hospital Association to reduce avoidable ED utilization statewide. The table at the top of page 10 shows that there was a decline in ED visits for each of the sub-groups analyzed.

MORTALITY

Age-Adjusted Mortality Rate
Per 1,000 enrollees



Despite having greater health risk relative to the October 2009 cohort, the age-adjusted mortality rate is actually slightly lower for both the October 2010 and 2011 cohorts.[3] Specifically, while the mortality rate was 6.9 per 1,000 enrollees for the October 2009 cohort, it was 5.4 for the October 2010 cohort and 5.1 for the October 2011 cohort. The table at the top of page 10 of the Technical Notes shows that the lower mortality rate for the 2011 cohort is largely driven by a lower rate among later leavers, a group whose program exits are more likely to be due to a death than those who left in the month cash assistance was eliminated. For this group, the age-adjusted mortality rate dropped 10 percentage points (from 17.6 per 1,000 enrollees for the October 2009 cohort to 7.6 per 1,000 enrollees for the October 2011 cohort).

[2] See Gilmer, T., Kronick, R., Fishman, P., & Ganiats, T. G. (2001). The medicaid R-x model - Pharmacy-based risk adjustment for public programs, *Medical Care*, 39(11), 1188-1202 and Kronick, R., Gilmer, T., Dreyfus, T., & Lee, L. (2000). Improving health-based payment for Medicaid beneficiaries: CDPS, *Health Care Financing Review*, 21(3), 29-64.

[3] We applied the "crude" death rates by age group observed in the 2009 and 2010 cohorts to the age distribution of the October 2011 cohort to produce age-adjusted death rates that take into account the different age distributions observed across the three cohorts.

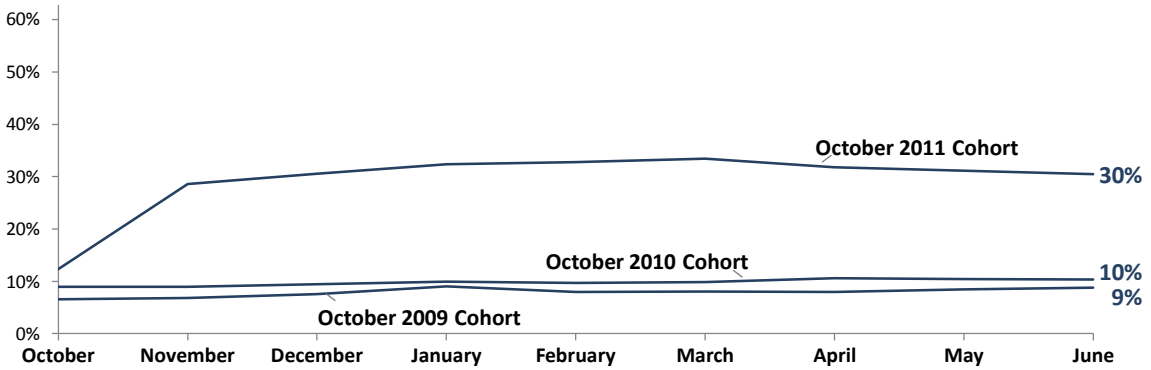
Q3. *Are people getting connected to housing and food assistance?*

HOUSING STATUS | Housing Need and Housing Assistance Penetration

Prior research on the effects of terminating General Assistance (GA) cash assistance in other states suggests an associated increase in housing instability,[4] which would lead us to expect a similar increase in housing need associated with the reduction (and ultimate elimination) of the DL cash grant. Given the housing assistance available through the HEN program, we would also expect there to be a greater incentive for those with a need for housing to stay enrolled in MCS after the replacement of the cash grant with HEN assistance. Consistent with these expectations, we find that the baseline proportion of individuals with identified housing need was higher for the October 2011 cohort (44 percent), than for the October 2010 (41 percent) and October 2009 (37 percent) cohorts. Housing need was identified using an indicator of homelessness and housing instability that combines data from five different information systems, including the Homeless Management Information System (HMIS).[5]

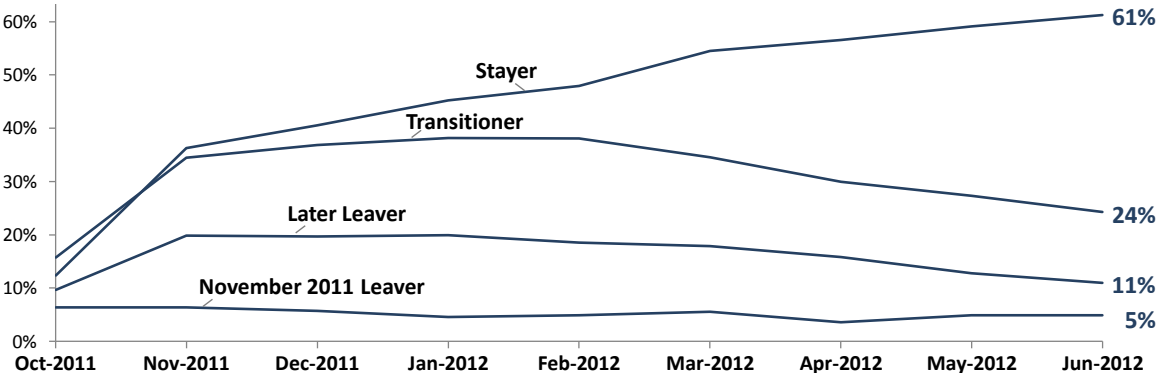
By June of the follow-up period, the monthly housing assistance penetration rate, among those with an identified housing need, was three times higher for the October 2011 cohort than for the two earlier cohorts (30 percent compared to 9 percent for the 2009 cohort and 10 percent for the 2010 cohort).

HMIS-Recorded Housing Assistance[6] among those with Identified Housing Need, by Cohort



The higher housing assistance penetration observed for the October 2011 cohort is largely due to higher penetration among "stayers" (see chart below), who had the opportunity to receive housing assistance through the HEN program beginning in November 2011.

HMIS-Recorded Housing Assistance among those with Identified Housing Need, October 2011 Cohort

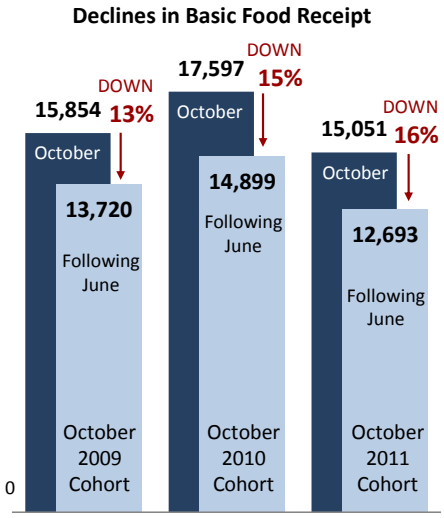


[4] See, for example: Pennsylvania Co. Joint Study of Act 75: The impact of welfare reform. Harrisburg, PA: Act 75 Interagency Evaluation Subcommittee, Department of Labor and Industry, Department of Public Welfare, Department of Revenue and Community Affairs, the Governor's Office of Policy Development, and the Governor's Office of the Budget, 1984 and McDonald B, Parks S, Conyers G, Mutchler W. The Impact on Individuals and Communities of the Reductions in Social Services in Michigan in 1991-1992. Lansing, MI: Michigan League for Human Services , 1993.

[5] Housing need is defined using the criteria developed in: Shah, MF, et al. (2012). Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems, Olympia, WA: Research and Data Analysis Division, http://publications.rda.dshs.wa.gov/1457/.

[6] Housing assistance is defined as receipt of Emergency Shelter, Transitional Housing, Homelessness Prevention and Rapid Re-housing, or Permanent Supportive Housing services recorded in the state's Homeless Management Information System (HMIS).

FOOD ASSISTANCE | Declines in Basic Food Receipt were comparable across cohorts



The federally funded Basic Food program is intended to ensure that low-income individuals do not go hungry. We observe high rates of Basic Food receipt for each cohort in October of each year (95 percent in 2009, 96 percent in 2010, and 97 percent in 2011). By 8 months follow-up, the rate of Basic Food receipt had dropped to 82 percent for each cohort. In each case, this decline is primarily driven by a substantial decline in Basic Food receipt among those who left MCS coverage (see table below).

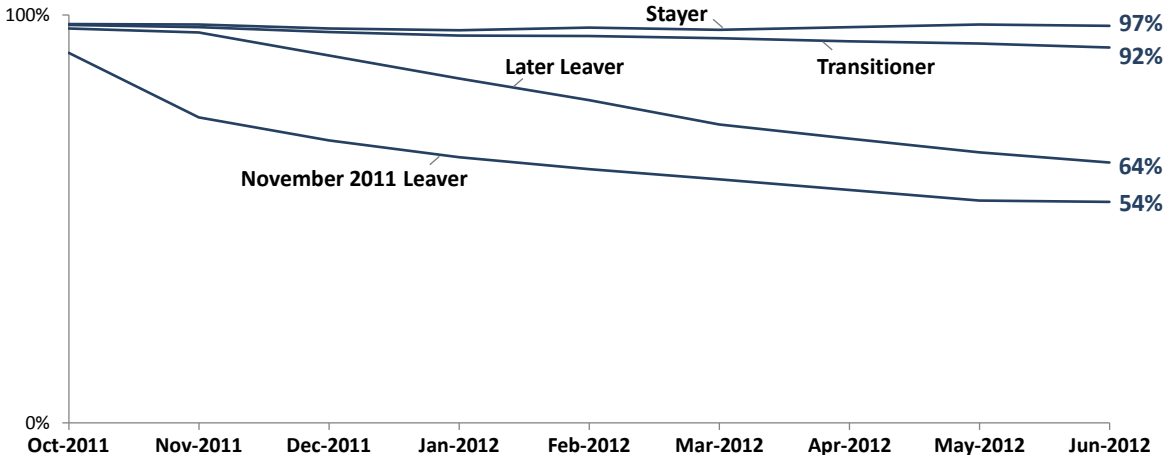
Percent change in Basic Food Receipt from October to June, by Cohort and Subgroup

Percent Change, October to June	TOTAL	Transitioner	Stayer	November Leaver	Later Leaver
October 2009 Cohort	**–13%**	–5%	1%	–55%	–40%
October 2010 Cohort	**–15%**	–6%	1%	–49%	–37%
October 2011 Cohort	**–16%**	–6%	0%	–40%	–34%

OCTOBER 2011 COHORT

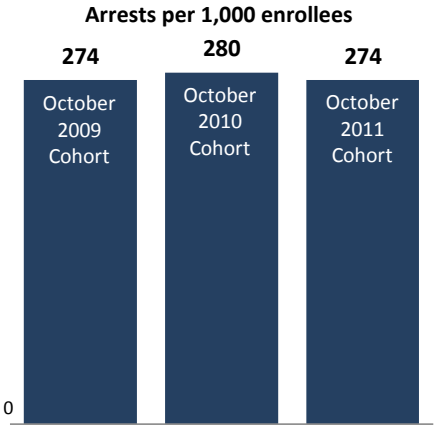
Similar to the pattern observed for the two earlier cohorts, individuals in the October 2011 cohort who remained on MCS or transitioned to other medical coverage were more likely to stay connected to Basic Food (see chart below). As was also true with the earlier cohorts, individuals who left MCS coverage in November experienced the greatest decline in receipt of food assistance.

Declines in Basic Food Receipt, October 2011 Cohort



Q4. *Have rates of arrest and incarceration changed?*

ARRESTS | Arrest rates have remained stable

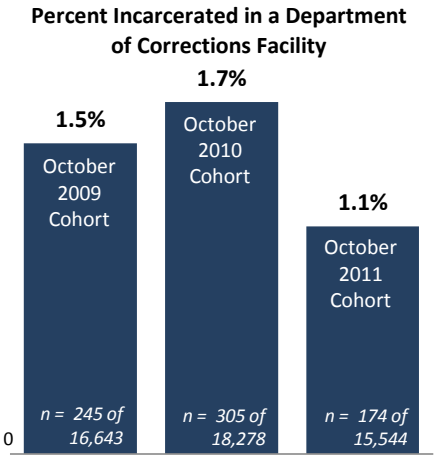


The overall rate of arrest for felonies and gross misdemeanors, as recorded in Washington State Patrol data,[7] remained stable and across all three cohorts. As shown in the table below, the differences observed between the different subgroups are on the whole smaller than the between-group differences we see on other measures (such as receipt of housing and food assistance). One notable finding is that November leavers had higher arrest rates than any other subgroup in the October 2011 cohort. By contrast, November leavers in the earlier cohorts had lower arrest rates than either stayers or later leavers.

Arrest Rates per 1,000 Enrollees, by Cohort and Subgroup

Arrest rates per 1,000 enrollees	TOTAL	Transitioner	Stayer	November Leaver	Later Leaver
October 2009 Cohort	**274**	231	271	251	329
October 2010 Cohort	**280**	223	275	252	329
October 2011 Cohort	**274**	231	276	322	314

INCARCERATION | October 2011 cohort had a lower incarceration rate



We examined the proportion of each cohort that was incarcerated in a State Department of Corrections facility at some point over the 8-month follow-up period. We find that a somewhat lower proportion of the October 2011 cohort was incarcerated compared to the earlier cohorts. The table below shows that this difference is driven by lower incarceration rates among November leavers and later leavers in the October 2011 cohort. Although recent policy changes have significantly reduced the Department of Corrections caseload that is under community supervision, the prison population has remained fairly stable over the study period.[8]

Percent Incarcerated in a Department of Corrections Facility, by Cohort and Subgroup

Percent Incarcerated in a DOC Facility	TOTAL	Transitioner	Stayer[9]	November Leaver	Later Leaver
October 2009 Cohort	**1.5%**	0.5%	0.3%	5.0%	3.7%
October 2010 Cohort	**1.7%**	0.7%	0.3%	5.1%	3.5%
October 2011 Cohort	**1.1%**	0.4%	0.2%	3.9%	2.1%

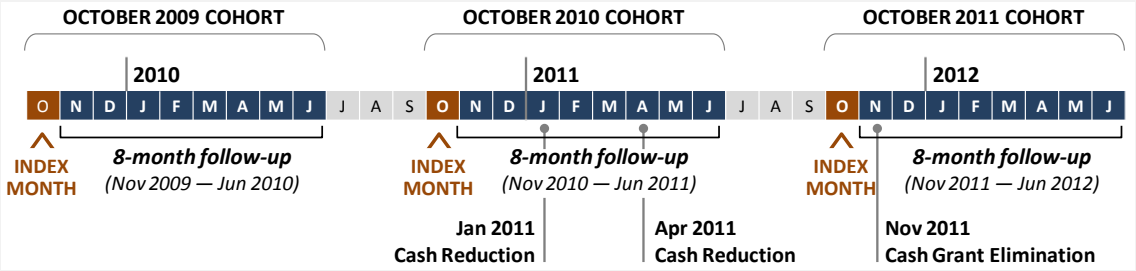
[7] WSP arrest data do not include misdemeanors and, therefore, reflect arrests for only more serious types of offenses.
[8] See "Major Sentencing Changes Impacting Supervision Caseloads and Prison Population," Washington State Department of Corrections, http://www.doc.wa.gov/aboutdoc/docs/MajorSentencingChangesImpactingCommunitySupervisionCaseloadsandPrisonPopulation_001.pdf.
[9] There are a few possible explanations for why we observe a small number of stayers who were incarcerated: 1) a small degree of "mismatch" is likely to occur in the process of linking DOC data with DSHS records, 2) stayers were defined to include persons still receiving MCS coverage as of June in the follow-up period, and were not required to be enrolled continuously in MCS in all 8 months of the follow-up period, and 3) incarceration spells may have begun in or around the same month an individual left MCS coverage or ended in the same month the individual's MCS coverage began.

The objective of this analysis was to look at how changes to the General Assistance/Disability Lifeline program—in particular, the elimination of the DL cash assistance program in November 2011—may have impacted caseload trends and measures of well-being among individuals enrolled in the Medical Care Services program. Individuals who exited coverage or transitioned to other medical coverage are likely to be different from those who remained in ways that make it difficult to say whether the policy change itself led to any differences observed in outcomes. We therefore look at three cohorts of MCS enrollees, each selected based on enrollment in October:

1. October 2009 cohort: this group did not experience major programmatic changes over the eight month follow-up period (November 2009 to June 2010).
2. October 2010 cohort: this group experienced reductions in the amount of their monthly cash grant in the eight month follow-up period (specifically, in January and April 2011).
3. October 2011 cohort: this group experienced the elimination of DL cash assistance in November 2011.

STUDY TIMELINE

Each enrollee was assigned an "index month" of October and we examined a variety of outcomes over an eight month follow-up period from November to June. Enrollees could be included in more than one cohort.



DEMOGRAPHICS

	October 2009 Cohort		October 2010 Cohort		October 2011 Cohort	
Age Categories	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT
Age 18-24	924	6%	1,568	9%	1,484	10%
Age 25-34	3,548	21%	4,203	23%	3,359	22%
Age 35-44	3,504	21%	3,986	22%	3,543	23%
Age 45-54	5,973	36%	6,174	34%	5,469	35%
Age 55+	2,694	16%	2,347	13%	1,689	11%
TOTAL	**16,643**	**100%**	**18,278**	**100%**	**15,544**	**100%**
Gender	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT
Male	10,387	62%	11,600	64%	9,509	61%
Female	6,256	38%	6,678	37%	6,035	39%
TOTAL	**16,643**	**100%**	**18,278**	**100%**	**15,544**	**100%**
Race|Ethnicity*	COUNT	PERCENT	COUNT	PERCENT	COUNT	PERCENT
White	13,471	81%	14,838	81%	12,513	81%
African American	2,532	15%	2,615	14%	2,249	15%
American Indian	1,516	9%	1,579	9%	1,290	8%
Asian, Pacific Islander	1,240	8%	1,257	7%	1,004	7%
Other	1,829	11%	2,106	12%	1,860	12%
Hispanic	1,244	8%	1,502	8%	1,320	9%

**Note that individuals can fall into more than one racial/ethnic category.*

HEALTH AND MORTALITY OUTCOMES, BY SUB-GROUP

Percent with chronic illness risk score at or above SSI recipient	TOTAL	Transitioner	Stayer	November Leaver	Later Leaver
October 2009 Cohort	**16%**	21%	16%	13%	12%
October 2010 Cohort	**18%**	23%	19%	15%	13%
October 2011 Cohort	**22%**	29%	21%	17%	15%

Outpatient Emergency Department Utilization *Per 1,000 member months*	TOTAL	Transitioner	Stayer	November Leaver	Later Leaver
October 2009 Cohort	**176**	178	177	N/A	166
October 2010 Cohort	**170**	187	170	N/A	148
October 2011 Cohort	**134**	137	141	N/A	115

Age-Adjusted Mortality Rates	TOTAL	Transitioner	Stayer	November Leaver	Later Leaver
October 2009 Cohort	**6.9**	6.4	0.8	3.1	17.6
October 2010 Cohort	**5.4**	5.3	1.4	2.3	11.1
October 2011 Cohort	**5.1**	6.2	0.6	3.6	7.6

STATE PROGRAMS AVAILABLE FOLLOWING THE ELIMINATION OF DISABILITY LIFELINE

	State Programs for Low-Income Individuals with Temporary and Long-Term Disabilities		
	Aged, Blind or Disabled (ABD) Cash	**Medical Care Services (MCS)**	**Housing and Essential Needs (HEN)**
Income Limit	Countable monthly income under $197	Countable monthly income under $339	Countable monthly income under $339
Disability/Incapacity	Must be age 65 or older, blind or likely to meet SSI disability criteria.	Unable to work for at least 90 days due to a physical or mental incapacity.	Must be eligible for the MCS program.
Benefit Level	$197 per month maximum	N/A	Housing and utility assistance amounts vary by county.
Medical Coverage	Categorically Needy (CN) Medicaid Coverage	MCS medical coverage	Must be enrolled in MCS medical coverage

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Please request REPORT NUMBER 11.187