REPORT TO THE LEGISLATURE

Analysis of Options for Expanding SSI-Related Categorically Needy Medicaid Coverage

As Required by Engrossed Substitute Senate Bill 5950

(Chapter 376, Laws of 2024)

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Executive Summary

Before residents are eligible for Medicare, Washington State offers a robust Medicaid program, with coverage for behavioral health care, dental care, non-emergency medical transportation, and other benefits with no requirement for co-pays and deductibles. Medicaid also provides long-term services and supports, which Medicare does not cover and are often needed by persons who are elderly or have a disability. Once on Medicare, Medicaid acts as a supplemental insurance to Medicare for those who are eligible for continued "full dual" coverage. However, stricter asset and income tests are applied which results in tens of thousands of persons losing their eligibility for full Medicaid benefits.

The loss of Medicaid supplemental coverage due to stricter income and asset tests increases out-of-pocket spending and the risk of incurring catastrophic health care costs for low-income persons who lose Medicaid coverage. Those who lose Medicaid subsequently use fewer outpatient services and fill fewer prescriptions for chronic conditions, and experience increases in mortality. Elderly persons with incomes above the existing Medicaid standards are also often not able to afford needed long-term services and supports that would delay the need for more expensive nursing home placement. The increased out-of-pocket costs associated with the Medicare Cliff have real adverse impacts on Washingtonians.

Engrossed Substitute Senate Bill 5950 (Chapter 376, Laws of 2024) directed the Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA) to conduct a study of the costs to expand Apple Health categorically needy (CN) coverage for SSI-related coverage groups under a variety of income and asset limit options that would reduce the impact of the Medicare Cliff. Cost estimates assume eligibility changes would become effective in December 2027, following implementation of the required Automated Client Eligibility System (ACES) programming changes, Medicaid State Plan amendment, and potential Medicaid waiver (for elimination of asset requirements in some programs).

The ramp-up of the financial impact of the proposed eligibility changes is modeled on the State's experience implementing "New Adult" coverage under the Affordable Care Act. Under these assumptions, the eligibility changes would achieve their full effect in SFY 2031 after a 36-month ramp-up period. A full discussion of modeling assumptions is provided in the main body of the report, and detailed modeling workbooks are available from RDA.

The options for expanding Apple Health CN coverage for SSI-related individuals would have financial impacts in several Health Care Authority (HCA) and DSHS program areas, including:

- HCA medical and behavioral health (BH) service utilization and associated capitation payments for CN Aged and Disabled coverage groups,
- Modest cost offsets associated with Medically Needy and Qualified Medicare Beneficiary Only (QMB-Only) coverage group members who would shift to a CN coverage group,
- Medicare Part D "Clawback" payments from HCA to the Centers for Medicare and Medicaid Services (CMS) tied to the size of the full-benefit Medicaid/Medicare "dual eligible" caseload which would increase under the specified options,
- DSHS Aging and Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA) long-term services and supports (LTSS) costs,
- ALTSA, Area Agency on Aging (AAA), and DDA staff workload costs associated with increased LTSS caseloads,

- Economic Services Administration (ESA) staff workload costs associated with increased medical eligibility processing,
- ESA staff workload cost offsets associated with options eliminating asset requirements for SSI-related Medicaid beneficiaries in the specified income ranges, and
- Costs associated with the ACES programming changes required to implement the proposed eligibility changes.

Estimates are provided for expanding Medicaid coverage for coverage for SSI-related Medicaid coverage groups in incremental steps from 75 percent to 100 percent of the federal poverty level. Estimates are also provided for options with the elimination of existing asset requirements at each income level. Based on 2023 population data, approximately 53,400 additional persons would be eligible for Medicaid by raising the income limits to 100 percent FPL, and an additional 17,100 would be eligible if asset limits were eliminated. Nationwide, 19 states have elected to expand coverage to this income level.

Except where explicitly noted, only General Fund - State (GF-S) costs are referenced in this report. General Fund - Federal (GF-F) cost estimates are included in the detailed modeling workbooks available from RDA. The GF-S costs associated with each option are summarized in Table 11 in the final section of the report. Key findings include:

- Options for expanding SSI-related CN Medicaid coverage are associated with estimated full-implementation SFY 2031 costs ranging from (a) $35.2 million GF-S to expand income limits to 80 percent FPL at current asset limits to (b) $302.4 million GF-S to expand income limits to 100 percent FPL and eliminate asset limits.
- Medicare Part D “Clawback” costs represent a significant share of estimated impacts on HCA GF-S costs.
- Projected ALTSA and DDA LTSS costs impacts accrue only in the options eliminating asset requirements, and in those scenarios reflect a significant proportion of the total estimated GF-S impact.

Background

For over half a century, the poverty-reducing effects of programs such as Social Security, Medicare, and Medicaid have been dramatic, keeping tens of millions of people nationwide out of poverty.[1] In the first 50 years of operation of the Medicare and Social Security programs, the poverty rate among Americans 65 and older dropped from 28.5 percent to 9.1 percent.[2] However, critical gaps in Medicare's coverage of health care expenses persist for elders and persons with disabilities who are poor or near poor. Over the past decade, homelessness and food insecurity among elders in Washington State has been rising more rapidly than among younger adults.[3] Further, women and persons from BIPOC communities are disproportionately represented among elders and persons with disabilities who are poor or near poor, for whom health care expenses create more significant economic challenges.

Before residents are eligible for Medicare, Washington State offers a fairly generous Medicaid program, with coverage for behavioral health care, dental care, non-emergency medical transportation, and other benefits with no requirement for co-pays and deductibles. Once on Medicare, Medicaid acts as a supplemental insurance to Medicare for those who are eligible for continued "full dual" coverage. However, stricter asset and income tests are applied which results in tens of thousands of persons losing their eligibility for full Medicaid benefits.

Supplemental coverage is unaffordable for most low-income people, who are faced with significant out-of-pocket costs for inpatient hospital deductibles and daily coinsurance for skilled nursing facility stays lasting 21–100 days. Medicare Part B includes an annual deductible and coinsurance for most services. Expenditures for those on Medicare are projected to increase in the future. One study projects that "Medicare beneficiaries' average out-of-pocket health care spending is projected to rise as a share of average per capita Social Security income, from 41 percent in 2013 to 50 percent in 2030."[4] These challenges disproportionately affect women, people over 85, those with lower income, and those in poorer health.

The loss of Medicaid coverage due to stricter income and asset tests for Medicare beneficiaries is a phenomenon known as the "Medicare Cliff". Roberts et al found "Among partial Medicaid recipients, the rate of disenrollment was 40 percent lower (adjusted hazard ratio of 0.6) in states with less restrictive asset limits for partial Medicaid compared to federal standards."[5] The consequences of the loss of cost-sharing coverage were studied by Roberts et al (2021) using a regression discontinuity design. They found that, compared to those who maintained Medicaid coverage, "near-poor beneficiaries exposed to this coverage cliff incurred $2,288 in additional out-of-pocket spending (over two years) and were 33 percentage points more likely to incur catastrophic spending."[6] In addition, those who lost Medicaid used fewer outpatient services and filled fewer prescriptions for chronic conditions. In another study, the loss of prescription drug

[1] Consumer Affairs article, found at Elderly Poverty Statistics (2022): Senior Poverty Rate | ConsumerAffairs.
[2] Who's poor in America? 50 years into the 'War on Poverty,' a data portrait | Pew Research Center.
[3] https://waseniorlobby.org/wp-content/uploads/MANCUSO-DSHS-Research-and-Data-Analysis.pdf
[4] Kaiser Family Foundation, January 2018, Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future, Prepared by: Juliette Cubanski, Tricia Neuman, Karen E. Smith, Anthony Damico.
[5] Roberts et al, 2019. Association of State Policies with Medicaid Disenrollment Among Low-Income Medicare Beneficiaries, Health Affairs 38, NO. 7 (2019): 1153–1162.
[6] Roberts et al, 2021.

coverage was linked to missed refills of medication and increases in mortality.[7] Increasing out-of-pocket costs have real adverse impacts on poor and near-poor individuals.

Many states have elected to expand Medicaid coverage for elderly and disabled persons to mitigate adverse impacts on essential health services for low-income Medicare beneficiaries. According to a 2022 Kaiser Family Foundation survey of states, 27 states and the District of Columbia have expanded income eligibility beyond SSI limits, and 19 have raised their income eligibility standard to 100 percent of the federal poverty level.[8] Thirteen states have increased the asset limits above the SSI limits, with two states eliminating asset test requirements.

Medicaid Eligibility in Washington State

Income Eligibility. Adults under 65 who are not eligible for Medicare qualify for Modified Adjusted Gross Income (MAGI) Medicaid expansion programs with income up to 138 percent of the Federal Poverty Level (FPL). However, the income limit for SSI-related Medicaid programs for low-income seniors and individuals with a disability is approximately 75 percent FPL. In Washington State, we refer to SSI-related Medicaid coverage (medical programs for individuals who are aged, blind, or have a disability) as Classic Apple Health (Medicaid). Because individuals 65 and over or those who have Medicare coverage are not eligible for Apple Health for Adults, they are required to meet the lower income limits associated with Classic Apple Health. This results in many of the most vulnerable adults losing access to free or low-cost health care coverage options. While Medicare Savings Programs (MSPs) help to alleviate some of the financial burden by assisting with out-of-pocket costs such as premiums and co-pays, MSP income limits are lower than those for MAGI Apple Health, leaving this population at risk of losing Apple Health and being forced to pay potentially high out-of-pocket Medicare costs.

Asset Eligibility. While MAGI Apple Health for Adults does not require an asset test, Classic Apple Health programs maintain low asset limits that match the SSI program. Currently, allowable assets are limited to $2,000 for an individual and $3,000 for a couple in Aged, Blindness, or Disability (ABD), Long Term Support Services (LTSS), and Medically Needy (MN) programs. Spousal impoverishment protections do permit a household where only one member of a married couple is seeking LTSS to have higher assets to protect the community spouse. However, with such low limits, those who meet other eligibility requirements are often faced with the decision to either remain ineligible for essential health coverage or spend down assets to meet the allowable limits. Several states including California, New York, and Illinois have made recent updates to their asset test policies. New York increased limits for all programs, providing access to coverage for most who are otherwise eligible. California eliminated the asset test for SSI-related Medicaid coverage groups programs effective January 2024.

CMS has released new rules that mandate states to align some MAGI and Classic Medicaid eligibility rules over the next three years.[9] Therefore, aligning income standards and removing asset limits for Classic Medicaid would help lay the foundation for compliance with these rules.

[7] The Health Costs of Cost-Sharing, Amitabh Chandra, Evan Flack, Ziad Obermeyer; Working Paper 28439 http://www.nber.org/papers/w28439, National Bureau of Economic Research, February 2021.

[8] Kaiser Family Foundation, July 11, 2022, "Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey"

[9] See https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health

Alignment of income standards and reduction or elimination of asset tests for Classic programs also would move DSHS and HCA closer to a simplified, single application for client benefit enrollment, and are actions aligned with the future vision of a streamlined Medicaid eligibility process. These policy changes would reduce existing biases and inequities in Medicaid eligibility for individuals who are aged or have a disability. Advancing alignment in eligibility standards between MAGI and Classic Medicaid programs supports modernization of technologies used in determining eligibility and automating enrollments and renewals, and would improve both client and staff experiences.

Proviso-Specified Policy Options

The policy options considered in this report were directed by the budget proviso language reflected in the box below. The specified eligibility changes would require Automated Client Eligibility System (ACES) programming changes, a Medicaid State Plan amendment, and, in the case of asset limit changes, a Section 1115 Medicaid waiver. The implementation timeline is uncertain, in particular for options involving asset limit changes, due to dependencies on engagement with CMS. The previously referenced new CMS rules that mandate states to align some MAGI and Classic Medicaid eligibility rules may impact the implementation timeline and approach. We note that there is currently a significant 1115 Medicaid Waiver application backlog at CMS, including pending requests related to the State's current Medicaid Transformation Project waiver. We assume a December 2027 implementation timeline for all options, based on the timeline necessary for implementation of the required ACES system changes, assuming new eligibility standards were adopted in the 2025 legislative session. However, we note that options requiring an 1115 Medicaid Waiver to implement asset limit changes could require a longer implementation timeline.

This report is organized as follows. The next section examines the impact of SSI-related CN Medicaid coverage expansion options on HCA medical costs, behavioral health costs, and Part D clawback costs.[10] The subsequent section examines the impact of SSI-related Medicaid coverage expansion options on ALTSA and DDA LTSS service and staff workload costs. The following section examines impacts on ESA staff workload and costs associated with the ACES IT system programming changes required to implement the proposed changes. We close with a summary of the main findings.

BUDGET PROVISO LANGUAGE

Sec.208(10) $20,000 of the general fund—state appropriation for fiscal year 2024 and $70,000 of the general fund—state appropriation for fiscal year 2025 are provided solely for the research and data analysis division of the department to conduct a study of the costs to expand apple health categorically needy coverage for SSI-related individuals who meet the criteria in WAC 182-512-0050. The study shall provide the cost of expanding Medicaid services to individuals at the following percentages of the federal poverty level: 75 percent, 80 percent, 85 percent, 90 percent, 95 percent, and 100 percent. The study should also provide the cost of eliminating the state asset limits at each of these income increments. The study must be submitted to the appropriate committees of the legislature by December 1, 2024.

[10] The Part D clawback is a mechanism through which states will help finance the Medicare Part D drug benefit. The clawback is a monthly payment made by each state to the federal Medicare program roughly reflecting the state-fund expenditures that would have been incurred if the state were responsible for prescription drug coverage for full-benefit "dual eligibles".

HCA Cost Impacts

Estimating the impact of the proposed eligibility changes requires data on income and assets for Medicare beneficiaries. We rely on modeling developed by Hunter Plumer to estimate the number of Medicare beneficiaries eligible under the proposed expansion scenarios, based on American Community Survey, Medicare Beneficiary Survey, and CMS Medicare program data. Ramp-up assumptions are based on Washington State's experience implementing the Affordable Care Act "Expansion Adult" coverage group in January 2014.

Table 1 provides the estimated number of Medicare beneficiaries eligible for SSI-related Medicaid under current eligibility criteria (approximately 75 percent FPL income limit and $2,000/$3,000 asset limits), and under the expansion options. Based on 2023 population data, about 53,400 additional persons would be eligible for Medicaid by raising the income limits to 100 percent of FPL, and an additional 17,100 would be eligible if asset limits were eliminated.

TABLE 1.

Estimated Number of Washington State Medicare Beneficiaries

By age group, income level, and asset threshold, Calendar Year 2023

GROUP 1 Medicare Beneficiaries Age 65 & Older			
Income Levels	Existing Asset Limit ($2,000 Single Person & $3,000 Couple)	No Asset Limit	Number Gaining Eligibility with Elimination of Asset Limit at Specified Income Level
Below 75% FPL	*78,871* *	87,876	9,005
75% - 80% FPL	10,406	11,789	1,383
80% - 85% FPL	6,672	7,609	937
85% - 90% FPL	7,679	8,800	1,121
90% - 95% FPL	7,750	8,918	1,167
95% - 100% FPL	7,379	8,479	1,100

GROUP 2 Medicare Beneficiaries Under Age 65			
Income Levels	Existing Asset Limit ($2,000 Single Person & $3,000 Couple)	No Asset Limit	Number Gaining Eligibility with Elimination of Asset Limit at Specified Income Level
Below 75% FPL	*26,700* *	28,125	1,424
75% - 80% FPL	2,443	2,621	179
80% - 85% FPL	2,767	2,958	191
85% - 90% FPL	2,870	3,082	212
90% - 95% FPL	2,643	2,851	208
95% - 100% FPL	2,790	3,002	212

* Eligible under current rules.

SOURCE: Hunter Plumer, MHA.

DATA: American Community Survey (ACS) 5-Year (2018-2022) Public Use Microdata Sample (PUMS). Medicare Current Beneficiary Survey (MCBS), 2018. CMS Program Statistics - Medicare Enrollment Dashboard Data, 2023.

Table 2 provides the HCA per capita cost assumptions associated with the projected increase in enrollment. HCA-paid medical claims and Health Home payments were calculated by RDA based on SFY 2023 experience for fee-for-service CN Aged and Disabled clients, with a 3 percent annual trend factor. Contracted transportation and interpreter services costs are based on SFY 2023 data from the February 2024 OFM per cap forecast with a 3 percent annual trend factor. Behavioral health per caps are based on CY 2024 Behavioral Health Services Only (BHSO) per caps, also trended using a 3 percent annual trend factor. We assume a 50 percent General Fund State (GF-S) share of these costs. Since we anticipate most persons newly eligible for CN coverage under the proposed expansion options would be transitioning from QMB-only coverage, we do not estimate additional costs associated with coverage of Medicare premiums, coinsurance, or copayments.

TABLE 2.
GF-S Component of Base HCA Medical, BHSO, and Medicare Part D Clawback PMPM Estimates

		Age Group	
Component	**Time Period**	65+	Under 65
BHSO Capitation	CY 2024	$22.00	$101.81
ProviderOne HCA-Paid Claims and Health Home Payments	SFY 2023	$52.10	$53.68
Non-Emergency Transportation and Interpreter Services	SFY 2023	$10.35	$9.94
Part D Clawback	SFY 2025	$225.52	$225.52

In addition to impacts on Medicaid medical and behavioral health costs, the proposed eligibility changes would increase Medicare Part D clawback costs. The GF-S cost of the Part D clawback is substantially larger than the GF-S share of medical and behavioral health service costs for the expansion populations and reflects a cost shift from federal to state funds for existing Medicare Part D coverage for persons who would become full-benefit dual eligibles under the expanded rules. Our estimates assume 100 percent Part D take up; to the extent Part D enrollment would be less than 100 percent, costs would be lower than projected here.

We estimated cost offsets associated with beneficiaries who would transition to CN Medicaid coverage from Medically Needy (MN) coverage or a “Limited Medicaid Benefit” Medicare Savings Program (QMB-only coverage) as a result of the proposed eligibility changes. These offsets are modest in magnitude, relative to the projected increase in HCA medical, behavioral health, and Part D clawback costs. A detailed workbook containing all financial modeling summarized in this report, including estimated MN and QMB-only offsets, is available from RDA.

Combining forecast increased coverage months with projected per cap costs and enrollment ramp-up assumptions produces the overall estimates presented for the 100% FPL options in Table 3. Table 4 provides adjustment factors for the scenarios associated with lower FPL income limit options, derived directly from the base population estimates reported in Table 1. We note that the cost associated with eliminating asset limits decreases at a slower rate as FPL levels are reduced, because a significant proportion of persons who would gain eligibility due to this change have income below 75% FPL. Estimated overall HCA cost impacts for all options are summarized in Table 11 in the final section of this report.

TABLE 3.

Summary of HCA GF-S State Impacts of Options to Expand SSI-Related Categorically Needed Coverage: 100% FPL Options

Option 1A. Expand to 100% FPL with Current Asset Limit							
	HCA Medical/BH						
SFY	Member Months 65+	Member Months Under 65	GF-S 65+	GF-S Under 65	Part D Clawback GF-S Total	HCA MN and MSP Offsets GF-S	HCA Total GF-S
2028	91,372	35,009	$8,968,429	$6,487,198	$31,144,304	($5,969,334)	**$40,630,598**
2029	232,047	87,374	$23,459,316	$16,676,149	$81,076,769	($10,540,138)	**$110,672,097**
2030	271,384	99,988	$28,259,270	$19,656,327	$97,091,320	($10,856,342)	**$134,150,575**
2031	291,244	104,968	$31,237,166	$21,254,214	$106,692,936	($11,182,032)	**$148,002,284**

Option 1B. Expand to 100% FPL with no Asset Limit							
	HCA Medical/BH						
SFY	Member Months 65+	Member Months Under 65	GF-S 65+	GF-S Under 65	Part D Clawback GF-S Total	HCA MN and MSP Offsets GF-S	HCA Total GF-S
2028	125,078	41,294	$12,276,771	$7,651,898	$40,999,471	($7,304,864)	**$53,623,276**
2029	317,646	103,061	$32,113,166	$19,670,153	$106,785,661	($12,898,302)	**$145,670,677**
2030	371,494	117,940	$38,683,762	$23,185,386	$127,957,325	($13,285,251)	**$176,541,221**
2031	398,680	123,813	$42,760,167	$25,070,155	$140,698,485	($13,683,809)	**$194,844,998**

TABLE 4.

Adjustment Factors Relative to 100% FPL Option Estimates

	FPL Change with Existing Asset Limit - CN Medicaid Caseload Impact	FPL Change with Elimination of Asset Limit - CN Medicaid Caseload Impact	Assets Limit Elimination Impact on ALTSA and DDA Caseloads
95% FPL Option as a Percent of 100% FPL Option			
Age 65+	81.5%	84.5%	92.5%
Under Age 65	79.4%	81.2%	91.3%
Overall	81.0%	83.7%	92.3%
90% FPL Option as a Percent of 100% FPL Option			
Age 65+	62.1%	68.1%	84.6%
Under Age 65	59.8%	63.3%	82.7%
Overall	61.5%	67.0%	84.3%
85% FPL Option as a Percent of 100% FPL Option			
Age 65+	42.8%	52.0%	77.0%
Under Age 65	38.5%	43.9%	73.9%
Overall	41.7%	50.2%	76.5%
80% FPL Option as a Percent of 100% FPL Option			
Age 65+	26.1%	38.1%	70.6%
Under Age 65	18.1%	25.4%	66.1%
Overall	24.1%	35.2%	70.0%
75% FPL Option as a Percent of 100% FPL Option			
Age 65+	0.0%	16.5%	61.2%
Under Age 65	0.0%	8.9%	58.7%
Overall	0.0%	14.8%	60.8%

ALTSA and DDA LTSS Estimates

In this section we estimate the impacts on ALTSA and DDA LTSS expenditures. Because persons with income up to (and above) 100 percent FPL are already eligible for ALTSA and DDA LTSS services through a variety of waiver programs, we do not anticipate a significant effect on program costs associated with the proposed changes to income eligibility criteria. Estimated impacts on ALTSA and DDA program costs are based solely on the elimination of asset limits at the proposed income levels.

The estimated number of additional Medicare beneficiaries who would become eligible for CN Medicaid coverage with the elimination of asset limits at the proposed income levels can be inferred from Table 1 above for the CY 2023 baseline period. As a proxy for LTSS utilization in the expansion population, we applied Medicaid LTSS utilization risk weights developed for the full-benefit dual eligible population using available Medicare claims data, and then applied those risk models to the QMB-only population based on their available Medicare claims data.

Table 5 provides estimates of per-member, per-month (PMPM) expenditures (all funds) on ALTSA and DDA Medicaid LTSS services among full-benefit Medicaid-Medicare dual eligibles in SFY 2023, by age group. LTSS services used to form these estimates include in-home personal care services, all community residential service modalities, nursing home services, and PACE program capitation payments. **Note that PMPM values are calculated over all dual eligible coverage months ("member months"), not just months of receipt of LTSS services, and hence are significantly lower than "per user per month" LTSS per caps.**

TABLE 5.

Baseline ALTSA and DDA Medicaid LTSS Expenditures (PMPM) for Full-Benefit Duals

SFY 2023, All Funds

SFY 2023	ALTSA	DDA	Total All Funds
Under 65	$889.71	$1,185.33	**$2,075.03**
65+	$1,715.53	$137.06	**$1,852.59**

The Medicaid LTSS risk modeling described above produced utilization relativity factors of 61.07% for the under 65 QMB-only population, and 50.08% for the 65 QMB-only population age 65 and above. Applying those risk relativities to Table 5 produces the Medicaid LTSS PMPM utilization estimates reported in Table 6 for the expansion populations for the SFY 2023 base year.

TABLE 6.

Risk-Adjusted Medicaid LTSS Expenditure (PMPM) Estimates Based on LTSS Risk Model for QMB-only Population, Relative to Full-Benefit Duals

SFY 2023, All Funds

SFY 2023	ALTSA	DDA	Total All Funds
Under 65	$543.30	$723.82	**$1,267.12**
65+	$859.13	$68.64	**$927.77**

PMPM trend assumptions are provided in Table 7. We assume a 50% FMAP for both ALTSA and DDA Medicaid LTSS services. PMPM trends are based on the following assumptions:

- For trending from the SFY 2023 base period to SFY 2025, we estimated the trend impact of LTSS funding increases in the 2023-25 Biennial Budget on PMPM Medicaid LTSS expenditures for CN Aged and Disabled Medicaid beneficiaries.
- For trending from SFY 2025 to SFY 2027, we estimated the forecast trend in PMPM Medicaid LTSS expenditures for CN Aged and Disabled Medicaid beneficiaries derived from June 2024 Caseload Forecast Council (CFC) and Summer 2024 ALTSA and DDA Maintenance Level Per Cap Forecast processes, using the higher of the implied PMPM Maintenance Level growth rate or 3 percent.
- For the SFY 2028 to SFY 2031 time period, we assumed PMPM Medicaid LTSS per cap growth of 3 percent.

TABLE 7.

Medicaid LTSS PMPM Trend Factors Based on ALTSA and DDA Caseload and Per Cap Forecasts

SFY	ALTSA	DDA
2024	19.11%	16.08%
2025	13.49%	8.71%
2026	3.00%	3.00%
2027	4.49%	3.00%
2028	3.00%	3.00%
2029	3.00%	3.00%
2030	3.00%	3.00%
2031	3.00%	3.00%

LTSS cost impacts estimates are based on (a) the forecast number of additional financially eligible persons due to asset limit changes alone, (b) the projected enrollment take-up trajectory, (c) baseline PMPM Medicaid LTSS utilization, (d) PMPM LTSS expenditure trends factors, and (e) federal match assumptions. GF-S expenditure estimates are reported in Table 8 for the option that would expand SSI-related eligibility to 100 percent FPL and eliminate asset limits. Table 4 above provides adjustment factors for scenarios associated with eliminating asset limits at lower FPL thresholds. Estimated overall ALTSA and DDA Medicaid LTSS service cost impacts for all options are summarized in Table 11 in the final section of this report.

TABLE 8.

Option 1B: Expand to 100% FPL with No Asset Limit

ALTSA and DDA Medicaid LTSS Services GF-S Impacts, Excludes Workload Impacts

Under Age 65			
SFY	ALTSA	DDA	Total GF-S
2028	$2,558,644	$3,136,613	**$5,695,257**
2029	$6,577,312	$8,063,053	**$14,640,364**
2030	$7,752,736	$9,503,993	**$17,256,729**
2031	$8,382,966	$10,276,584	**$18,659,550**
Age 65+			
SFY	ALTSA	DDA	Total GF-S
2028	$21,696,965	$1,595,001	**$23,291,967**
2029	$56,754,194	$4,172,151	**$60,926,345**
2030	$68,366,531	$5,025,804	**$73,392,335**
2031	$75,570,837	$5,555,412	**$81,126,249**

To estimate workload impacts, we assume ALTSA and DDA LTSS cost impacts would be distributed across in-home personal care and community residential service settings in proportion to expenditure projections for SFY 2027 based on (a) the June 2024 CFC ALTSA and DDA caseload forecasts and (b) the associated projections from the Summer 2024 ALTSA and DDA Per Cap Forecast. We assume no impact on nursing facility caseloads. Community residential service modalities include adult family home, adult residential care, and assisted living facility settings. In-home services may be provided by individual or agency providers.

Estimated ALTSA and DDA monthly caseload impacts are presented in Table 9 for the option that would expand SSI-related eligibility to 100 percent FPL and eliminate asset limits. Estimated monthly caseload impacts were translated into ALTSA and DDA staffing cost impacts based on formulas provided by ALTSA and DDA finance staff. ALTSA and DDA workload cost estimates are provided for all options in Table 11. Formulas mapping caseload impacts to staffing levels and costs are contained in the detailed modeling workbook available from RDA.

TABLE 9.
Average Monthly LTSS Caseload Impacts
Option 1B: Expand to 100% FPL with no Asset Limit

ALTSA HCBS					
SFY	**Adult Family Home**	**Adult Residential Care**	**Assisted Living**	**Individual Provider**	**Agency Provider**
2028	161	42	43	427	193
2029	408	107	109	1083	490
2030	476	125	127	1263	572
2031	509	133	136	1353	612

DDA Medicaid Personal Care				
SFY	**Adult Family Home**	**Adult Residential Care**	**Individual Provider**	**Agency Provider**
2028	17	1	138	17
2029	42	2	346	44
2030	49	2	399	50
2031	52	2	422	53

ESA Estimates

This section provides estimates of ESA CSO eligibility staff workload and ACES system change costs developed by ESA fiscal and policy staff and DSHS Technology Innovation Administration staff. Detailed modeling workbooks underlying these estimates are available upon request.

CSO eligibility staff workload cost estimates are relatively modest, under the assumption that most persons in the expanded eligibility group would already be receiving assistance through other programs. ESA GF-S cost impacts are presented for the 100% FPL options in Table 10. Table 4 above provides adjustment factors for the scenarios associated with lower FPL income limit options. Estimated overall ESA GF-S cost impacts for all options are summarized in Table 11 in the final section of this report. Note that ACES system change costs are fixed across all options and include costs incurred in the 2025-27 Biennium.

TABLE 10.
ESA GF-S Financial Impact Summary

Option 1A: Expand to 100% FPL with Current Asset Limit				
SFY	GF-S	GF-F	Total All Funds	FTE
2026	$242,000	$242,000	$484,000	0.9
2027	$239,500	$239,500	$479,000	0.9
2028	$468,500	$468,500	$937,000	6.4
2029	$568,500	$568,500	$1,137,000	9.8
2030	$629,000	$629,000	$1,258,000	10.2
2031	$629,000	$629,000	$1,258,000	10.2

Option 1B: Expand to 100% FPL with no Asset Limit				
SFY	GF-S	GF-F	Total All Funds	FTE
2026	$242,000	$242,000	$484,000	0.9
2027	$239,500	$239,500	$479,000	0.9
2028	$508,000	$508,000	$1,016,000	7.0
2029	$629,000	$629,000	$1,258,000	10.9
2030	$758,500	$758,500	$1,517,000	12.4
2031	$758,500	$758,500	$1,517,000	12.4

Summary

The options for expanding Apple Health CN coverage for SSI-related individuals would have financial impacts in several HCA and DSHS program areas, including:

- HCA medical and behavioral health service utilization and associated capitation payments for CN Aged and Disabled coverage groups,
- Cost offsets associated with Medically Needy and QMB-Only coverage group members who would shift to a CN coverage group,
- Medicare Part D Clawback payments from HCA to CMS tied to the size of the dual eligible caseload which would increase under the specified options,
- DSHS ALTSA and DDA LTSS costs,
- ALTSA, DDA, and AAA staff workload costs associated with increased LTSS caseloads,
- ESA staff workload costs associated with increased medical eligibility processing, and
- Costs associated with the ACES programming changes required to implement the proposed eligibility changes.

Except where explicitly noted, only GF-S costs are referenced in this report. GF-F cost estimates are included in the detailed modeling workbooks available from RDA. As summarized in Table 11 below, the options for expanding SSI-related CN Medicaid coverage are associated with estimated full-implementation SFY 2031 costs ranging from $35.2 million to $302.4 million GF-S. In addition to the costs summarized in Table 11, there would be ACES programming change costs of $242,000 GF-S and $239,500 GF-S in SFYs 2026 and 2027, respectively.

Medicare Part D Clawback costs represent a significant share of estimated impacts on HCA GF-S costs. Projected ALTSA and DDA LTSS costs impacts accrue only in options involving elimination of asset limits, and in those scenarios reflect a significant proportion of overall estimated impacts on GF-S costs. We note that the cost associated with eliminating asset limits

decreases at a slower rate as FPL levels are reduced, because a significant proportion of persons who would gain eligibility due to this change have income below 75% FPL.

TABLE 11.
Summary of GF-S State Impacts of Options to Expand SSI-Related Categorically Needed Medicaid Coverage

Option 1A. Expand to 100% FPL with Current Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$40,631,000	$0	$0	$85,500	$383,000	**$41,099,500**
2029	$110,672,000	$0	$0	$0	$568,500	**$111,240,500**
2030	$134,151,000	$0	$0	$0	$629,000	**$134,780,000**
2031	$148,002,000	$0	$0	$0	$629,000	**$148,631,000**

Option 1B. Expand to 100% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$53,623,000	$28,988,000	$2,032,000	$85,500	$422,500	**$85,151,000**
2029	$145,671,000	$75,567,000	$5,322,000	$0	$629,000	**$227,189,000**
2030	$176,541,000	$90,649,000	$6,390,000	$0	$758,500	**$274,338,500**
2031	$194,845,000	$99,786,000	$7,048,000	$0	$758,500	**$302,437,500**

Option 2A. Expand to 95% FPL with Current Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$32,837,000	$0	$0	$85,500	$310,000	**$33,232,500**
2029	$89,456,000	$0	$0	$0	$460,000	**$89,916,000**
2030	$108,440,000	$0	$0	$0	$509,000	**$108,949,000**
2031	$119,645,000	$0	$0	$0	$509,000	**$120,154,000**

Option 2B. Expand to 95% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$44,791,000	$26,769,000	$1,876,000	$85,500	$342,000	**$73,863,500**
2029	$121,697,000	$69,780,000	$4,915,000	$0	$509,000	**$196,901,000**
2030	$147,502,000	$83,707,000	$5,901,000	$0	$614,000	**$237,724,000**
2031	$162,808,000	$92,145,000	$6,508,000	$0	$614,000	**$262,075,000**

Option 3A. Expand to 90% FPL with Current Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$24,926,000	$0	$0	$85,500	$251,000	**$25,262,500**
2029	$67,907,000	$0	$0	$0	$372,000	**$68,279,000**
2030	$82,320,000	$0	$0	$0	$412,000	**$82,732,000**
2031	$90,829,000	$0	$0	$0	$412,000	**$91,241,000**

Option 3B. Expand to 90% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$35,795,000	$24,443,000	$1,713,000	$85,500	$277,000	**$62,313,500**
2029	$97,270,000	$63,719,000	$4,488,000	$0	$412,000	**$165,889,000**
2030	$117,904,000	$76,436,000	$5,388,000	$0	$497,000	**$200,225,000**
2031	$130,149,000	$84,141,000	$5,943,000	$0	$497,000	**$220,730,000**

Option 4A. Expand to 85% FPL with Current Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$16,848,000	$0	$0	$85,500	$203,000	**$17,136,500**
2029	$45,913,000	$0	$0	$0	$301,000	**$46,214,000**
2030	$55,668,000	$0	$0	$0	$334,000	**$56,002,000**
2031	$61,431,000	$0	$0	$0	$334,000	**$61,765,000**

Option 4B. Expand to 85% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$26,660,000	$22,188,000	$1,556,000	$85,500	$224,000	**$50,713,500**
2029	$72,473,000	$57,839,000	$4,073,000	$0	$334,000	**$134,719,000**
2030	$87,868,000	$69,383,000	$4,891,000	$0	$402,000	**$162,544,000**
2031	$97,011,000	$76,377,000	$5,395,000	$0	$402,000	**$179,185,000**

Option 5A. Expand to 80% FPL with Current Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$9,570,000	$0	$0	$85,500	$164,000	**$9,819,500**
2029	$26,106,000	$0	$0	$0	$244,000	**$26,350,000**
2030	$31,674,000	$0	$0	$0	$270,000	**$31,944,000**
2031	$34,972,000	$0	$0	$0	$270,000	**$35,242,000**

Option 5B. Expand to 80% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$18,483,000	$20,281,000	$1,421,000	$85,500	$181,000	**$40,451,500**
2029	$50,284,000	$52,867,000	$3,723,000	$0	$270,000	**$107,144,000**
2030	$60,997,000	$63,418,000	$4,470,000	$0	$325,000	**$129,210,000**
2031	$67,374,000	$69,810,000	$4,931,000	$0	$325,000	**$142,440,000**

Option 6B. Expand to 75% FPL with no Asset Limit						
SFY	HCA Med/BH/Part D Total GF-S	ALTSA/DDA LTSS Total GF-S	ALTSA/AAA/DDA Workload Total GF-S	ESA ACES Changes GF-S	ESA Workload GF-S	Total GF-S
2028	$7,691,000	$17,638,000	$1,236,000	$85,500	$133,000	**$26,783,500**
2029	$20,935,000	$45,981,000	$3,239,000	$0	$198,000	**$70,353,000**
2030	$25,406,000	$55,158,000	$3,888,000	$0	$219,000	**$84,671,000**
2031	$28,071,000	$60,717,000	$4,289,000	$0	$219,000	**$93,296,000**