Report:

1986 STUDY OF THE CHARACTERISTICS OF STATE GENERAL ASSISTANCE PROGRAMS

WASHINGTON STATE
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

OFFICE OF PLANNING, EVALUATION AND PROFESSIONAL DEVELOPMENT

1986 STUDY OF THE CHARACTERISTICS OF STATE GENERAL ASSISTANCE PROGRAMS

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EXECUTIVE SUMMARY

This report compares Washington's General Assistance-Unemployable (GA-U) program with general assistance programs in other states. The GA-U program provides financial assistance and medical treatment to people with medically verifiable incapacities which last at least 60 days and which prevent employment.

The report examines the design of general assistance programs in other states, general assistance caseload trends, and factors predicting participation in the federally-funded Supplemental Security Income (SSI) Disability program.

The SSI-Disability program provides cash and medical benefits to people with disabilities that are expected to prevent work for at least 12 months or to cause death. Most states try to move as many general assistance recipients as possible to the SSI-Disability program to save state funds and provide disabled residents with more generous benefits.

Findings on General Assistance Program Design :

- Thirty-six states had general assistance programs in all or virtually all jurisdictions. The remaining states either had no general assistance programs or had programs provided by local governments at local option.

- General assistance programs can be classified into four groups, by type of eligibility requirement:

  a) Income-Based Programs. A needs test and cooperation with work requirements, if applicable, are the only eligibility criteria (8 states).

  b) Categorical Programs. Recipients must fall into one of several categories of eligible individual in addition to meeting a needs test (7 states). Categories may include incapacitated adults, adults over a set age (40 to 60), children not eligible for AFDC, and so on. Some of these states offer short-term assistance to employable recipients.

c) Incapacity-Based Programs. Similar to categorical programs, except that over 90 percent of all cases are eligible due to incapacity (8 states). Washington's GA-U program is in this group.

d) Mixed Programs. Four states had programs that varied by county or municipality in ways that made categorization difficult. However, some program was available in all jurisdictions within those states.

- General Assistance payments were higher in Washington State than anywhere else in the United States, with the exception of Suffolk County, New York.

- One state -- Wisconsin -- adopted a 60 day residency requirement with qualifications designed to overcome Supreme Court challenges. State officials expected the limit to be overturned in court when challenged.

- States relied on a number of methods for moving disabled general assistance recipients to the SSI-Disability program, including:

  a) Specialized general assistance staffs such as Washington's incapacity specialists (Rhode Island, Utah, Washington);

  b) Specialized staffs for SSI referral (Oregon and Pennsylvania);

  c) Specialized consultants and trainers for regular eligibility staffs (Michigan and New York);

  d) Contingency fees for attorneys representing SSI applicants (Illinois, Oregon, and Washington), and;

  e) Contracts with legal services organizations representing SSI applicants (Maryland, Massachusetts, Montana, and New York).

Findings on General Assistance Caseloads :

- Caseloads per 1,000 residents were generally higher in states with income-based and categorical programs than in states with incapacity-based programs. Incapacity-based programs that treated alcohol and drug addiction as qualifying incapacities had higher caseloads than those that did not.

- Washington's caseload per 1,000 residents has been rising to levels observed in other states treating drug and alcohol addiction as qualifying incapacities.

- Washington's SSI-Disability caseload per 1,000 residents dropped by 15 percent between December 1978 and December 1982. This reduction, associated with federally-mandated Continuing Disability Reviews, was the third largest experienced by any state. Incapacity-based general assistance programs grew faster in states with large SSI-Disability cutbacks than in states with milder SSI reductions.

Findings on October 1986 SSI-Disability Caseloads :

- Almost 80 percent of the variation in state SSI-Disability caseloads per 1,000 residents was explained by differences in the size of state disabled populations and the size of SSI payments made to disabled recipients living at home.

- Washington State's SSI-Disability caseload per 1,000 residents was lower than the national average, ranking 29th out of the 50 states. However, Washington also had fewer residents with disabilities preventing work than the national average. Washington's SSI-Disability caseload was very close to that predicted from the size of its disabled population and SSI payment standard.

- Only two states -- Louisiana and Mississippi -- had SSI-Disability caseloads significantly higher than predicted. Neither state had a general assistance program.

- None of the states with special programs to move general assistance recipients to the SSI program had SSI-Disability caseloads that were significantly higher than predicted. Only New York, New Mexico, and possibly Illinois, had SSI-Disability caseloads even moderately higher than expected.

- The difference between Washington's GA-U payment standard and SSI-Disability payment was $30 to $50 per month, depending on location. The average difference nationwide was $188 per month for states whose general assistance payment standards were known. However, the difference between general assistance and SSI payment standards did not have a statistically measurable impact on SSI-Disability participation.

CHAPTER 1: INTRODUCTION

This report examines and compares state general assistance programs for incapacitated persons. The report describes general assistance programs in other states and identifies states with similar program designs and problems. Information on programs in other states helps place Washington's policies and problems in perspective.

Also, the report describes participation in the federally funded Supplemental Security Income (SSI) - Disability program in Washington and other states. Most states attempt to move disabled indigents into the SSI program whenever possible to reduce state costs and increase benefits to recipients. The report presents a model for predicting SSI-Disability participation that can be used to identify states that have high rates of SSI-Disability participation.

Washington State operates two general assistance programs, the General Assistance-Unemployable (GA-U) program and General Assistance for Pregnant Women. The GA-U program, provided for persons who are unemployable due to an incapacitating condition, is the focus for interstate comparisons in this report.

Data Sources

This report summarizes and relies heavily on Characteristics of General Assistance Programs, 1982, a report prepared by Urban Systems Research and Engineering, Incorporated, in 1983. 1/ Prepared at the request of the U.S. Department of Health and Human Services (DHHS), it is the most recent national survey of general assistance programs. When cited in this report, the 1983 characteristics study will be referred to as the 1983 Urban Systems report.

In order to update information in the 1983 study, queries about general assistance programs for the incapacitated were made by mail and telephone to the agency responsible for income assistance programs in each state. Replies were

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1/ Copies may be obtained from The National Technical Information Service, U.S. Department of Commerce, Springfield, Virginia. Report Number ASPE/E&TA 82-01, PB84-115336.

received from 49 states (98 percent). 2/

Each informant was given a set of standardized questions designed to identify general assistance eligibility requirements and program procedures for persons with physical or mental incapacities. Informants were also asked to supply information on current payment standards, caseloads, reasons for caseload trends, and programs to refer incapacitated recipients to treatment, vocational rehabilitation, and SSI.

Features of Washington's GA-U Program

Washington's GA-U program provides cash grants and medical services to adults between the ages of 18 and 65 who are unemployable due to a mental, emotional, or physical incapacity. In order to become a GA-U recipient, incapacitated people must qualify both financially and medically. Figure 1.1 shows the steps in the approval process. Financial eligibility is based on income and resource tests. Medical eligibility is determined using the Progressive Evaluation Process (PEP).

1. Eligibility Determination

Financial eligibility is determined by Financial Services Technicians (FSTs), who determine financial eligibility for all departmental income and medical assistance programs. Medical eligibility is determined by Incapacity Specialists, a separate set of staff who provide case management services to recipients of GA-U and incapacitated recipients of Aid to Families With Dependent Children (AFDC).

The Progressive Evaluation Process is a method for determining if an incapacity qualifies an applicant for GA-U. Current physician evaluations are obtained and used in a seven step process to determine the existence, severity, functional limitations, and duration of an incapacity.

Incapacity type and severity, recommended treatments, and the decision making process used to determine eligibility are documented in a set of forms retained in case records. Eligibility depends on whether an incapacity will prevent gainful employment for at least two months.

Age, education, and work history are considered in determining GA-U eligibility when the client's physical or emotional incapacity is not severe. Applicants aged 55 and

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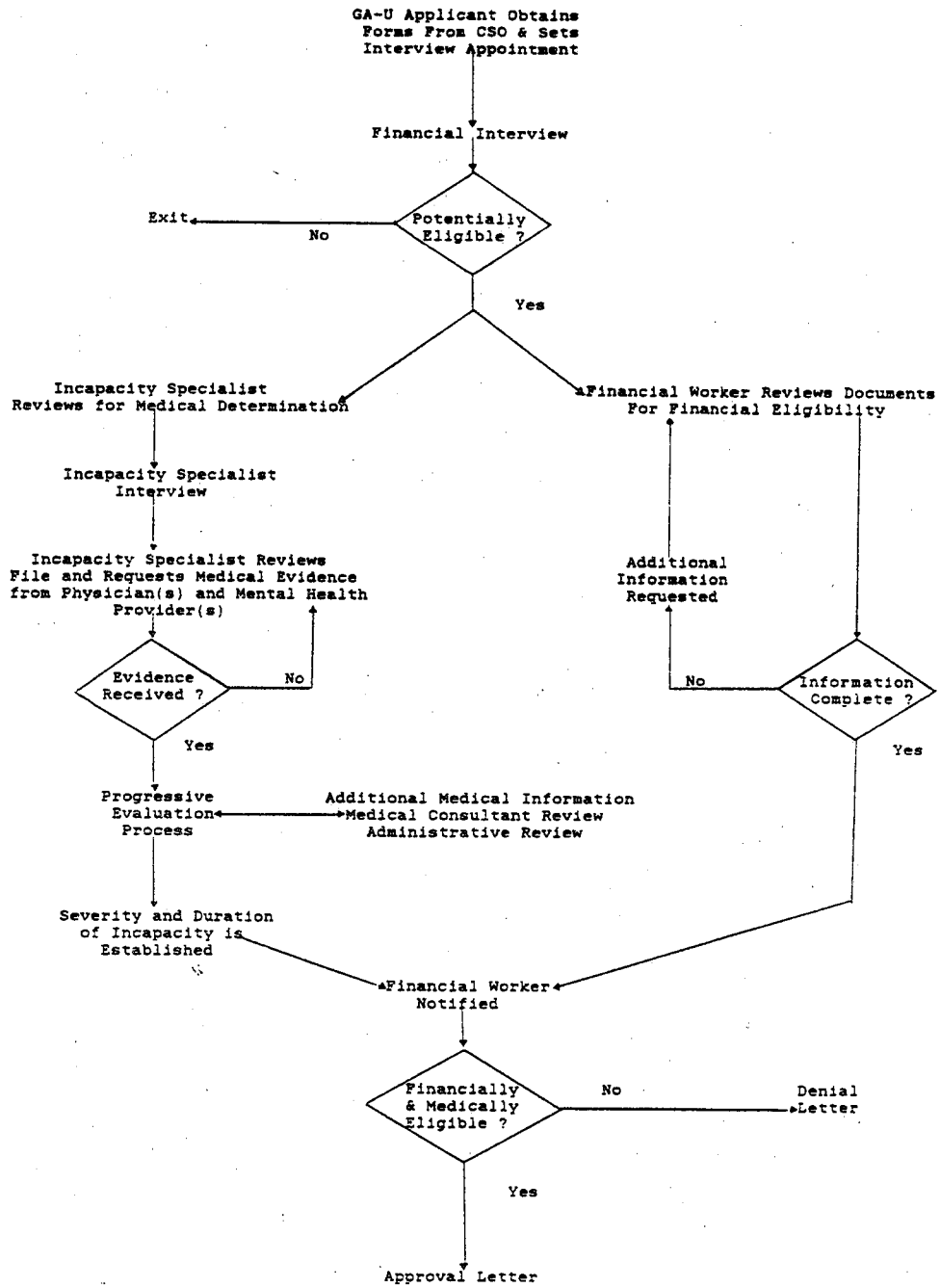
2/ Officials in Colorado did not respond to the request for information.

FIGURE 1.1

GA-U ELIGIBILITY DETERMINATION PROCESS



over are approved for GA-U if their incapacities prevent them from working in their past occupation. Younger applicants may also be approved based on lack of English abiliy, ack of a high school diploma, and lack of relevant work history, depending on the degree of limitation caused by their incapacity.

Medical eligibility may be approved for periods of up to one year, depending on the expected length of the incapacity. Financial eligibility is reviewed every six months or when change is reported in the client's financial status.

GA-U benefits are provided to patients released from mental hospitals for up to 60 days. Recipients must meet program financial criteria and be participating in outpatient treatment (if available). Recipients must go through the Progressive Evaluation Process to be certified eligible for benefits beyond 60 days.

2. GA-U Benefits

Most GA-U recipients get a check of $314 per month plus food stamps and medical assistance. The $314 payment is the amount provided by DSHS to single people who pay housing costs and have no other income. Those without housing costs (six percent of the caseload) receive $186 per month. The payment standard for GA-U is identical to that for the state's AFDC program.

A few GA-U recipients (four percent) live in treatment facilities called Congregate Care Facilities. Recipients in those facilities receive $36.62 per month for clothing and personal incidentals. The cost of care, room, and board is paid directly to the facility.

GA-U benefits are provided for a fixed length of time, as determined by the Progressive Evaluation Process. However, there is no limit to the number of times that eligibility can be redetermined. In practice, this means that recipients can remain eligible for GA-U benefits as long as they continue to meet financial and medical eligibility rules.

3. Referrals to Other Programs and Services

Once approved, recipients are referred for treatment and other programs by their Incapacity Specialists. Treatment includes participation in alcohol and drug rehabilitation programs, mental health services through community mental health centers, physical therapy, and medical services.

Programs to which referrals are made include SSI and Social Security Disability Insurance (SSDI). Recipients are also

referred to the Veterans Administration, the Division of Vocational Rehabilitation, and the Division of Developmental Disabilities.

a) Treatments for Incapacities

Recipients can be required to participate in treatment and other programs if treatment is expected to improve their condition. Continued receipt of GA-U grants is conditioned on cooperation with treatment reverrals. Participation in required treatments is monitored by Incapacity Specialists.

b) Referral to Supplemental Security Income

The Progressive Evaluation Process used to determine GA-U eligibility identifies recipients whose incapacities are likely to last one year or more. Applicants with such incapacities are required to apply for SSI if it appears that they meet SSI eligibility requirements. Clients may also be required to apply for SSI when eligibility is redetermined. Medical documentation collected during the Progressive Evaluation Process is supplied to SSI eligibility workers.

Incapacity Specialists determine whether a recipient will be required to submit an SSI application and monitor the progress of that application. They may assist in preparing the application, preparing appeals of denials, or providing transportation to hearings. Incapacity Specialists also obtain interim assistance reimbursement agreements under which the state is reimbursed for GA-U payments made to SSI applicants if thier SSI application is successful.

Washington provides attorneys' fees, on a contingency basis, to attorneys who assist with appeals of SSI denials. Fees of up to 25 percent of the GA-U benefits recovered from SSI can be paid. Referrals to attorneys are provided by Incapacity Specialists.

Some referrals take the form of telling recipients that they can seek legal help if their SSI application is denied. Incapacity Specialists in other Community Services Offices (CSOs) refer clients who have been denied to specific attorneys.

c) Work Requirements and Job Preparation

There are no "work requirements" imposed by Washington's GA-U program other than cooperation with Vocational Rehabilitation referrals.

d) Sanctions for Non-Compliance

Those who do not cooperate with a required treatment or referral without good cause may be terminated from the program. Recipients may reapply for benefits, but must cooperate with program referrals. In addition, those terminated due to non-cooperation are not eligible to return to the program immediately. The sanction for the first refusal is loss of one week's grant; second refusal: one month's grant; third and subsequent refusals: two month's grants.

CHAPTER 2 : GENERAL ASSISTANCE PROGRAMS IN OTHER STATES

The 1983 Urban Systems study noted that most state and local general assistance programs provide continuing or emergency income assistance as a "safety net" for low-income individuals who do not qualify for federally supported programs. Beyond this, programs vary widely. In the authors' words:

> ... general assistance programs have few common characteristics. Eligibility criteria vary from strict disability requirements (often pending SSI determinations) to broad income requirements with no categorical restrictions. Benefit levels vary from small one-time payments to regular payments virtually identical to AFDC or SSI. Forms of assistance vary from bus tickets or fire wood to vendor payments to vouchers to cash...Some are funded, controlled, and administered by states, some are state supervised and locally administered, and some are totally a local (county or municipal) function. Compounding all this variation is the fact that general assistance program characteristics -- particularly eligibility criteria and benefit levels -- are unusually sensitive to budget pressures. As a result, general assistance programs fluctuate and change much more frequently than any other part of the welfare system. 1/

This chapter describes general assistance programs along the following dimensions: eligibility criteria, residency requirements, benefit levels, payment methods, time limits on participation, medical benefits, type of administration, and methods of staffing. Referrals to treatment for incapacities, to SSI, to vocational rehabilitation, and to employment or work programs are also explored.

This chapter focuses on the 36 states in which general assistance (state or local) is available state-wide.

1/ Characteristics of General Assistance Programs,1982. Urban Systems Research and Engineering, Inc., Cambridge, Massachusetts, May 1983, pages 1-2.

Eligibility Criteria

For purposes of comparison with Washington's GA-U program, there are four basic types of general assistance program:

- Income-Based Programs. Low income is the sole or primary eligibility criterion in such programs. Other criteria can include participation in work or job search programs by "able bodied" recipients. Medical incapacity is usually a ground for exemption from work requirements.

- Categorical Programs. In order to receive assistance from such programs, financially eligible recipients must fall into one of several categories. Categories can include the incapacitated, ex-offenders, older people, people with limited work history, etc.

- Incapacity-Based Programs. These are defined as categorical programs in which over 90 percent of cases are eligible due to physical or emotional incapacities that prevent work. Washington's GA-U program falls into this category.

- Mixed Programs. Some states mandate that local governments provide general assistance programs but do not specify the eligibility rules to be used. Programs may be income-based, categorical, or incapacity-based from one jurisdiction to the next. Some states share the costs of such programs; others do not.

Twenty-seven of the 36 states had open-ended general assistance programs. They provided, or mandated that other jurisdictions provide, funds sufficient to pay benefits to all persons eligible for assistance.

Nine states had fund-limited programs. A fixed amount is appropriated for general assistance in each fiscal period. In some states, payments may be reduced to conserve funds if utilization is higher than expected. In others, there is no expectation that appropriated amounts will meet all needs, and applicants are turned away when funding is exhausted.

Table 2.1 categorizes state general assistance programs by type of eligibility requirements and whether they are open-ended or fund-limited.

TABLE 2.1

ELIGIBILITY CRITERIA AND FUNDING STATUS OF STATE GENERAL ASSISTANCE PROGRAMS

Eligibitity Criteria	Funding Status: Open-Ended	Funding Status: Fund-Limited
Income-Based Programs:	Connecticut, Maine Michigan, Montana a/ New York, New Jersey Ohio, Wisconsin b/	Arkansas, North Dakota, South Dakota Wyoming
Categorical Programs:	Arizona, Delaware Hawaii, Kansas c/ Massachusetts Minnesota c/ Pennsylvania	Alaska, Vermont
Incapacity-Based Programs:	Maryland, New Mexico Oregon, Rhode Island South Carolina, Utah Washington, West Virginia	Missouri
Mixed Programs:	California, Illinois New Hampshire Virginia	Indiana, Nebraska
States With No State-Wide Program:	Alabama, Colorado, Florida, Georgia, Idaho Iowa, Kentucky, Louisiana d/, Mississippi Nevada, North Carolina, Oklahoma d/, Tennessee Texas	

SOURCE: Characteristics of General Assistance Programs, 1982; Urban Systems Research and Engineering, Inc. and contacts with state officials between September 1986 and January 1987.

NOTES: a/ Montana took over administration of its county-run general assistance programs in its most populated counties in 1985. Montana attempted to establish a categorical program in 1986, but has been blocked from doing so in court.

b/ Wisconsin increased state funding and responsibility for its county administered program and imposed a state-wide payment standard in 1986.

c/ Kansas and Minnesota have changed their income-based programs to categorical programs since 1983.

d/ Louisiana and Oklahoma have abolished their fund-limited programs since 1983.

1. Incapacity-Based Programs

All nine states with incapacity-based programs -- Maryland, Missouri, New Mexico, Oregon, Rhode Island, South Carolina, Utah, Washington, and West Virginia -- used medical evidence to determine incapapacity. Cases could be approved for reasons other than verified incapacity in each state, but 90 percent or more of current caseloads were eligible due to incapacity.

a) Programs Similar to GA-U

Four states had programs for incapacitated individuals similar to Washington's GA-U program -- Maryland, Oregon, Rhode Island, and Utah. The remaining states -- Missouri, New Mexico, South Carolina, and West Virginia -- had programs that were much more limited.

With few exceptions, Washington's GA-U recipients must have physical, mental, or emotional incapacities that are expected to last 60 days or more. The four states most similar to Washington differed somewhat in duration requirements and qualifying incapacities.

Oregon's duration requirement for incapacities was the closest to Washington's. Oregon set a 60 day duration requirement for incapacities, but made slightly different exceptions to this rule. Utah set a 30 day limit and allowed district managers to approve persons with incapacities of shorter duration. Maryland and Rhode Island set no minimum duration for qualifying incapacities.

Maryland, Rhode Island, and Washington treated alcoholism and drug addiction as incapacities qualifying a person for assistance. Oregon served alcoholics and drug addicts only if their diseases caused irreversible physical or mental damage.

Utah provided caseworkers with considerable discretion in eligibility determination. Two categories of recipients were served: the "unemployable" (as determined from physician's statements), and the "marginally employable". Alcoholics can be enrolled as marginally employable recipients at the discretion of district managers, even if they are not unemployable for medical reasons. State officials reported that, in practice, alcoholics tend to be excluded from the program.

Age, education, and prior work experience were used to determine the degree to which physical or emotional limitations prevent work in each of the five states. The combinations in which such factors were considered varied from state to state.

In general, Maryland and Washington considered past work history and education in their eligibility determinations at younger ages (50 to 55 and below, depending on the severity of physical or emotional limitations) than Oregon and Utah (age 60).

Maryland and Washington also allowed less discretion in how social factors were considered in determining eligibility. The qualifying combinations of age, education, work experience, and physical or emotional limitations were specified in tables included in state welfare manuals.

Rhode Island and Utah provided more latitude to caseworkers in considering social factors in eligilibity determination. Borderline cases were usually reviewed or approved by supervisors.

b) Programs More Restrictive than GA-U

The remaining incapacity-based programs had fewer similarities to Washington's GA-U program due to restrictive eligiblity standards, limited benefits, or both. Three of the four states (Missouri, South Carolina, and West Virginia) paid cash benefits of less than $100 per month. Two states (New Mexico and South Carolina) provided no medical benefits to program participants. New Mexico and South Carolina also imposed time limits on participation.

c) Interim Assistance Programs for SSI Applicants

Two states, Alaska and Illinois, ran interim assistance programs for SSI applicants that functioned as incapacity-based programs for the disabled. These programs were separate from their state's general assistance programs and had different, more generous, payment standards.

The 1983 Urban Systems report did not describe separate interim assistance programs, probably because state officials did not consider them to be a form of general assistance. Our survey of state officials did not include questions about separate interim assistance programs.

While additional states could offer separate interim assistance programs, the number is probably small. References in the the 1983 Urban Systems report identified interim assistance to SSI applicants as a common use of most state general assistance programs.

2. Categorical Programs

Categorical programs had five basic types of eligibility categories: incapacity, age, employable adults, children or families not eligible for AFDC, and persons being released

from prisons or treatment institutions. Recipients were also required to meet income and resource requirements.

All categorical programs provided benefits to incapacitated adults. Some states also provided assistance to family members providing care for incapacitated adults. However, incapacitated adults accounted for less than 90 percent of categorical program caseloads, by definition.

Minimum age requirements set by states in which age was one of the eligibility factors ranged from 40 in Vermont to 55 in Hawaii and Kansas. 2/ Arizona, Kansas, Minnesota, and Pennsylvania provided temporary assistance for employable individuals. Categories related to the AFDC program included families or children not eligible for AFDC, high school students completing their education, and displaced homemakers.

Categories related to institutionalization included residents in alcohol and drug abuse treatment facilities, persons recently released from such facilities, residents in psychatric half-way houses, persons recently released from mental institutions, and ex-convicts.

Miscellaneous categories used by some states included participants in vocational rehabilitation programs, persons unable to communicate in English, persons who had exhausted Unemployment Compensation benefits, and persons in rural areas who lack transportation.

Residency Requirements

Most states required general assistance recipients to be state residents at the time of application and required that applicants intend to continue residing in the state. Some states also provided temporary assistance to non-resident transients, such as bus tickets, to help non-residents move on.

Until recently, no state required a minimum length of residency as a condition of eligibility. The United States Supreme Court ruled, in 1969, that such durational residency requirements are not legal.

The state of Wisconsin established a 60 day residency requirement in 1986, using language intended to meet

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2/ Age limits set in other states included 45 (Pennsylvania and Massachusetts) and 54 (Delaware). Age was considered in combination with other factors in Vermont. Arizona and Minnesota consider aged in determining eligibility, but did not set formal age limits.

constitutional challenges. The limit was necessary to obtain passage of legislation raising payment standards above levels available in Illinois. However, state officials did not expect the limit to survive court challenge.

Benefits Levels

Washington's GA-U payment standard of $314 per month was one of the highest in the United States. Only Suffolk County, in New York, paid a higher amount. Payment standards for individuals with no income who pay shelter costs are shown in Figure 2.1.

In 1982, Washington was one of 10 states that paid single general assistance recipients the same amount as a one-person AFDC case would receive. Table 2.2 lists states with general assistance payment standards lower than, equal to, or higher than AFDC payment standards.

West Virginia is unique in that it provides only medical assistance. The cash grant portion of its general assistance program has not been funded since 1980.

Payment Methods

States varied widely in payment method. Twenty-two of the 36 states with statewide programs paid benefits in cash. Four states provided benefits only through vendor payments or vouchers and two states provided cash, vendor payments, and/or vouchers. Payment methods varied by county or municipality in seven states. West Virginia, as noted earlier, provided no income assistance payments in any form. Table 2.3 lists states using each arrangement.

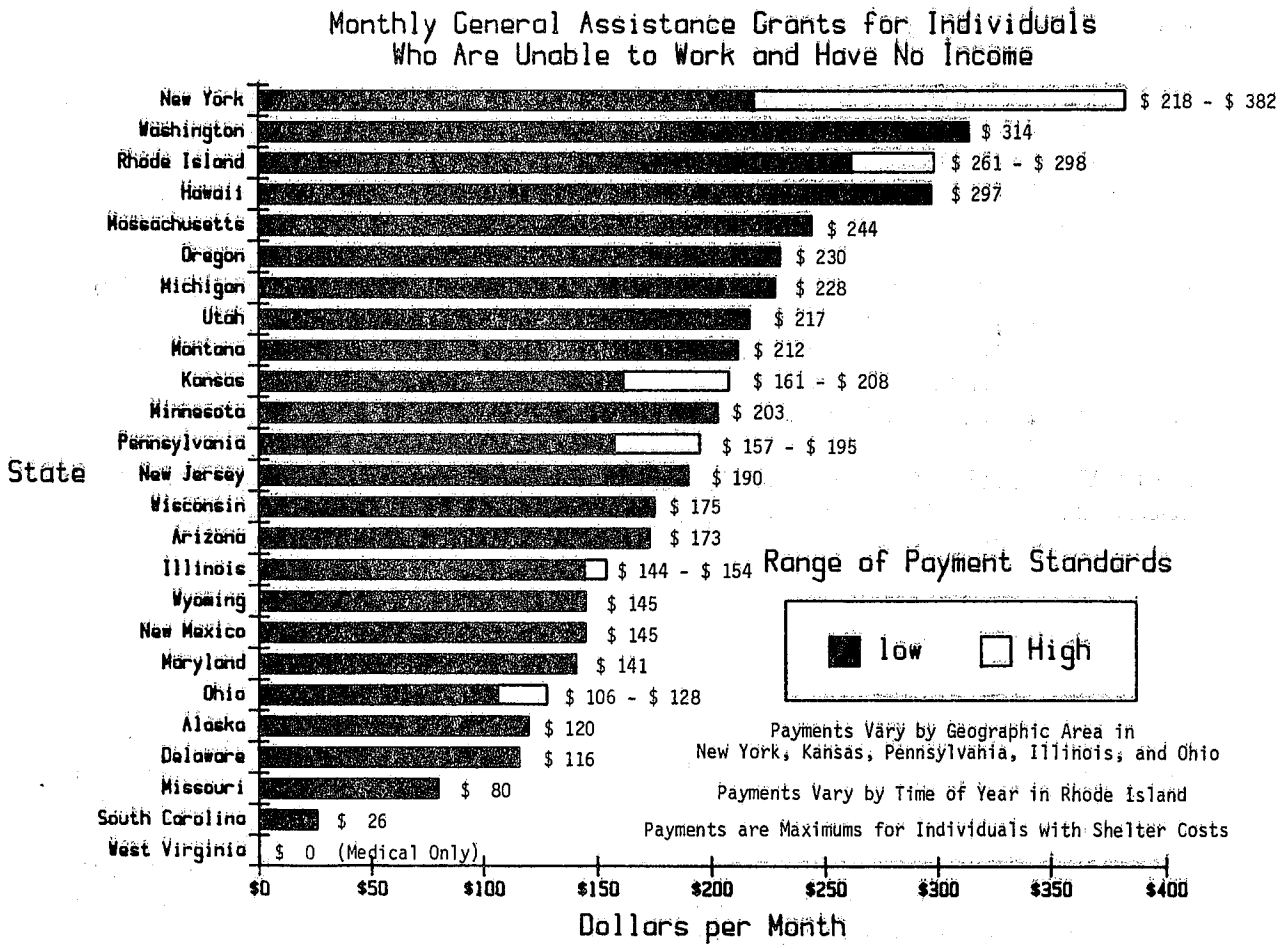
According to the 1983 Urban Systems study, seven of the states making cash payments provided vendor payments for recipients who could not manage their financial affairs. Washington was included in this category.

Washington generally uses protective payee arrangement rather than vendor payments when recipients cannot manage their affairs. Vendor payments are provided only at the request of the payee. In July 1986, less than one percent of Washington's GA-U recipients recieved benefits through a protective payee.

Time Limits on Participation

Most states with incapacity-based programs allowed recipients to receive assistance as long as they were medically and financially eligible. South Carolina and New Mexico were

FIGURE 2.1



SOURCE: Contacts with state officials between December 1986 and January 1987.

TABLE 2.2

RELATIONSHIP BETWEEN STATE AFDC PAYMENTS AND GENERAL ASSISTANCE PAYMENTS FOR INDIVIDUALS WHO ARE UNABLE TO WORK

Relationship	State
General Assistance Higher than AFDC:	New Hampshire, New Jersey a/, New Mexico
General Assistance Equal to AFDC:	Arizona, Hawaii, Illinois, Indiana, New York, Ohio Rhode Island, Utah, Washington, Wyoming
General Assistance Lower than AFDC:	Alaska, Arkansas, California, Connecticut, Delaware Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Oregon, Pennsylvania, South Carolina, West Virginia, Wisconsin Vermont, Virginia
Unknown/Varies:	Maine, North Dakota, South Dakota

SOURCE: See Table 2.1. All comparisons, except for Michigan, are taken from the 1983 Urban Systems report and are for 1982.

NOTES: a/ Only for individuals who are unable to work. The payment standard for individuals who are able to work was lower than the AFDC payment standard.

TABLE 2.3

PAYMENT METHODS USED IN STATE GENERAL ASSISTANCE PROGRAMS

Payment Method	State
Direct Cash: a/	Arizona, Delaware, Hawaii, Kansas, Maryland Massachusetts, Missouri, Montana, New Mexico New Jersey, Ohio, Pennsylvania, Rhode Island South Carolina, Wyoming
Cash, with Vendor Payments for those unable to handle funds: b/	Michigan, Minnesota, New York, Oregon, Utah Washington, Wisconsin
Vendor Payments and Vouchers:	Arkansas, Maine, North Dakota, South Dakota
Cash, Vendor Payments, and Vouchers:	Alaska, Vermont
Method Varies by County or Municipality:	California, Connecticut, Illinois, Indiana Nebraska, New Hampshire, Virginia
Medical Benefits Only:	West Virginia

SOURCE: See Table 2.1. Most data were taken from the 1983 Urban Systems report and are for 1982. Methods are known to have changed since 1982 in Montana and Wisconsin.

NOTES: a/ Some states in this category probably use protective payee arrangements for recipients deemed unable to manage their funds, but did not report this to Urban Systems researchers.

b/ The Urban Systems report states that Washington provides vendor payments for those who are unable to manage their funds. Washington actually uses protective payee arrangements. When the department assumes the role of protective payee it provides vendor payments on behalf of recipients. This may be the case for other states in this category as well.

the only states that placed time limits on assistance to incapacitated individuals.

South Carolina limited general assistance eligibility to one six-month episode per person. New Mexico limited benefits to 11 out of any 12 months for disabilities regarded as temporary.

States with categorical programs often set time limits on participation within some categories. Pennsylvania provided assistance to those participating in alcohol treatment programs for up to 9 months. Kansas provided benefits to patients released from psychiatric hospitals to three months. Recipients could reapply under regular general assistance guidelines to continue beyond those time limits.

Four states with categorical programs -- Arizona, Kansas, Minnesota, and Pennsylvania -- offered time-limited programs for "employable" adults and continuing programs for incapacitated adults. Such time-limited programs are similar to the General Assistance-Noncontinuing Program offered by Washington State until 1981. Montana enacted a similar program in 1986, but implementation has been blocked in court by challenges based on that state's constitution.

Pennsylvania's program, called the Transitionally Needy program provided benefits for 90 days in any year. Alcoholics could enter this program if they were not old enough or incapacitated enough to continue in the state's Categorically Needy program after the nine months of alcohol treatment eligibility were exhausted.

Arkansas and Wyoming limited eligibility to four months per year in their fund-limited, income-based programs.

Washington's GA-U program, although primarily incapacity-based, places time limits on participation for some types of recipients. Washington provides benefits to persons participating in residential (in-patient) alcohol or drug abuse treatment for periods ranging from 30 to 180 days, depending on the type of program, and for 60 days to persons being released from inpatient psychiatric treatment. Recipients must reapply under regular general assistance guidelines in order to continue receiving assistance.

Medical Benefits

Medical coverage for general assistance recipients varied widely. Twenty-one states, including Washington, provided medical benefits directly through their general assistance programs. Nine more states had separate state-funded medical assistance programs for which general assistance recipients were categorically eligible. Two states had

separate medical programs for indigents with eligibility criteria similar, but not identical, to general assistance criteria. Four states, including two with incapacity-based programs, provided no medical benefits at all.

Nineteen states, including Washington, provided medical assistance benefits to general assistance recipients that are less comprehensive than those available under their federally-funded Medicaid programs. Ten states provided similar coverage, and three states provided more comprehensive coverage than available under Medicaid. Table 2.4 lists states by type of medical program and comprehensiveness of coverage.

Type of Administration

Sixteen of the 36 states with state-wide general assistance programs administered their programs directly. Another 11 supervised programs that were administered by county or municipal governments according to state guidelines. Six states mandated programs but did not supply guidelines on program rules. The remaining states administered their programs directly in some parts of the state and allowed counties or municipalities the option of administering their own programs. Table 2.5 lists states by level of government administering the program.

General Assistance Program Staffing

In most states, general assistance eligibility was determined by the same income maintenance staff who determined eligibility for all other assistance programs. Only five states -- Illinois, New Mexico, Rhode Island, Utah, and Washington -- employed staff who were specialists in general assistance eligibility determination or case management.

In Rhode Island, General Public Assistance Workers performed the same functions as Washington's Incapacity Specialists, but also determined financial eligibility. Caseloads were limited to 75 per worker under the provisions of union contracts.

Utah is currently conducting a pilot project to provide case management to general assistance recipients in the Salt Lake City area. Specialists provided case management and advocacy services only. Financial and medical eligibility were still determined by income maintenance workers.

Illinois used general assistance specialists to conduct redeterminations in Chicago, where it administers general assistance directly.

TABLE 2.4

MEDICAL BENEFITS PROVIDED WITH STATE GENERAL ASSISTANCE PROGRAMS

Type of Program	Scope of Coverage		
	Less Than Medicaid	Similar To Medicaid	Greater Than Medicaid
Part of General Assistance Program:	Arkansas, Illinois Maine, Massachusetts Michigan, Missouri Nebraska, New Hampshire, North Dakota Ohio, South Dakota Vermont, Virginia Washington, Wisconsin	Connecticut Kansas, New Jersey, Oregon West Virginia	Alaska
Separate Program; General Assistance Categorically Eligible:	California, Minnesota Montana	Hawaii, Maryland New York, Pennsylvania	Rhode Island Wyoming
Separate Program; Separate Eligibility Criteria:	Utah	Arizona	
No Program:	Delaware, Indiana New Mexico, South Carolina		

SOURCE: See Table 2.1. All data are for 1982 from the 1983 Urban Systems report.

TABLE 2.5

LEVEL OF GOVERNMENT ADMINISTERING GENERAL ASSISTANCE PROGRAMS

Level of Government	State
State Administered:	Alaska, Arizona, Delaware, Hawaii, Kansas Massachusetts, Michigan, Missouri, New Mexico Oregon, Pennslyvania, Utah, Vermont Washington, West Virginia, Wyoming
State Supervised, County Administered:	Arkansas, Maryland, Minnesota, New York, Ohio South Carolina, Virginia a/, Wisconsin
State Supervised, Municipally Administered:	Connecticut, New Jersey, Rhode Island Virginia a/
County Administered:	California, Nebraska, New Hampshire b/ North Dakota, South Dakota
Municipally Administered:	Indiana, New Hampshire b/
Mixed Administration: c/	Illinois, Maine, Montana

SOURCE: See Table 2.1. The administration of programs in Montana and Wisconsin have changed since the 1983 Urban Systems report was written.

NOTES: a/ Virginia's general assistance program is county administered in some areas and municipally administered in others. All programs are under state supervision.

b/ New Hampshire's general assistance program is county administered in some areas and municipally administered in others.

c/ General assistance is administered directly by the state in some areas and by counties (Illinois and Montana) and municipalities (Maine) in others. The state administers general assistance in the most urban areas of Illinois and Montana and in the most rural areas of Maine.

New Mexico employed one examiner in its state headquarters to make all medical eligibility determinations.

States that did not employ specialized general assistance staffs sometimes provided medical consultants to assist income maintenance workers in making incapacity determinations.

Referrals to Other Programs and Services

1. Referrals to Treatment

Most states did not require general assistance recipients with substance abuse or mental health problems to participate in treatment as a condition of receiving benefits. Hawaii, New York, New Mexico, Oregon, Rhode Island, and Washington required treatment for alcoholics, drug addicts, and/or the mentally ill. New York provided shelter, but no cash, to alcoholics who were not participating in treatment.

2. Referrals to SSI

Virtually all states took steps to identify general assistance applicants or recipients who might be eligible for SSI, required recipients to apply for SSI, provided assistance payments while SSI applications were pending, and attempted to recover the costs of those benefits after SSI approval. Methods of facilitating SSI approval varied widely.

a) Use of Specialized General Assistance Staff

States that employed specialized staff to serve general assistance recipients, including Rhode Island, Utah, and Washington used those workers to make and monitor SSI referrals. Case workers were responsible for assisting with SSI applications, providing transportation, tracking outcomes, assisting with appeals, and making referrals to legal assistance if necessary. Workers were expected to stay in close contact with SSI eligibility determination staff to make sure that clients kept appointments and provided complete medical information.

Rhode Island provided case workers with computerized methods of tracking SSI applications and approvals. Washington is currently testing an automated clerical support system with similar capabilities in several King County CSOs. Computerized crossmatching of files GA-U authorization files with files indicating SSI application status is also being implemented.

Vocational rehabilitation counselors also played a case management role for general assistance recipients in some states.

b) Use of SSI Specialists

Some states -- such as Oregon and Pennsylvania -- hired SSI specialists whose sole job was to assist general assistance recipients with SSI applications, medical documentation, and appeals. The scale of such activities varied widely. Pennsylvania employed 100 such specialists, with average caseloads of 328. Oregon employed three to four specialists, with caseloads of 400 to 425. These states did not use specialized staff to examine medical eligibility or provide social services within their general assistance programs, and therefore needed specialized staff to assist with SSI applications.

Oregon's staff were assigned to regional offices and handled referrals from local office eligibility staff. They used a consulting nurse to assist in determining which clients, of those referred, should be required to sumbit SSI applications and which SSI denials should be appealed.

Pennsylvania's staff was located in local welfare offices. They were assisted by Medical Review Teams, teams of doctors who assist in determining who should be referred to SSI and review SSI denials. Medical Review Teams submitted their own medical evidence when appealing SSI denials. The SSI approval rate for general assistance recipients referred under this system was 63 percent.

Both systems were believed to save money. Oregon has evaluated its system based on whether interim assistance recovered from SSI was sufficient to cover the costs of added staff. The results of this analysis were not available.

Pennsylvania justified its system as a way to reduce general assistance caseloads rather than through increased SSI recoveries. Pennsylvania staff estimated that their system saved the state $9,300,000 per year based on an average of 3,600 SSI approvals. This figure was based on the assumption that general assistance cases would have remained on public assistance for an average of one year in the absence of the program. 3/

c) Use of SSI Trainers

Most states, including Washington, trained eligibility workers in SSI referral techniques and specific referral

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3/ Annualized figures were calculated from findings for the first 20 months of the project.

procedures. Use of generic income maintenance workers to handle general assistance eligibility requires greater efforts in this area. Michigan and New York, for example, have established special staffs of trainers to assist county eligibility staff in determining which general assistance recipients should be referred to SSI and in how to prepare documentation for SSI eligibility determinations. New York has used former SSI eligibility examiners to perform this task.

d) Contingency Fees for Attorneys Representing General Assistance Recipients Appealing SSI Denials

Three states -- Illinois, Oregon, and Washington -- paid attorneys a contingency fee for representing SSI applicants on appeal. The fee may be up to 25 percent of the general assistance payments recovered from SSI by the state. Any attorney, public or private may participate. In fiscal year 1986, Washington attorneys received $ 314,000 under this arrangement, or just under four percent of all recoveries of general assistance benefits. Attorneys were reimbursed in cases involving just under 15 percent of all financial recoveries.

e) Contracts with Legal Services Organizations

Other states, such as Massachusetts, Maryland, Montana, and New York contracted directly with local legal services organizations to represent general assistance clients on SSI appeals and assist clients with SSI applications when clients would have difficulty preparing applications on their own. Potential clients were screened and referred by public assistance offices. Legal services staff then tracked applications and represented clients on appeal.

Massachusetts had the most experience with legal services contracts. Its program has been in operation since 1983, and was established by statute in 1985. The program was managed by the Massachusetts Legal Assistance Corporation. Assistance was provided by trained paralegals supervised by attorneys in 14 legal offices state-wide. Project attorneys, or private attorneys paid by project funds, represented SSI appellants in federal court. The project served all SSI applicants, regardless of whether they received general assistance. 4/

4/ Information on the Massachusetts contract was obtained from Cost/Benefit Analysis of the Disability Benefits Project; Developmental Disabilities Law Center; Boston, Massachusetts, March 1986. Additional information was obtained from the scope of work for the project's 1986 contract.

The Massachusetts program was successful in 85 percent of the 541 decisions reached for its clients in 1985. Forty-five percent of the project's successful appeals involved general assistance recipients. The remainder were AFDC recipients (10 percent) and non-assistance recipients (45 percent).

The project claimed that its 1985 performance produced $ 2,667,000 in savings over three years at a cost of $ 929,000, yielding net savings of $1,738,000. Net financial recoveries of general assistance payments from SSI through interim assistance agreements amounted to $ 318,000, or just over one-third of the project's cost.

The balance of the projected savings were based on presumed reductions in general assistance caseloads. Legal services analysts assumed that 92 percent of those represented would have received general assistance for three years in the absence of the project. While caseload reductions are likely, there is no way of knowing how many SSI applicants assisted by the legal assistance project would have been approved without its help.

In 1986, Massachusetts paid the legal assistance program $1,191 per SSI applicant referred for services and selected the persons to be referred. Massachusett's contract also included a maintenance of effort clause designed to ensure that local legal services offices received no money until they represented more general assistance recipients than would have been served without the project.

Maryland is contracting with local legal services organizations to provide services to 100 general assistance recipients on a pilot basis. Proposed budgets called for spending approximately $ 1,160 per referral to legal services.

3. Referrals to Vocational Rehabilitation

Most states, including Washington, refer general assistance recipients with temporary incapacities to their Divisions of Vocational Rehabilitation for assistance. Referrals are required of all incapacitated general assistance recipients in Hawaii, Kansas, Ohio, and Utah.

The proportion of referrals accepted by vocational rehabilitation staff was not known in any state, but estimates ranged from less than 10 percent in New Mexico to 30 percent in Utah. Washington's Division of Vocational Rehabilitation serves approximately seven percent of GA-U recipients. The percent of recipients referred and accepted by vocational rehabilitation may vary from state to state with the characteristics of local general assistance recipients.

In some states, vocational rehabilitation staff take on some of the case-management role assumed by incapacity specialists in Washington State. In Massachusetts, Kansas, and Rhode Island, vocational rehabilitation staff refer general assistance recipients who cannot be rehabilitated to the SSI program, providing vocational work-ups to SSI eligibility examiners. These work-ups are designed to demonstrate that the incapacities of the recipients have prevented, and prevent return to, employment.

4. Work Requirements and Job Preparation

Twenty-three of the 36 states offering general assistance imposed work, job search, or training requirements (other than vocational rehabilitation) in some or all jurisdictions. Rhode Island and Utah were the only states with incapacity-based programs to offer such services, and Rhode Island's program was offered primarily for the 10 percent of its caseload deemed employable.

Utah distinguished between "unemployable" and "marginally employable" recipients, and required some marginally employable recipients to participate in Utah's Work Relief program, working 96 hours per month. Those who did not cooperate were rarely sanctioned because of their marginal employability.

The remaining 21 states mandated participation in work, job search, or training for employable recipients. Employability was generally determined by physician's statements, so incapacitated recipients were usually excluded from participation. However, voluntary participation may be possible in some states.

The 12 states without work programs were Alaska, Arizona, Arkansas, Delaware, Maryland, Missouri, New Mexico, Oregon, South Carolina, Vermont, Washington, West Virginia, and Wyoming. These states tended to have incapacity based programs (seven states) and/or benefits so low that recipients could work them off in less than 40 hours per month at the minimum wage (six states).

CHAPTER 3 : CASELOAD GROWTH IN GENERAL ASSISTANCE PROGRAMS

Washington's GA-U caseloads have doubled since 1980, and grew by 22 percent between January 1986 and January 1987. This chapter compares caseload growth in Washington's GA-U program with caseload growth in other state general assistance programs.

Interactions between the SSI-Disability program and general assistance programs are also examined. SSI-Disability program cutbacks in the early 1980s may have contributed to general assistance program growth, and caseload trends in the two programs need to be considered jointly.

Findings:

- General assistance caseloads per 1,000 residents were lower in states with incapacity-based programs than in states with income-based or categorical programs.

- Washington's GA-U caseloads per 1,000 residents have risen from levels experienced by states with incapacity-based programs that exclude alcoholics and drug addicts toward levels experienced by states that provide benefits to those groups.

- Washington experienced the third largest SSI-Disability caseload decline of any state between 1978 and 1982. Caseloads have grown quickly since 1982, recovering all of the lost ground. However, Washington's SSI-Disability caseload growth between 1978 and 1986 remained the sixth lowest of any state.

- Caseload growth among incapacity-based programs similar to GA-U was highest in states that experienced large SSI-Disability cutbacks. States with low cutbacks actually experienced general assistance caseload declines.

- Other factors linked to caseload decline included use of quality control procedures and maintenance of low payment standards.

Methods

General assistance and SSI-Disability caseloads are expressed per 1,000 residents throughout this chapter. All changes

in caseloads are measured as changes per 1,000 residents. This allows direct comparison of caseloads and caseload trends between states with different populations.

Published sources of caseload and population data are listed in Appendix A. Current general assistance caseloads were collected by telephone from state officials. Caseload data were requested for November 1986. In some cases November 1986 data were not available, and caseload figures from other months were supplied. 1/

State population figures used to calculate caseloads per 1,000 are for July of the year indicated. State population figures for 1986 were not available in time for use in this analysis, and were estimated by increasing 1985 populations by the population increases experienced between 1984 and 1985.

SSI-Disability Program Caseloads

According to 1980 Census figures, 4.4 percent (44 per 1,000) of the working age United States population had disabilities that prevented them from working. In October 1986, 11.2 United States residents per 1,000 participated in the SSI-Disability program.

Unless the incidence of disabilities has changed since 1980, roughly one in four working age Americans with disabilities severe enough to prevent work participated in SSI. The remainder were supported by other means, which could include income from family members, payments by other insurance programs, and state general assistance programs.

SSI-Disability program cutbacks increased the number of individuals eligible for state general assistance programs in the early 1980s. Nationally, SSI-Disability caseloads dropped from 9.9 per 1,000 residents in December 1978 to 9.7 per 1,000 in December 1982, before increasing to 11.2 per 1,000 residents in October 1986.

1/ Caseloads supplied by Ohio, Maryland, New Jersey, and Montana were for September 1986. Caseloads supplied by Oregon and Delaware were for October 1986. Caseloads supplied by Hawaii were for December 1986. Caseloads supplied by New York were for December 1985 and July 1986. Data for December 1985 were expected to reflect winter caseloads more closely than July 1986 caseloads and were used in these analyses. Caseloads for West Virginia and Maine were averages of caseloads between October and December. Month to month caseload figures varied widely in those states due to reporting methods.

In percentage terms, national SSI-Disability caseloads per 1,000 residents dropped by 2.7 percent between December 1978 and 1982, but increased by 15.4 percent between December 1982 and October 1986. Between December 1978 and October 1986, national SSI-Disability caseloads per 1,000 residents increased by 12.3 percent.

The SSI cutbacks in the early 1980s resulted from a program of Continuing Disability Reviews. These reviews were controversial, and were halted by 1982. Federal legislation has required use of a medical improvement standard in disability redeterminations since that time. The medical improvement standard is similar to Washington's termination proviso, which was modeled after it.

General Assistance Caseload Trends

Since 1980, general assistance caseloads have grown faster than state populations in 18 of the 36 states with statewide programs. Caseloads have declined in nine states and were not available for the remaining nine.

Caseload trends per 1,000 residents varied by type of general assistance program. Figure 3.1 displays average general assistance caseloads in November 1980, 1982, and 1984, and in the most current month available, as supplied by state officials. Separate averages are calculated by type of program. Data are for the 22 state with open-ended programs. Appendix Figures A.1 to A.3 provide caseloads for individual states, by category.

1. Income-Based Programs

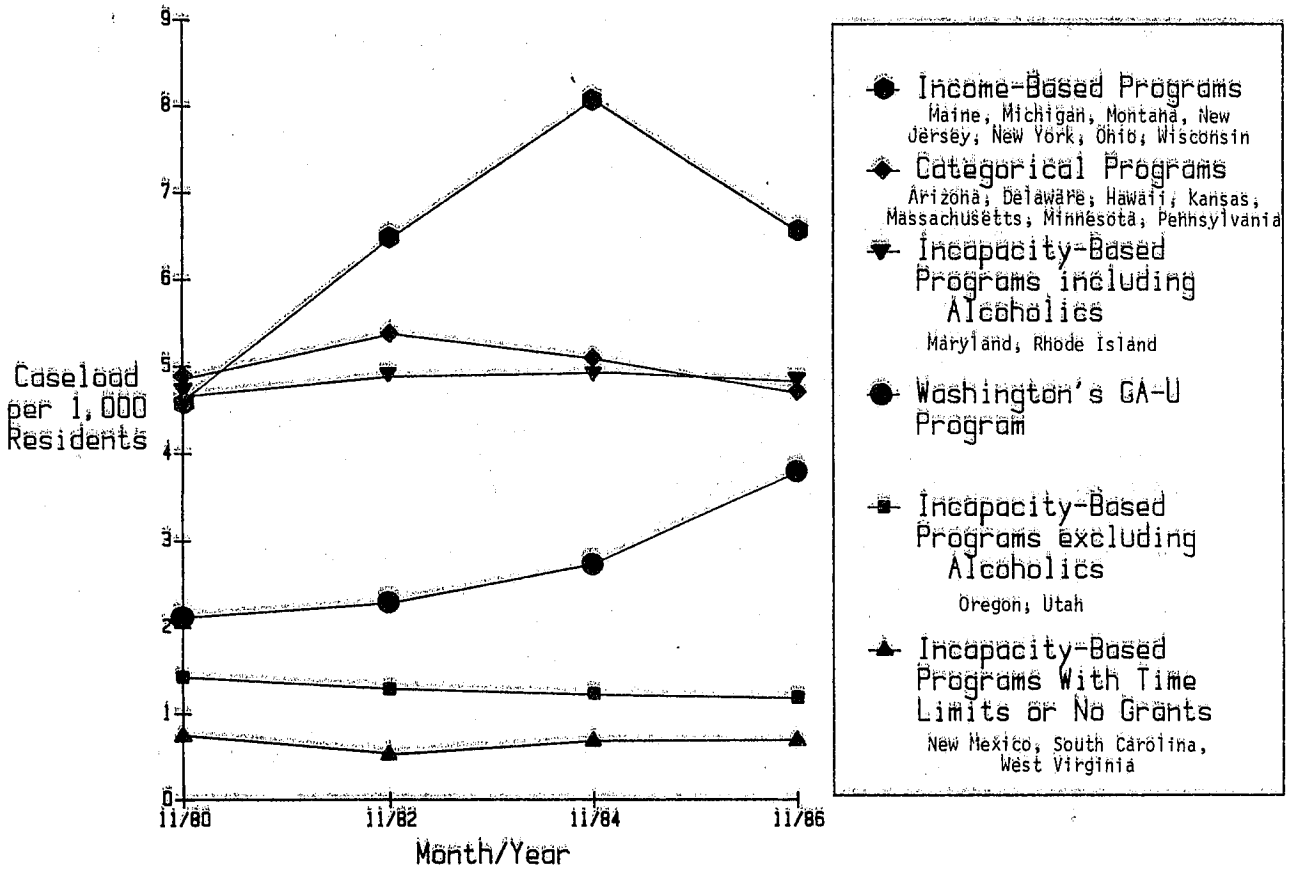
Income-based programs had the highest caseloads. Income-based caseloads were also the most volatile, increasing between 1980 and 1984 and declining subsequently. The average caseload in states with income-based programs was 6.7 recipients per 1,000 residents in the most recent month available.

2. Categorical Programs

The average caseload for states with categorical programs remained almost constant between 1980 and 1986. However, individual states experienced substantial caseload shifts. Pennsylvania, Kansas, and Delaware reduced the number of categories under which residents could obtain assistance during the period. Minnesota expanded the number of categories in its program. The average categorical caseload reported by state officials was 4.9 recipients per 1,000 residents.

FIGURE 3.1

Washington's GA-U Caseload Compared With General Assistance Caseloads in Other States



SOURCE: U.S. Department of Health and Human Services, Public Assistance Statistics and Quarterly Public Assistance Statistics; U.S. Census Bureau, Current Population Reports, Series P-25.

November 1986 caseloads were obtained through contacts with state officials between December 1986 and January 1987. Data for some states are for other months. See footnote 1/ on page 28 for details.

NOTES: Caseloads shown in the figure are the average caseloads for the states indicated. Caseload trends for individual states are shown in Appendix Figures A.1 to A.3, by category. States with fund-limited programs are excluded from this table.

State populations for 1986 were estimated based on population increases between July 1984 and July 1985.

3. Incapacity-Based Programs

Incapacity-based programs are divided into four groups on Figure 3.1. These groups are: programs treating substance abuse as a qualifying incapacity; Washington State (which has been enrolling increasing numbers of substance abuse cases); programs excluding substance abuse as a qualifying incapacity; and states with limited programs or benefits.

The average caseload for states serving persons with substance abuse incapacities was 4.9 recipients per 1,000 residents in 1986, up only slightly from the 4.8 per 1,000 in November 1980 and quite similar to the average caseload for categorical programs. The average caseloads in states that did not serve residents with substance abuse problems and states with limited programs and benefits also remained stable.

Washington's GA-U caseload has increased toward levels experienced by other states serving alcoholics and drug addicts -- from 2.1 per 1,000 in November 1980 to 3.8 per 1,000 in November 1986. Such increases would be expected, given the increase in alcohol and drug abuse caseloads described in companion GA-U Characteristics reports.

4. Mixed Programs

Caseload trends in states with mixed programs are much more difficult to describe. While state agencies sometimes collect county or municipal caseload data, it is not clear whether jurisdictions count cases consistently or if all jurisdictions have reported.

Current caseloads reported for mixed programs varied widely, from 2.8 per 1,000 residents in California to 9.8 per 1,000 in Illinois.

Factors Leading to General Assistance Caseload Growth

The five states with the largest caseload growth per 1,000 residents since November 1980 were Wisconsin (179 percent increase), Ohio (160 percent increase), California (157 percent increase), Montana (157 percent increase), and Minnesota (88 percent increase).

Three of the top five states (Minnesota, Montana, and Wisconsin) expanded their general assistance programs between 1980 and 1986. The reasons for caseload growth in California and Ohio are unknown. SSI-Disability caseload reductions could have been a factor in California -- one of only two states in which SSI-Disability caseloads per 1,000 residents were lower in 1986 than in 1978.

Factors Leading to General Assistance Caseload Decline

The five states with greatest caseload declines per 1,000 residents (excluding Louisiana and Oklahoma, which abolished their programs entirely) were South Carolina (98 percent reduction), Delaware (42 percent reduction), Missouri (30 percent reduction), New Jersey (29 percent reduction) and Hawaii (23 percent reduction).

Causes of caseload decline cited by state officials included low benefits (Delaware, Missouri, and South Carolina), reduction in the number of categories served (Delaware), and failure to increase payment standards over time (Hawaii). Although Hawaii's general assistance payment was relatively high -- at $ 297 per month -- it had not been increased since 1978.

Caseload Trends in Washington State

Washington's GA-U caseload per 1,000 residents increased by 78 percent between November 1980 and November 1986, the sixth highest overall growth rate. Several factors may have contributed to this growth.

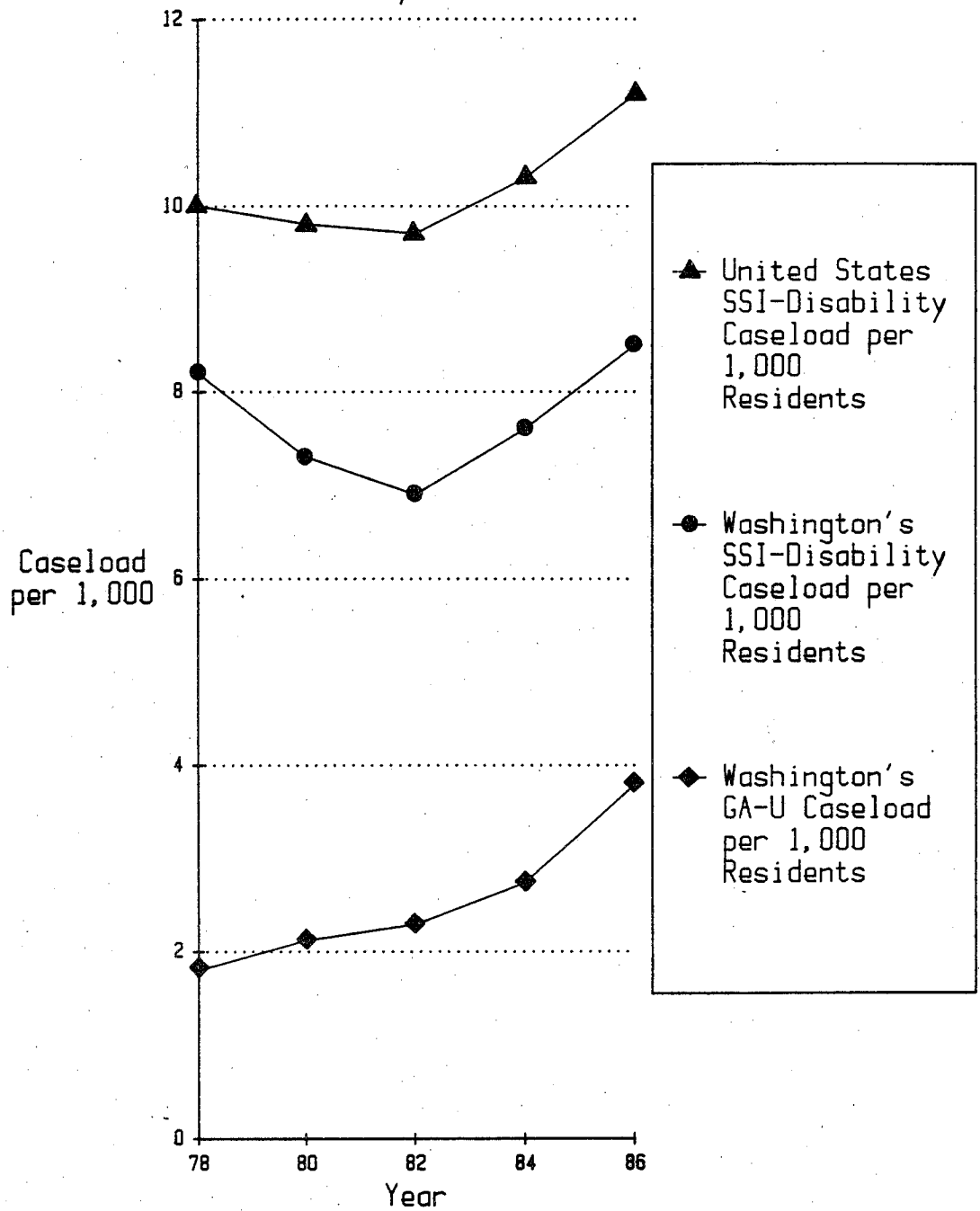
The adoption of the Progressive Evaluation Process and termination proviso may have had some impact on caseload growth by changing the way in which substance abuse cases are handled. Companion GA-U Characteristics studies document increases in the number of substance abuse cases and length of assistance use for substance abuse cases since 1982.

In addition, SSI-Disability cutbacks probably contributed to some GA-U caseload growth. SSI-Disability caseloads per 1,000 residents dropped by 15 percent in Washington between 1978 and 1982 -- the third largest decline experienced by any state. Recovery of SSI-Disability caseloads since 1982 has also been rapid. However, Washington's SSI-Disablity caseload in October 1986 was less than four percent higher than its December 1978 caseload -- the sixth lowest increase of any state. Figure 3.2 compares national SSI-Disability caseloads per 1,000 residents with Washington's GA-U and SSI-Disability caseloads.

Figure 3.2 shows Washington's SSI-Disability caseload to be lower than the national average. As will be seen in Chapter 4, this occurred largely because Washington has fewer disabled residents than the national average -- 3.7 percent of Washington residents reported disabilities preventing work versus a national average of 4.4 percent. If SSI-Disability caseloads had an impact on GA-U caseloads, it was the change in SSI caseloads rather than their absolute levels that had the effect.

FIGURE 3.2

Washington's GA-U and SSI-Disability Caseloads Compared with National SSI-Disability Caseloads

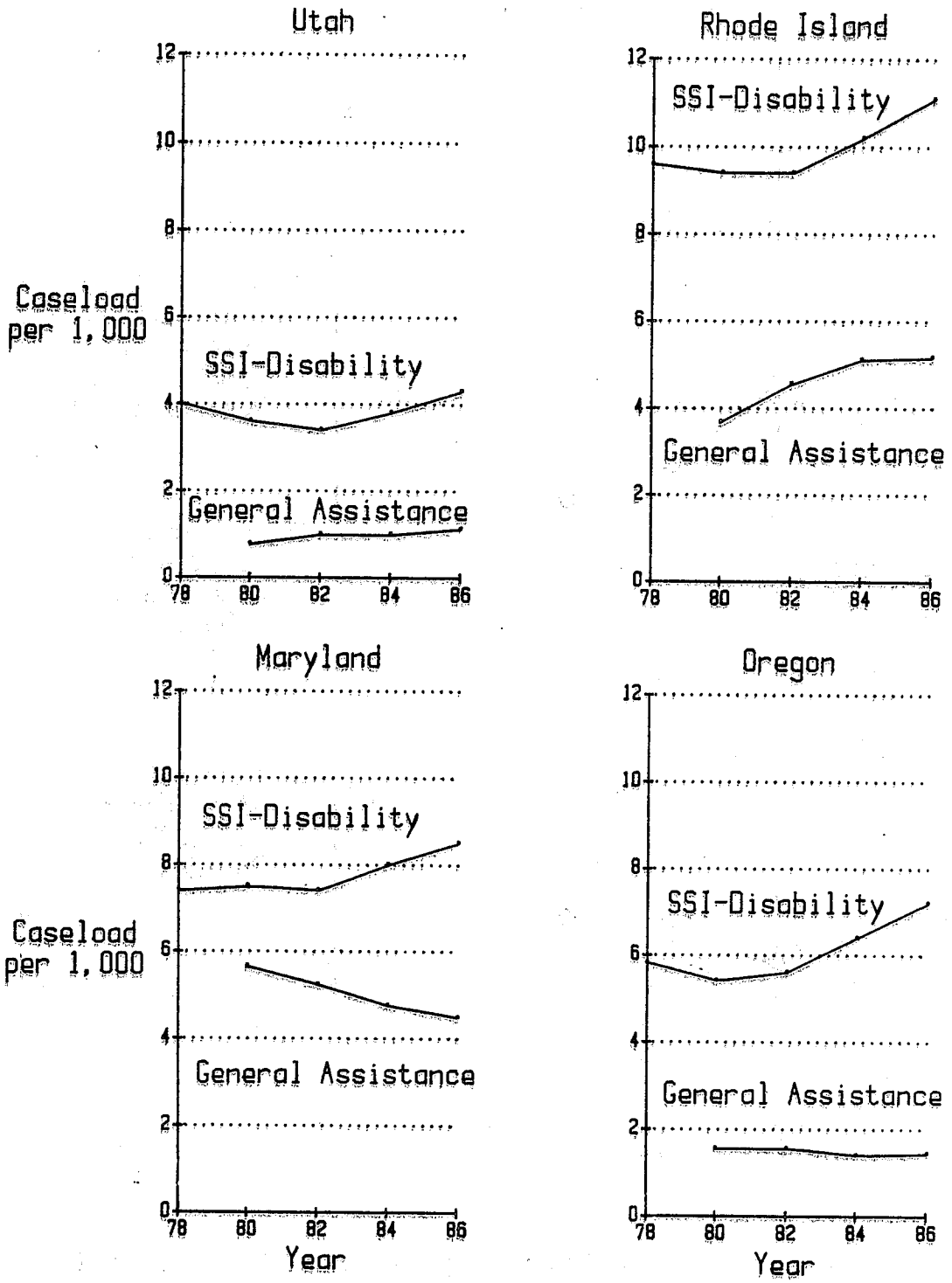


SOURCE: Social Security Bulletin, Annual Statistical Supplements; DSHS Blue Books; U.S. Census Bureau, Current Population Reports, Series P-25.

NOTES: SSI-Disability caseloads are for December 1978, 1980, 1982, 1984, and October 1986. GA-U caseloads are for November of those years.

FIGURE 3.3

GENERAL ASSISTANCE AND SSI-DISABILITY CASELOAD TRENDS IN UTAH, RHODE ISLAND, MARYLAND, AND OREGON



SOURCE and NOTES: See Figures 3.1 and 3.2.

Caseload Trends in States Similar to Washington

Since 1980, Utah has experienced the largest caseload growth of the four incapacity-based programs similar to the GA-U program. Utah's general assistance caseload per 1,000 residents increased by 47 percent between November 1980 and 1986, followed closely by Rhode Island which experienced a 41 percent increase. Utah and Rhode Island officials cited growth in the number of eligible individuals as reasons for caseload growth.

Caseloads declined by 21 percent in Maryland and seven percent in Oregon. General Assistance and SSI-Disability caseloads for the four states are shown in Figure 3.3.

1. Utah

Utah officials reported that in-migration of homeless people could contribute to caseload growth in that state. In addition, Utah experienced large SSI-Disability program cutbacks similar to those in Washington. Utah's SSI-Disability caseloads declined by 14 percent between December 1978 and December 1982 and increased by only 7 percent between December 1978 and October 1986.

Utah's SSI-Disability caseload was 4.3 recipients per 1,000 residents in October 1986. Only 2.7 percent of that state's population reported that they were disabled and unable to work in the 1980 U.S. Census.

2. Rhode Island

SSI caseload reductions were less severe in Rhode Island, which experienced less general assistance caseload growth. Declines in Rhode Island's SSI-Disability caseloads were smaller than average (1.7 percent) between 1978 and 1982. Growth between 1978 and 1986 was greater than the national average (16.0 percent).

The size of Rhode Island's disabled population was close to the national average in 1980 -- 4.5 percent of the state's population reported disablities that prevented work. Its SSI Disability caseload in October 1986 (11.1 per 1,000) was also close to the national average.

3. Maryland

Maryland's caseload decline stemmed from four factors: changes in eligibility procedures; computerization of case counting; development of quality control procedures, and lack of major SSI-Disability cutbacks.

In 1982, Maryland adopted a medical eligibility system similar to Washington's current system. Length of medical eligibility is based on the expected length of the incapacity, but medical eligibility cannot be extended beyond 12 months. Annual redeterminations are necessary, even for incapacities that are expected to be permanent.

Computerization of Maryland's income maintenance programs standardized the state's case counting procedures. Caseloads dropped in some counties solely because the definitions of countable cases changed.

Maryland's general assistance quality control system, modeled on the federal quality control system used for AFDC and food stamps, also had a caseload impact. Use of the quality control system, combined with changes in medical eligibility procedures cited above, cut Maryland's payment error rate for general assistance by over 60 percent. In March 1981, 19 percent of all general assistance payments were made in error. By July 1986, Maryland had reduced this figure to 7 percent.

Maryland's experience with SSI-Disability cutbacks was also fortunate. SSI-Disability caseloads per 1,000 actually increased slightly (by 0.9 percent) between 1978 and 1982, and increased at an above average rate (15.2 percent) between 1978 and 1986.

Maryland's SSI-Disability caseload in October 1986 was the same as Washington's -- 8.5 per 1,000 residents. Maryland's disabled population was larger than average -- 5.9 percent of its population reported disabilities preventing work in the 1980 Census.

4. Oregon

The reasons for Oregon's caseload declines are unknown. Oregon has expanded eligibility standards somewhat since 1982, but does not appear to have increased its caseloads as a result. Oregon's SSI conversion project has been in operation since 1984.

Oregon's SSI-Disability caseloads declined by almost 4 percent between December 1978 and December 1982, but has increased rapidly since 1982. Oregon's SSI-Disability caseloads increased by 23 percent between December 1978 and October 1986.

Despite the faster rate of growth, Oregon's SSI-Disability caseload of 7.2 per 1,000 residents in October 1986 was lower than Washington's. Disabilities were somewhat more common in Oregon than in Washington -- 4.2 percent of Oregon's working age residents reported that disabilities prevented them from working, according to the 1980 U.S. Census.

CHAPTER 4 : FACTORS INFLUENCING SSI-DISABILITY CASELOADS

Efforts to move general assistance recipients to the federal SSI-Disability program are very attractive to state policy makers. States save money from such conversions because the federal government pays a large share of SSI costs. Disabled residents also receive higher incomes and better medical benefits. Almost all states with general assistance programs make efforts to ensure that applicants who may be eligible for SSI are referred to that program.

One way to evaluate the effectiveness of such efforts is to identify states with above average SSI-Disability caseloads. In theory, states that are effective in moving people to the SSI program should have lower general assistance and higher SSI caseloads than those which do not. This chapter describes a statistical model developed to predict SSI-Disability participation and identifies states with high participation rates.

In October 1986, Washington was 29th out of the 50 states in SSI-Disability participation per 1,000 residents. Its caseload of 8.5 recipients per 1,000 residents was almost exactly what would be predictied based on the size of its disabled population and its SSI-Disability benefits.

Other findings include:

- Almost 80 percent of the variation between state SSI-Disability caseloads resulted from differences in the size of states' disabled populations and the size of optional state supplements to SSI-Disability payments.

- Only two states -- Louisiana and Mississippi -- had SSI-Disability caseloads significantly larger than predicted by the two variables. Neither had statewide general assistance programs.

- Four more states -- California, New Mexico, New York, and Wisconsin -- had SSI-Disability caseloads more than one standard deviation higher than predicted. Three of those states had county administered general assistance programs. The fourth -- New Mexico -- required a denied SSI application as a condition of long-term general assistance.

- Of states making special efforts to move general assistance recipients to the SSI-Disability program, only New York, and perhaps Illinois, had SSI-Disability participation rates noticeably higher than predicted. Participation rates were not statistically higher than predicted in either state.

- The size of a state's general assistance caseload and general assistance payment standard did not have any consistent effects on SSI-Disability caseloads. Neither did the proportion of a state's working age population that was employed.

The message for policy makers is discouraging. There is no clear evidence that any of the various state efforts to to move general assistance recipients to the SSI-Disability program have increased SSI caseloads to levels higher than would have been expected without them. The only state-controlled factor clearly associated with increased SSI participation was the grant amount paid to SSI recipients.

SSI caseload differences did not appear to involve the SSI eligibility determination process. State officials involved in disability determination in California and Wisconsin, for example, could see no reason why their eligibiltiy determinations should differ from those in other states. However, they did suggest that local client advocates were well organized.

Methods

SSI-Disability caseloads per 1,000 residents were estimated for October 1986 using a linear regression model. Linear regression procedures calculate the equation that best fits the relationship between independent variables that are expected to influence a particular outcome and the outcome itself. The equation can then be used to predict what the outcomes would be if they behaved exactly as predicted by the model.

The statistical model estimated to predict SSI-Disability participation in October 1986 used two variables:

- the percent of a state's population that was disabled and unable to work according to the 1980 U.S. Census, and;

- the amount paid to disabled individuals living at home under state SSI-Disability policies in effect in January 1986.

These two factors explained almost 80 percent of the variation in state SSI-Disability caseloads. Data on the size of the disabled populations and SSI-Disability payments in the various states are displayed in Figure 4.1. The regression equation used to predict SSI-Disability caseloads from these characteristics is shown in Appendix C.

Several other factors were also tested as potential predictors of SSI-Disability caseloads, including general assistance caseloads, general assistance payment standards, and a general measure of state employment opportunities. None of these variables made any statistically significant contribution to the basic model described above. Appendix C describes these findings in greater detail.

Disabled Population Size as a Predictor of SSI Caseloads

The percent of a state's population that was disabled and unable to work in 1980 had the most important impact on SSI-Disability caseloads -- explaining 75 percent of the variation in SSI-Disability caseloads by itself. SSI-Disability caseloads increased by 2.9 per 1,000 residents for every additional percent of the population reporting disabilities preventing work. 1/

SSI Payment Standards as a Predictor of SSI Caseloads

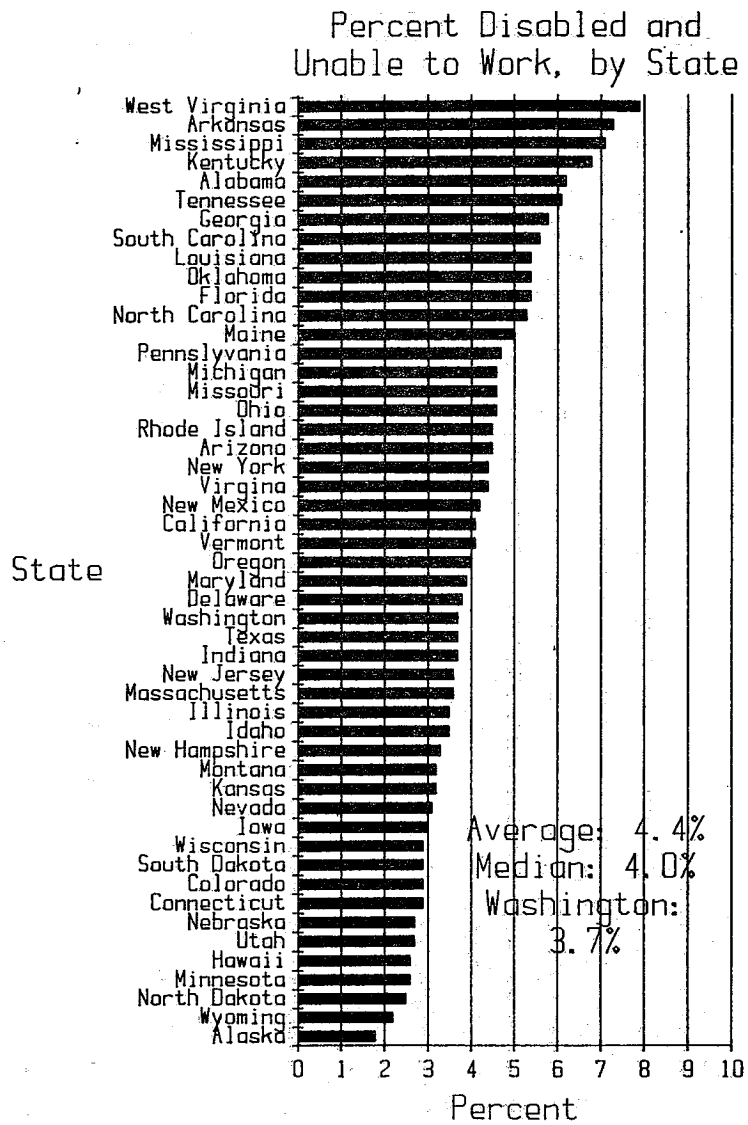
The size of SSI-Disability payments also influenced program participation. The federal SSI-Disability benefit was $336 per month. However, 24 states supplemented this benefit for disabled people living at home, and supplements in some states were quite high. Washington paid a state supplement to disabled persons, but its amount was relatively low -- $ 28 per month in the Puget Sound area and $ 8 elsewhere in the state.

The amount paid by SSI can influence participation in two ways. First, higher benefits make SSI participation more attractive. Second, and equally important, more disabled people are financially eligible to participate in SSI in states with higher state supplements.

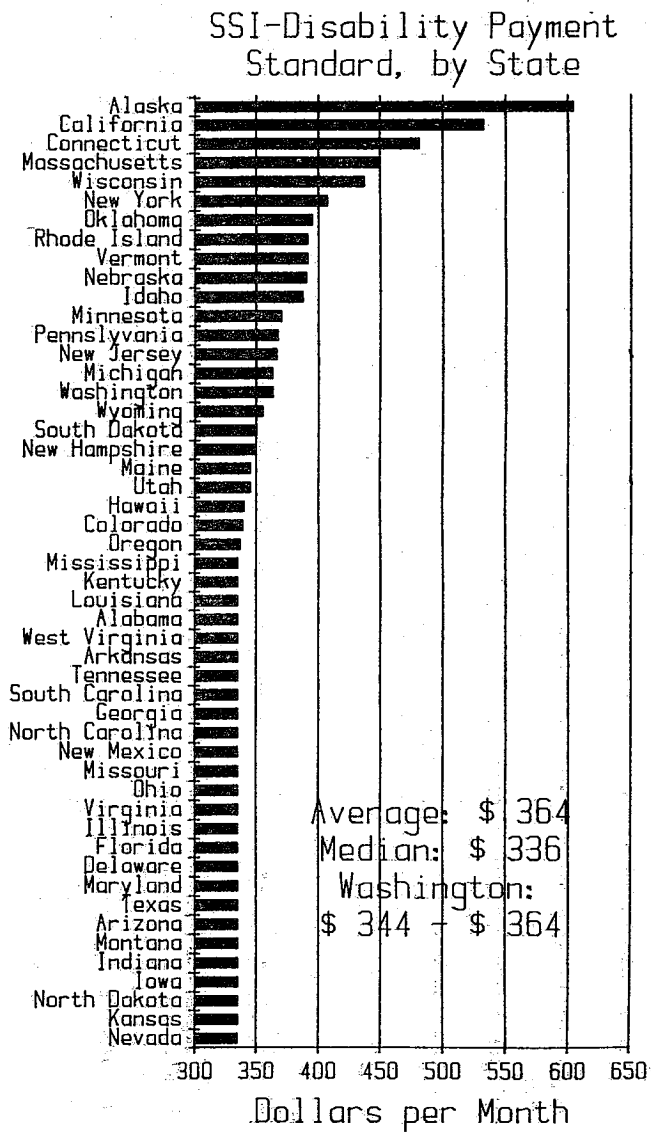
1/ This 29 percent figure is the average of the statistics calculated for each of the 50 states. The average for the population as a whole is 25 percent. These figures assume that the incidence of disabilities preventing work is the same now as it was in 1980. Some experts believe that the incidence of disabilities has increased since that time.

FIGURE 4.1

PERCENT DISABLED AND UNABLE TO WORK AND MONTHLY SSI-DISABILITY PAYMENTS FOR INDIVIDUALS LIVING AT HOME, BY STATE



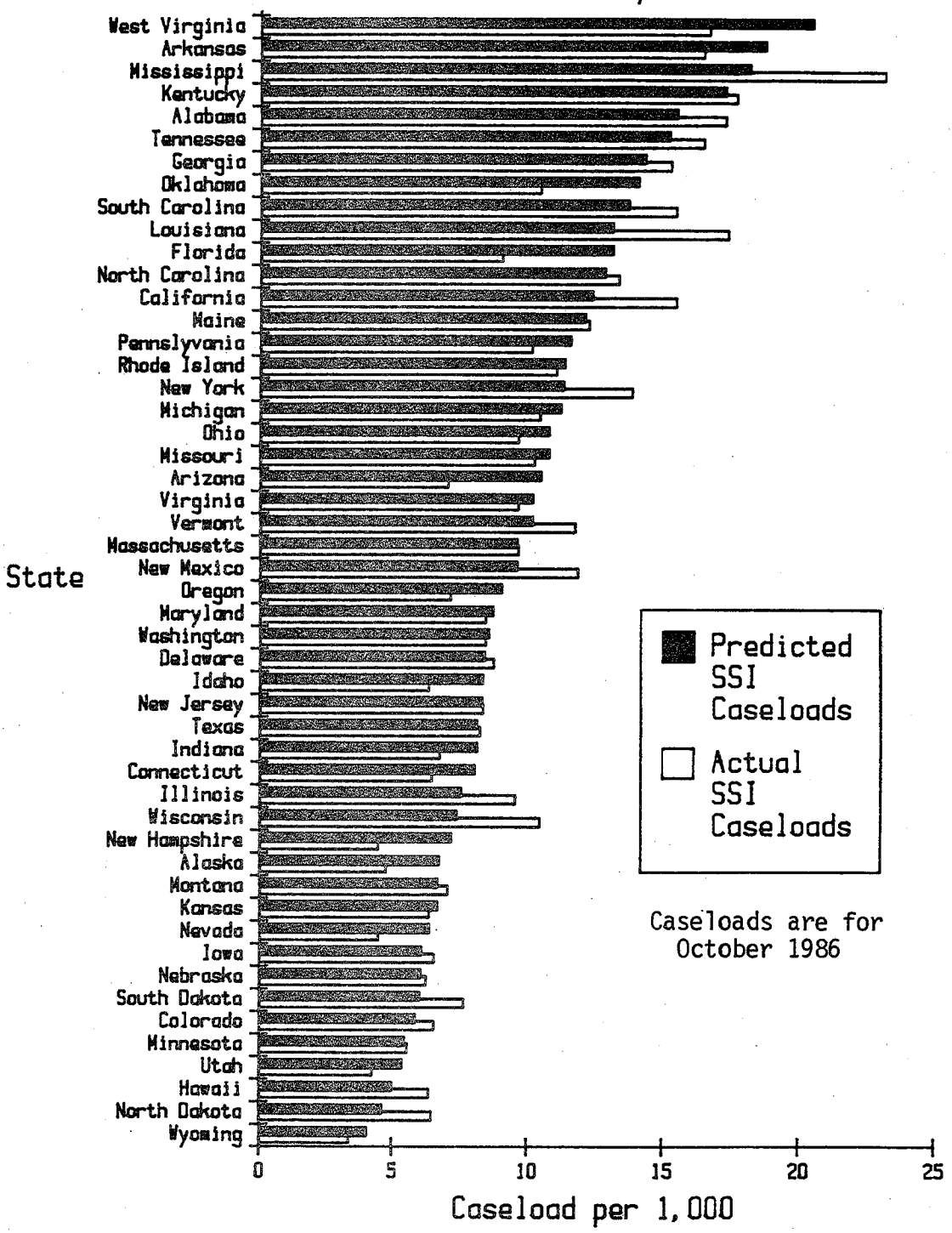
SOURCE: 1980 U.S. Census.



SOURCE: Social Security Administration, January 1986.

FIGURE 4.2

Predicted and Actual SSI-Disability Caseloads, by State



SOURCE: Actual caseloads: Monthly Benefit Statistics, Summary Program Data, U.S. Department of Health and Human Services. Predicted caseloads: Linear regression model based on data in Figure 4.1. The model is shown in Appendix Table A.1.

SSI-Disability caseloads increased by 1.6 per 1,000 recipients for every $ 100 increase in SSI-Disability payment standards. This means that states with large SSI supplements -- such as Alaska, California, Connecticut, Massachusetts, New York, and Wisconsin -- would be expected to have larger than average SSI-Disability caseloads regardless of what they did to refer general assistance recipients to SSI.

Actual and predicted SSI-Disability caseloads can be compared to determine which states had higher than expected SSI-Disability participation. Figure 4.2 shows this comparison. States are listed in order of their predicted caseloads.

States With High SSI-Disability Caseloads

Only two states -- Louisiana and Mississippi -- had caseloads higher than predicted by the model at the five percent level of significance. Neither state had a state-wide general assistance program or provided a state supplement to federal SSI-Disability benefits for individuals living at home. Both states had relatively large disabled populations.

According to the regression model less than five observations per 100 should be so far above predicted levels. Therefore, the fact that two of the 50 states had caseloads so high is not very surprising. This could easily have occurred by chance.

Four additional states -- California, New Mexico, New York, and Wisconsin -- had SSI-Disability caseloads that were more than one standard error above predicted levels. Such differences should occur by chance about 15 times per 100 observations. One would expect an average of 7.5 states out of the 50 to have caseloads this large, so the fact that six states fell into this range is not surprising.

All four states had state-wide general assistance programs. Three of the four -- California, New York, and Wisconsin -- paid generous state supplements to SSI-Disability recipients for individuals living at home. 2/ Wisconsin's disabled population was smaller than average. The sizes of the disabled populations in the other states were similar to the national average.

2/ Supplemental payments, in addition to the federal benefit of $ 336 per month, were $ 198 per month in California, $72 per month in New York, and $ 102 per month in Wisconsin. New Mexico paid no state supplement to individuals living at home.

Two of the states -- New Mexico and New York -- had policies that could explain high SSI-Disability participation rates. New Mexico required a denied SSI-Disability application as a condition of eligibility for long-term assistance under its general assistance program. New York had a well developed SSI-Disability referral program, which included state-funded legal support for all SSI-Disability applicants and well developed referral linkages between income maintenance and SSI-Disability eligibility determination staff.

State officials in California and Wisconsin could offer no explanation for the high SSI-Disability participation rates in their states. Wisconsin officials were under pressure to explain their high SSI-Disability participation, since the costs of their relatively generous SSI state supplements were running ahead of budget projections.

Three of the four states -- California, New York, and Wisconsin -- had county administered general assistance programs in which counties shared in the costs of benefits. It is possible that systems in which counties share general assistance costs provide more financial incentives to local office staff to move recipients to SSI. On the other hand, 20 of the 36 states with state-wide general assistance programs involved counties or municipalities in program administration. Three of any four state programs drawn at random would often involve local administration or cost sharing.

Caseloads in States With Special SSI Referral Procedures

Among states with well developed procedures for moving general assistance recipients to SSI, only New Mexico and New York had higher SSI-Disability caseloads than expected. Of the other states which reported special efforts or program features, only Illinois had an SSI-Disability participation rate that was moderately above predicted.

Massachusetts, Montana, Rhode Island, and Washington had SSI-Disability participation rates very close to those predicted by the statistical model. Oregon, Pennsylvania, and Utah had participation rates somewhat lower than expected.

In no case were the differences between actual and expected SSI-Disability caseloads statistically significant in states with special SSI referral programs for general assistance recipients.

APPENDIX A : PUBLISHED SOURCES OF STATE COMPARISON DATA

Bowe, Frank
U.S. Census and Disabled Adults, Arkansas Rehabilitation Research and Training Center, University of Arkansas, Hot Springs, Arkansas, April 1984. Percents of state populations unable to work due to disabilities were obtained from this summary of 1980 Census data.

Bureau of the Census, U.S. Department of Commerce,
Current Population Reports, Population Estimates and Projections, Series P-25. State populations used to calculate caseloads per 1,000 residents were obtained from this series.

_____,
State and Metropolitan Area Data Book, 1986. State employment to population ratios for 1984 were obtained from Table C, Item 758.

U.S. Department of Health and Human Services,
Monthly Benefit Statistics: Summary Program Data, Number 10, December 15, 1986. SSI-Disability caseloads for October 1986 were obtained from Table 8.

_____,
Public Assistance Statistics, October 1980, November 1980, December 1980, Social Security Administration. General assistance caseloads were obtained from Table 8.

_____,
Quarterly Public Assistance Statistics, October-December 1982, October-December 1984, Social Security Administration. General assistance caseloads were obtained from Table 11.

_____,
Social Security Bulletin: Annual Statistical Supplement 1977-79, 1980, 1982, 1984-85, Social Security Administration. SSI-Disability caseloads were obtained from Table 179.

_____,
The Supplemental Security Income Program for the Aged, Blind, and Disabled: Characteristics of State Assistance Programs for SSI Recipients, January 1986, Social Security Administration.

Urban Systems Research and Engineering, Inc.
Characteristics of General Assistance Programs, 1982, Cambridge, Massachusetts, National Technical Information Service Report Number PB84-115336, May 1983.

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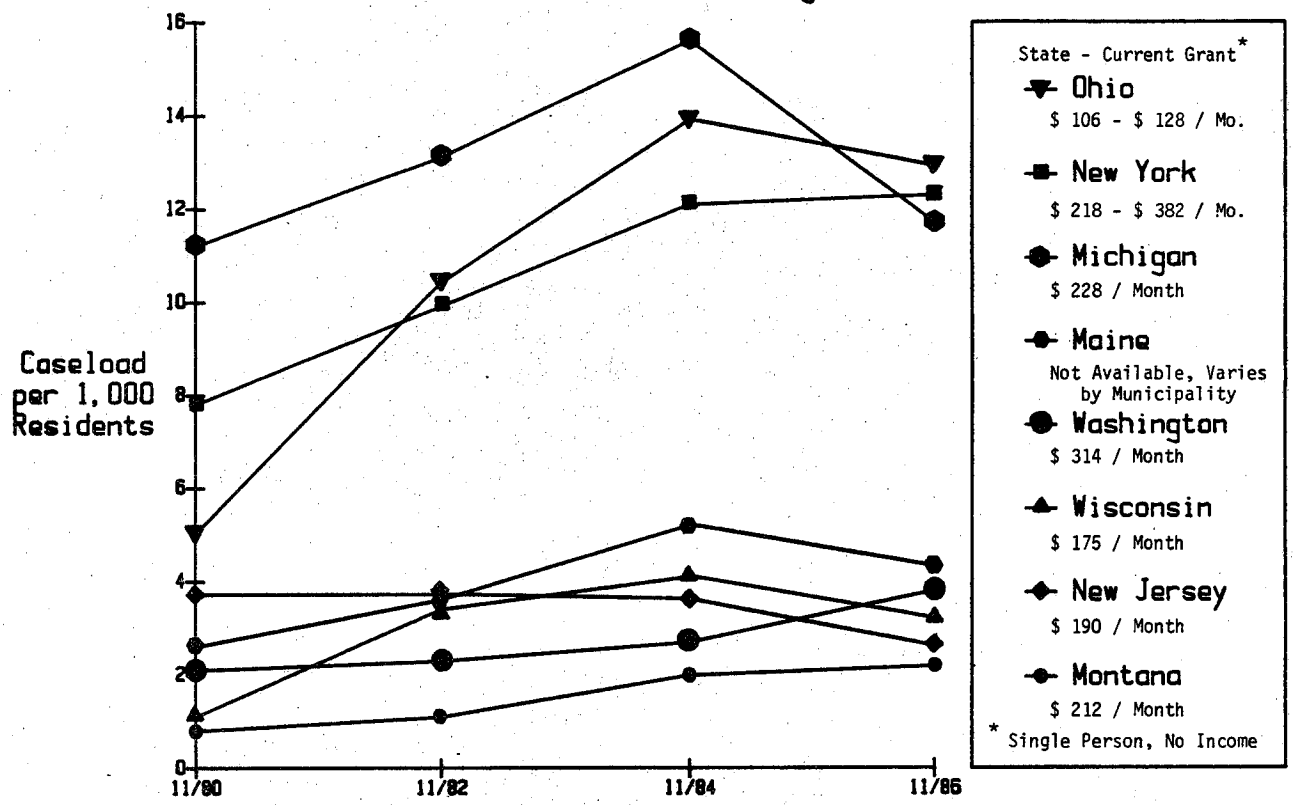
Wolfhagen, Carl
1986 Study of Characteristics of General Assistance-Unemployable Recipients: Length of Assistance Use, Department of Social and Health Services, Office of Planning, Evaluation, and Professional Development, January 1987.

APPENDIX B: SUPPLEMENTAL FIGURES AND TABLES

FIGURE A.1

Washington's GA-U Caseload Compared With Caseloads in States With Income-Based General Assistance Programs



SOURCE: U.S. Department of Health and Human Services, Public Assistance Statistics and Quarterly Public Assistance Statistics; U.S. Census Bureau, Current Population Reports, Series P-25.

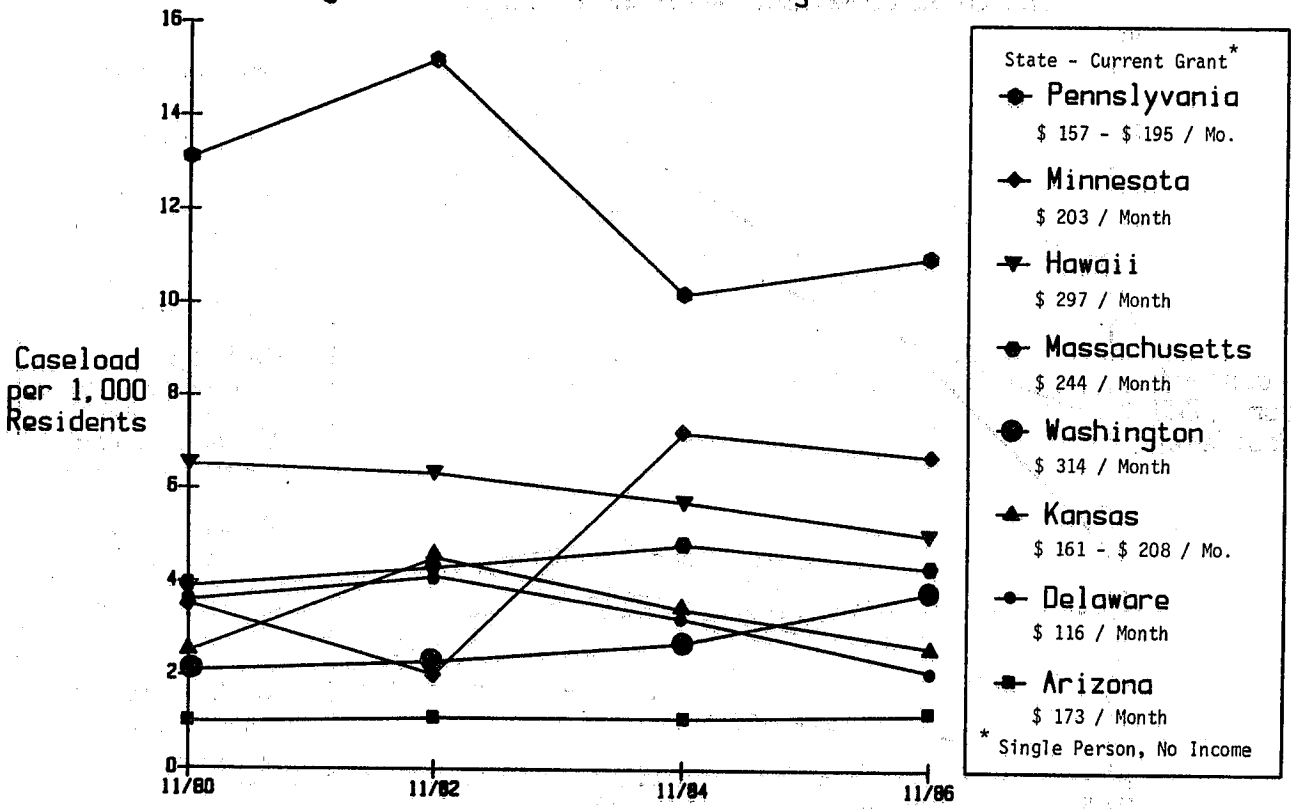
November 1986 caseloads were obtained through contacts with state officials between December 1986 and January 1987. Data for some states are for other months. See footnote 1/ on page 28 for details.

NOTES: States with fund-limited programs are excluded from this table.

State populations for 1986 were estimated based on population increases between 1984 and 1985.

FIGURE A.2

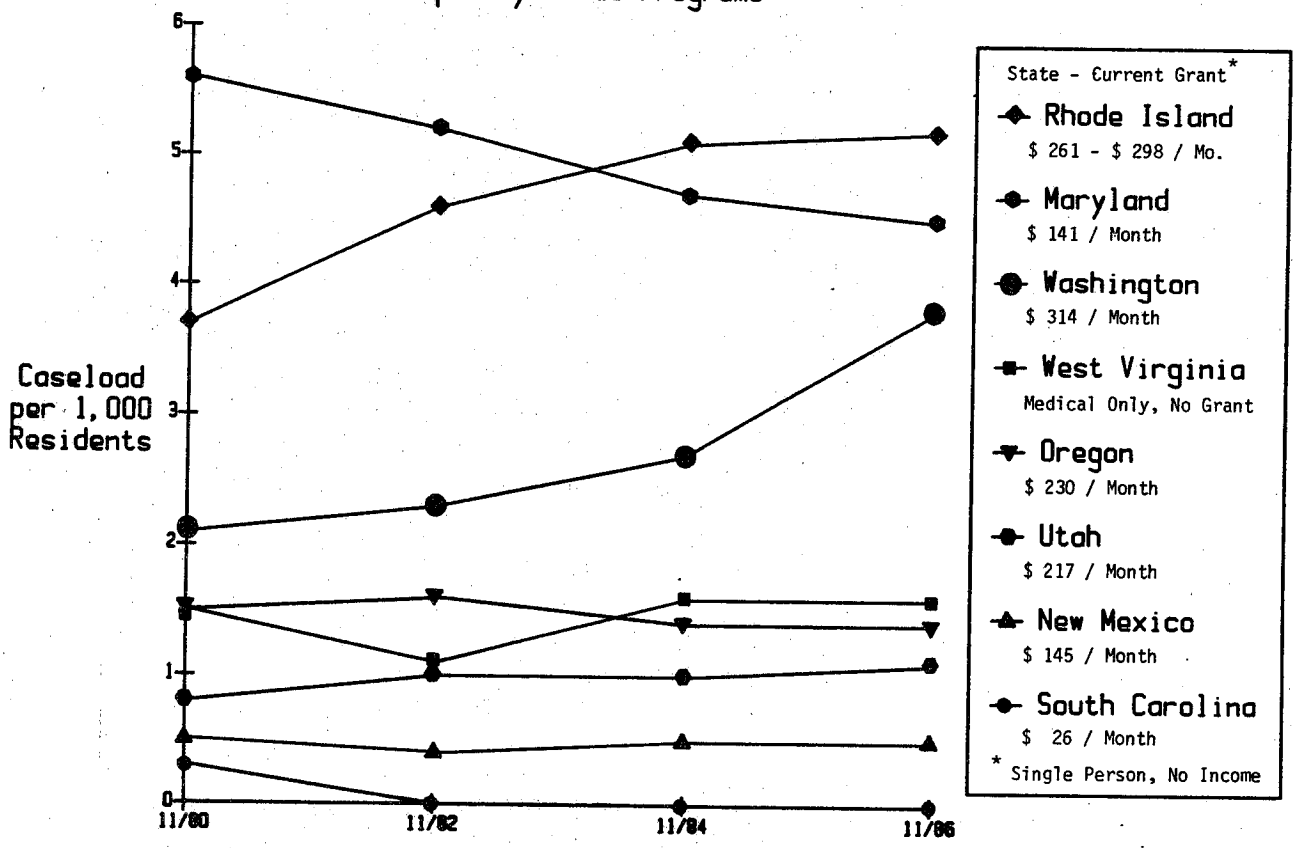
Washington's GA-U Caseload Compared With Caseloads in States With Categorical General Assistance Programs



SOURCE and NOTES: See Figure A.1.

FIGURE A.3

General Assistance Caseloads in States With Incapacity-Based Programs



SOURCE and NOTES: See Figure A.1. Incapacity-based programs are defined as categorical programs in which 90 percent or more of all cases are eligible due to incapacities which prevent work.

APPENDIX C: REGRESSION MODELS TO PREDICT SSI-DISABILITY PARTICIPATION

Table A.1 displays the linear regression model estimated to predict SSI-Disability participation in October 1986. State SSI-Disability caseloads per 1,000 residents were predicted as a function of the percent of the state's working age population that said it was disabled and unable to work according to the 1980 U.S. Census and the amount of SSI benefits paid to disabled individuals living at home.

Percent disabled was the most influential variable, accounting for 76 percent of the variation in state SSI-Disability caseloads. Curiously, 1980 Census data predicted SSI-Disability caseloads in December 1984 and October 1986 more accurately than they predicted caseloads in December 1980 or December 1982. Percent disabled, as measured in 1980 Census data accounted for only 70 percent of the variation in December 1980 SSI-Disability caseloads. It is possible that the Continuing Disability Review program initiated by the federal government between 1980 and 1982 had the effect of standardizing state SSI-Disability caseloads.

Several other factors were tested as possible predictors of SSI-Disability participation. These factors included the size of a state's general assistance caseload, the presence of a state-wide general assistance program, the difference between SSI-Disability and general assistance payment standards, and the state's employment to population ratio in 1984. (The employment to population ratio is the percent of a state's working age population that was employed).

Theoretically, all four variables could have had an impact on SSI-Disability caseloads. Each variable was tested in regression models that included the two final variables -- percent disabled and SSI payment standards. Regression coefficients estimated for most of the variables behaved as expected. However, estimated impacts were so small that they could easily have occurred by chance. The coefficients for the two basic variables -- percent disabled and SSI payment standards -- remained stable and statistically significant in each specification tested.

Several attempts were made to specify a non-linear relationship between SSI caseloads and SSI payment standards. None of these specifications performed significantly better than the linear specification.

TABLE A.1

REGRESSION MODEL PREDICTING STATE SSI-DISABILITY CASELOADS PER 1,000 RESIDENTS IN OCTOBER 1986

Variable	Coefficient	Standard Error
Percent of State Population Disabled and Unable to Work	+ 2.9396	0.2198
State SSI Benefits for Disabled Individuals Living at Home	+ 0.0148	0.0056
Constant	- 7.9156	
R Square	.795	
Standard Error of Estimated SSI-Disability Caseloads (y)	2.0227	

SOURCE: October 1986 SSI-Disability caseloads: Monthly Benefit Statistics: Summary Program Data, U.S. Department of Health and Human Services, Number 10, December 15, 1986.

Percent of state populations disabled and unable to work: 1980 U.S. Census data summarized in Frank Bowe, U.S. Census and Disabled Adults, Arkansas Rehabilitation Research and Training Center, University of Arkansas, April 1984.

SSI-Disability benefits: The Supplemental Security Income Program for the Aged, Blind, and Disabled: Characteristics of State Assistance Programs for SSI Recipients, January 1986. Social Security Administration, Publication 17-002.

State populations: Current Population Reports, Series P-25. U.S. Census Bureau.

NOTES: The regression model was estimated by ordinary least squares using Lotus 1-2-3, Release 2. The model has 50 observations.

General Assistance Caseloads

One of the key assumptions behind state efforts to refer general assistance recipients to SSI is that if this is not done, states will end up supporting people who should receive SSI. If the presence of state general assistance programs reduces SSI participation, then states with higher than average general assistance caseloads should have lower than average SSI caseloads.

General assistance caseloads for states without state-wide programs were estimated from information provided on programs available in major counties of those states obtained from the 1983 Urban Systems study and from caseload data provided in "Quarterly Public Assistance Statistics". Estimates could not be made for four states.

SSI-Disability caseloads dropped by 0.04 per 1,000 for every unit increase in general assistance caseloads per 1,000 after controlling for disabled population size and SSI-Disability payment amounts. This difference was not of any statistical or practical significance.

Presence of Statewide General Assistance Programs

The presence of a statewide general assistance program was also tested as a potential predictor of SSI-Disability caseloads in models controlling for percent disabled and SSI payment standards.

On average, SSI-Disability caseloads were 0.45 per 1,000 lower in the 36 states with statewide general assistance programs than in the 14 states without programs. The presence of a statewide program decreased SSI-Disability caseloads by 0.82 per 1,000 when general assistance caseloads were controlled for. However, neither of these differences was at all close to statistical significance.

Differences Between SSI and General Assistance Payments

The difference between general assistance and SSI-Disability payment standards was also tested as a possible factor in SSI participation rates. Washington's relatively high GA-U payment standard could serve as an impediment to increasing SSI-Disability participation.

Washington's GA-U payment levels are between $ 30 and $ 50 of current SSI-Disability payment levels, depending on geographic location. The average difference between SSI-Disability and general assistance payment standards was

$ 188 per month in states for which general assistance payment information was available. States in which the gap between general assistance and SSI payment standards were greater were expected to have higher SSI-Disability participation.

General assistance payment standards for programs with a range of payment standards were estimated by averaging high and low standards. The $ 188 average was for the 26 states shown in Figure 2.1. Payment standards for the 10 other states with statewide general assistance programs were estimated from information provided on major counties in the 1983 Urban Systems study. The difference between SSI payment standards and general assistance payment standards was assumed to be equal to the SSI payment standard in the 14 states without statewide general assistance programs.

SSI-Disability caseloads dropped by 0.07 per 1,000 for every $ 100 increase in the gap between general assistance and SSI-Disability payment standards, controlling for the size of state disabled populations and SSI payment standards. This difference was not in the expected direction, and was not of any statistical or practical significance.

Employment to Population Ratios

Employment to populations ratio were used as a general measure of employment opportunities in a state. Disabled residents of states in which high proportions of working age adults were employed were expected to have lower SSI-Disability caseloads than states in which fewer adults were working. Widespread employment opportunities provide more potential for the disabled people to be supported by family members.

Employment to population ratios for state working age populations were obtained for 1984, the most recent year available. SSI-Disability caseloads decreased by 0.04 per 1,000 for every percentage increase in a state's employment to population ratio, controlling for percent disabled and SSI payment standards. The decrease was not close to statistical significance.