



# MAKING THE CONNECTION

Meeting Requirements to Enroll  
People with Mental Illnesses in  
Healthcare Coverage

Judge David L. Bazelon Center for Mental Health Law



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**Making The Connection** is a publication of the Judge David L. Bazelon Center for Mental Health Law, developed by Jennifer Mathis, the center's Director of Programs; Bethany Lilly, Policy Attorney; Elaine Alfano, Deputy Policy Director; and Robert Bernstein, President and CEO.

The Bazelon Center gratefully acknowledges the essential support provided by

**The Robert Wood Johnson Foundation**

and

**The Morton K. and Jane Blaustein Foundation**

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June 2014

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# The Importance of Enrolling People with Serious Mental Illnesses in Healthcare Coverage

Historically, a substantial number of people with serious mental illnesses have lacked healthcare coverage. Many, while impoverished, have not qualified for Medicaid and instead have been reliant upon state-funded programs that often provide little beyond medications and emergency services. Lacking access to the services they need, these individuals have been at high risk of hospitalization for physical and mental health needs, homelessness, arrest and incarceration. These adverse outcomes not only affect the individuals with mental illnesses, but also their families and their communities. Furthermore, these preventable poor outcomes create substantial costs for state and local governments.

The Medicaid Expansion available to states under the Affordable Care Act (ACA), as well as coverage of individuals through the ACA's Marketplaces, can dramatically change this scenario in human terms, as well as in terms of costs incurred by state and local governments. Furthermore, legal mandates under the Americans with Disabilities Act (ADA) and the ACA require states to take affirmative steps to help people with disabilities enroll in states' Medicaid Expansion plans and Marketplaces.

In this report, we explore strategies that are useful to increase enrollment of individuals with serious mental illnesses in the Medicaid Expansion and Marketplaces. We first describe how these healthcare options enable states to offer expansive mental health services that vastly improve the lives of individuals with serious mental illnesses, and to realize savings by receiving enhanced federal reimbursement and by reducing hospitalization, homelessness, and incarceration. We explain how taking steps to maximize enrollment not only enables individuals and states to benefit from the ACA's healthcare options, but is also a requirement to comply with the ADA: states must provide people with disabilities equal opportunity to participate in their healthcare programs and must make reasonable modifications to their enrollment processes in order to meet the needs of people with disabilities. Maximizing enrollment of individuals with serious mental illnesses also helps states comply with their ADA obligation to administer services to people with disabilities in the most integrated setting appropriate. We present examples of outreach and enrollment strategies that have proven effective in connecting people with serious mental illnesses to other vital benefits, including several existing outreach and enrollment programs targeting homeless individuals with mental illnesses. Finally, we describe how we can build upon experience with these programs to create successful outreach and enrollment strategies that connect individuals with serious mental illnesses with healthcare coverage and states to fulfill their legal obligations. Recommendations include having outreach and enrollment programs use active one-on-one assistance that meets individuals where they live or receive services, involving community service providers, involving peers, and targeting efforts to incarcerated individuals.

## Tremendous Benefits...With Cost Savings

The ACA's Medicaid Expansion eliminates eligibility barriers that previously kept many people with mental illness out of states' Medicaid programs, and for the first time affords these individuals coverage for the services they critically need. Moreover, the Expansion not only allows states to offer them Medicaid coverage, but to do so almost entirely at federal expense.

People with serious mental illnesses are particularly well served by the Medicaid Expansion. They are among the group of individuals considered "medically frail" under the ACA.<sup>1</sup> This designation entitles them to opt out of receiving their Medicaid benefits under the new "alternative benefit plans" created under the ACA, and instead receive traditional Medicaid coverage.<sup>2</sup> States' traditional Medicaid plans often have more expansive coverage of services that are important for people with serious mental illnesses than do the alternative plans. These include specialized services such as assertive community treatment (ACT), case management, mobile crisis, supported employment, and peer support services.

Thus, the Medicaid Expansion allows states to realize savings through reimbursements for the often limited package of services to uninsured individuals that had been financed with state funds. Because these under-served individuals had been at extraordinarily high risk of adverse events such as emergency room care, hospitalization, and involvement with police and justice systems—also at the expense of state and local

governments—the vastly expanded scope of covered services can mean additional significant human and cost benefits. Finally, the services covered by Medicaid allow people with serious mental illnesses to live successfully in integrated settings in their communities, thus helping states to fulfill their obligations under the ADA.

For all of these reasons, the ACA's Medicaid Expansion is a critically important opportunity for people with low incomes who have mental illnesses, and for state and local governments. Similarly, the ACA's Insurance Exchanges, or

**The services covered by Medicaid allow people with serious mental illnesses to live successfully in integrated settings in their communities, thus helping states to fulfill their obligations under the ADA.**

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<sup>1</sup> 42 C.F.R. 440.315; Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160, 42306 (July 15, 2013).

<sup>2</sup> 42 U.S.C. § 1937(2)(B)(vi); Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160, 42306 (July 15, 2013).

Marketplaces, afford needed coverage for previously uninsured individuals with mental illnesses who do not qualify for the Medicaid Expansion. The Marketplaces offer basic health coverage and must cover a package of “essential health benefits” that includes mental health services.<sup>3</sup> Like the Medicaid Expansion, the Marketplaces will make needed community services available to individuals with mental illnesses and reduce hospitalization, emergency department use, incarceration, and shelter use, saving government dollars.

But for states to fully capitalize upon these opportunities—and for people with serious mental illnesses to actually realize their benefits—it is also essential that states have the appropriate mechanisms in place to ensure that eligible individuals are enrolled.

## Many People Remain Unenrolled

The first open enrollment period for ACA coverage ended in early April 2014, with 8 million people signing up for private insurance through the Health Insurance Marketplaces.<sup>4</sup> This figure exceeded the enrollment goal set by the White House by a million individuals.<sup>5</sup> Millions of additional individuals, however, are eligible for Marketplace coverage with subsidies to offset the costs: approximately 17.2 million individuals fall into that eligibility category.<sup>6</sup>

At least 3 million individuals have been covered under the Medicaid Expansion.<sup>7</sup> Millions of others who qualify under Medicaid rules that predate the ACA enrolled for the first time in states’ traditional Medicaid plans. The federal Centers for Medicare and Medicaid Services (CMS) reports that from October 2013, when eligibility determinations for newly eligible individuals began, through February 2014, 11.7 million individuals were found to be eligible for Medicaid.<sup>8</sup> This includes not only newly eligible individuals in

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<sup>3</sup> 42 U.S. Code § 300gg–6; Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Federal Register 12834 (Feb. 25, 2013).

<sup>4</sup> The White House, Office of the Press Secretary, *FACT SHEET-872: AFFORDABLE CARE ACT BY THE NUMBERS* (April 17, 2014), available at <http://www.whitehouse.gov/the-press-office/2014/04/17/fact-sheet-affordable-care-act-numbers>.

<sup>5</sup> *Id.*

<sup>6</sup> The Henry J. Kaiser Family Foundation, *STATE-BY-STATE ESTIMATES OF THE NUMBER OF PEOPLE ELIGIBLE FOR PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT 3*, Table 1 (Nov. 2013).

<sup>7</sup> Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *Medicaid & CHIP: February 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report 3* (April 4, 2014) available at <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/February-2014-Enrollment-Report.pdf>. This number is based on incomplete information and as CMS continues to collect additional data on the Expansion enrollments that have already occurred, this number is expected to rise substantially.

<sup>8</sup> Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *Medicaid & CHIP: February 2014 Monthly Applications, Eligibility Determinations, and*

states that have adopted the Medicaid Expansion, but also individuals who were already eligible for Medicaid but had not previously applied, and individuals who renewed their Medicaid enrollment.<sup>9</sup>

Nevertheless, larger numbers of individuals who are qualified for Medicaid have not yet applied. Estimates of the newly eligible adult population in the states that have adopted the Medicaid Expansion range from 15.1 million<sup>10</sup> to 18.7 million<sup>11</sup>—considerably more than the number who have actually enrolled. Since Medicaid does not have a set open enrollment period,<sup>12</sup> those still-uninsured, eligible individuals can continue to enroll. Furthermore, only 26 states and the District of Columbia were moving forward with the Medicaid Expansion at the beginning of 2014, leaving approximately 5.7 million additional eligible individuals uninsured in the states that chose not to expand.<sup>13</sup> Debate about adopting the Expansion is ongoing in several of those states, and some may adopt the Expansion and begin enrollment in the near future.

In summary, millions of newly eligible individuals are not enrolled in Medicaid; they are left without access to health care coverage and are at high risk of adverse events with human and fiscal consequences. States are losing the opportunity to afford them coverage, virtually at complete federal expense. Accordingly, now is an important time for states to focus on outreach and enrollment efforts to the Medicaid population—especially to groups that are traditionally underserved and hard to reach. Among them are individuals with serious mental illnesses, who make up approximately 7.1 percent of newly eligible adults. As is discussed later in this report, these individuals may be unenrolled because they face special barriers, including difficulties meeting the demands of complex application processes. State, local, and federal government agencies have legal obligations to ensure that individuals with disabilities, including serious mental illnesses, have an effective opportunity to apply for needed benefits and to receive the services that allow them to live successfully in their communities.

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*Enrollment Report 5* (April 4, 2014) available at <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/February-2014-Enrollment-Report.pdf>.

<sup>9</sup> *Id.*

<sup>10</sup> Genevieve M. Kenney et al., Urban Institute, *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?* 1 (July 5, 2012), available at <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>.

<sup>11</sup> SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT TOOLKIT FOR STATES 29, TABLE 9 (2013).

<sup>12</sup> For individuals purchasing commercial healthcare coverage through their Marketplaces, there is an annual open enrollment period and changes in health insurance cannot be made unless there has been a significant change in one's life, such as marriage or birth of a child. Medicaid enrollment is ongoing for people who qualify.

<sup>13</sup> The White House, Office of the Press Secretary, *FACT SHEET: AFFORDABLE CARE ACT BY THE NUMBERS* (April 17, 2014), available at <http://www.whitehouse.gov/the-press-office/2014/04/17/fact-sheet-affordable-care-act-numbers>.

# People with Mental Illnesses May Need Assistance to Enroll

Maximizing enrollment of individuals with mental illnesses in the new ACA insurance options means taking steps to overcome a variety of barriers that impede access to health coverage. Some of these are barriers that affect low income individuals generally. Others relate more specifically to the needs of individuals with mental illnesses. States' efforts to maximize enrollment of individuals with mental illnesses need to address both types of barriers

## General Enrollment Barriers

Historically, a substantial number of Americans have not been enrolled in health coverage, even when they could have obtained publicly subsidized coverage such as Medicaid and the Children's Health Insurance Program (CHIP). A 2012 study, for example, found that only 62.6 percent of Medicaid-eligible uninsured adults (ages 19–64) were enrolled in Medicaid.<sup>14</sup> Among the key reasons for low enrollment in subsidized health care coverage include:

- **Lack of basic information about healthcare programs** Individuals may know little about how these programs work and how to apply. Misinformation also may lead individuals to assume that they need to be unemployed to qualify or believe that coverage is unaffordable, before knowing what actual out-of-pocket costs could be expected. For example, one study found that childless adults in New York City are less aware than other individuals of their eligibility for public health insurance and assume that they will not be eligible.<sup>15</sup>
- **Literacy or language barriers** Individuals may not know that personalized assistance is available to help them and that materials are available in different languages.<sup>16</sup>
- **Insufficient access to the basic tools for completing applications** Individuals may not have access to a computer, phone, or transportation to an office that

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<sup>14</sup> Benjamin D. Sommers et al., *Reasons For The Wide Variation In Medicaid Participation Rates Among States Hold Lessons For Coverage Expansion In 2014*, 31 *Health Affairs* 909, 909-19, 912 (May 2012). Authors used data from the Current Population Survey (2005-2010) for the analysis.

<sup>15</sup> Aviva Goldstein, National Center for Law and Economic Justice, *Childless Adults: Barriers to Enrollment in Public Health Insurance 2* (April 2010), available at <http://www.nclj.org/documents/ChildlessAdultsBarriersPublicHealthInsurance.pdf>.

<sup>16</sup> The Kaiser Commission on Medicaid and the Uninsured, *Getting into Gear for 2014: Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act 3*, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8445-key-lessons-from-medicaid-and-chip.pdf>.

would facilitate the submission of an application.<sup>17</sup>

- **Difficulty contacting people who are homeless or moving between different housing situations** Missing contact information for the applicant or a third-party designee may mean that enrollment and renewal applications are thwarted because of missed communications about next steps.<sup>18</sup>
- **Demands of daily living that are complicated by poverty** For individuals who are uncertain about where they will sleep or where they will get their next meal, meeting these seemingly routine needs takes significant time and attention. Immediate needs may naturally take precedence over tasks related to an application for health care coverage.<sup>19</sup>
- **Concerns about confidentiality and stigma** Individuals may be reluctant to reveal personal information about impoverishment, the presence of a disability, literacy levels, or homelessness due to negative stereotypes. Similarly, they may be reluctant to pursue any public benefit at all because of damaging attitudes about people who receive public benefits.<sup>20</sup>

## Enrollment Barriers for Individuals with Mental Illnesses

### Individuals May Need Changes to Existing Enrollment Processes

Individuals with mental illnesses may need modifications to ordinary practices in order to have an equal opportunity to enroll and participate in health insurance. Some individuals with mental illnesses may need enrollment processes to be explained in simpler terms or broken down in ways that allow them to proceed in a step-by-step fashion. Some may need to have a person assigned to follow them through the enrollment process, including working with them to gather necessary information, helping them fill out an application, and following up to ensure that the application is completed and that they are, and remain, successfully enrolled. Some may need extensions to deadlines due to periods when their disability interferes with the ability to complete an application or when they are temporarily admitted to a hospital.

Accordingly, outreach, engagement, and assistance for enrollment in health insurance should be modified as needed to accommodate disability-related needs, including by providing more extensive assistance and follow-up than ordinarily provided. This is required by both the ADA and the ACA.

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<sup>17</sup> Jodi Ray & Margeau A. Chavez, Florida Covering Kids & Families, *Providing Pathways to Coverage: A Case Evaluation of the Outreach and Enrollment Model at a Federally Qualified Health Center Network in South Central Florida* 17-18 (2013).

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

## Individuals May Need Help

### Addressing the *Disability* Question on the Application

Individuals with mental illnesses may need help in answering the Marketplace application question concerning whether they have a disability. The new, single streamlined application for Medicaid and private health plans in the Marketplace has one question to make this determination:

*Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?*

This question serves important purposes: an affirmative answer helps to identify individuals who may be eligible for traditional Medicaid,<sup>21</sup> as well as individuals who are eligible for coverage under the Medicaid Expansion but are “medically frail” and can opt to receive traditional Medicaid services.

People with mental illnesses may find this question difficult to answer. Based on the question’s examples—which focus on physical tasks—many may assume that they should not indicate that they have a disability. People with mental illnesses may experience difficulties in areas such as concentration, memory, or interpersonal interactions. Yet absent help, which may entail carefully exploring the day-to-day challenges associated with their mental illness, it may not be obvious how they should answer this important question.

In addition, some individuals may interpret the question’s reference to living in a medical facility or nursing home as suggesting that if they have a condition causing functional limitations, they may be regarded as needing institutional care. Clearly, this is not the intent of the question, but it is another factor that may cause some individuals to be reluctant to respond openly. Again, people providing enrollment assistance may need to explain the question’s actual purpose.

Finally, many people who have mental illnesses—particularly serious mental illnesses—have experienced discrimination, trauma, or coercive mental health treatment. As a result of such negative experiences, they may be reluctant to acknowledge on a healthcare application either their mental illness or associated functional limitations.

All assisters should be aware of these barriers; assisters who have personal experience with mental illness may be particularly well equipped to deal with it.

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<sup>21</sup> One of the pathways to eligibility for traditional Medicaid is having a disability along with low income and assets.

## Incarcerated Individuals Need Additional Help in Enrollment

Individuals with mental illnesses who are incarcerated face special barriers to enrollment. As discussed earlier, people with serious mental illnesses who are uninsured are at risk of incarceration and other adverse outcomes because they lack access to essential services and supports. Connecting these individuals to Medicaid coverage is critically important in reducing incarceration. Medicaid does not pay for healthcare that is provided within correctional facilities, and historically jail and prison inmates have either not qualified for Medicaid or received little help in enrolling in benefits sufficiently early for them to be seamlessly in place upon release. With significant numbers of inmates likely to be eligible for Medicaid upon their release, in states that have pursued the ACA's Medicaid Expansion it is more important than ever—and more beneficial than ever to states—to provide enrollment assistance to these individuals.

In states that have adopted the Medicaid Expansion, millions of incarcerated individuals are expected to be newly eligible for coverage upon release. Many had not qualified for Medicaid prior to the ACA.<sup>22</sup> Approximately 10 million individuals are released every year from U.S. jails, and currently most of them have no health insurance either when they enter jail or when they are released.<sup>23</sup> A very large percentage of these individuals now qualify for coverage under the Medicaid Expansion; approximately 60 percent of jail inmates have incomes less than 138 percent of poverty—the threshold for eligibility—before being arrested. Incarcerated individuals with higher incomes may find themselves eligible for Medicaid by the time they are released because their incomes will have disappeared.<sup>24</sup> Additionally, as many as one-third of jail inmates could be eligible for premium subsidies for health insurance through the Marketplace.<sup>25</sup>

Maximizing enrollment of individuals leaving correctional facilities presents a particularly significant opportunity to ensure that they are connected to the health and mental health services that they need, as well as to reduce costs to states associated with re-incarceration and preventable medical emergencies. Individuals who are incarcerated have particularly critical needs for healthcare coverage upon their

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<sup>22</sup> In the traditional Medicaid program, low-income adults without dependent children in the home were generally not eligible unless they had a disability and qualified for Supplemental Security Income (SSI) benefits. Due to the cumbersome and time-consuming process of determining SSI eligibility, many individuals with mental illnesses have not received traditional Medicaid, either because they have not qualified or because they have not managed to complete the eligibility determination process. The ACA's Medicaid Expansion, by contrast, offers coverage to anyone who has income at or below 138 percent of the poverty level.

<sup>23</sup> Center for Health Care Strategies, Inc., *Medicaid Expansion and Jail-Involved Individuals: Opportunities to Promote Coverage, Improve Health, and Reduce Recidivism* 1 (Mar. 2014), available at [http://www.chcs.org/usr\\_doc/Medicaid\\_Expansion\\_and\\_Jails\\_Fact\\_Sheet\\_032714.pdf](http://www.chcs.org/usr_doc/Medicaid_Expansion_and_Jails_Fact_Sheet_032714.pdf).

<sup>24</sup> Stephen A. Somers et al., *Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals*, 33 *Health Affairs* 455, 455-56 (May 2014).

<sup>25</sup> *Id.* at 455.

community re-entry. They are seven times as likely as the general population to experience mental illness, substance abuse disorders, infectious disease, and chronic health conditions.<sup>26</sup> Disruptions in their treatment that may occur if their health benefits are not in place upon release contribute to re-incarceration as well as poor and costly health outcomes.

## Successfully Enrolling People with Mental Illnesses Aligns with States' Legal Obligations under the ACA and the ADA

Both the ACA and the ADA require states to afford equal opportunities to individuals with disabilities, including those with mental illnesses, in their Medicaid Expansion and Marketplace healthcare programs. Both laws also require healthcare enrollment programs to accommodate the needs of people with disabilities such as serious mental illnesses in order to ensure that they have the same access to health insurance and its benefits as do other citizens. Providing people with disabilities equal access does not mean applying the same enrollment process to everyone. In fact, assuring equal access to healthcare coverage for people with mental illnesses or other disabilities requires states to do things differently to overcome barriers experienced by individuals with disabilities so that there is a “level playing field.”

In addition, the ADA requires states to administer services to people with disabilities in the most integrated setting appropriate to their needs.<sup>27</sup> Medicaid is the major funder of the community-based services for people with serious mental illnesses, and thus expanding coverage of individuals with serious mental illness through Medicaid helps states fulfill their obligations under the ADA to promote community integration.

**Providing people with disabilities equal access does not mean applying the same enrollment process to everyone.**

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<sup>26</sup> Council of State Governments, Justice Center. *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System 1* (Dec.2013) at <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.

<sup>27</sup> 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d), *Olmstead v. L.C.*, 527 U.S. 581 (1999).

## The ACA's Requirements for Assistance with Enrollment

The ACA establishes a streamlined and simplified system of enrolling in health insurance, whether through the Medicaid program or private coverage through the health insurance exchanges. The law requires each state to establish a single entity called a Marketplace through which individuals may apply for public or private coverage.<sup>28</sup> States can choose among three types of Marketplaces: (1) they can elect to create and operate their own State-Based Marketplace, (2) they can choose to leave the entire process up to the federal government, which operates Federally-Facilitated Marketplaces,<sup>29</sup> or (3) they can choose to work with the federal government to create a State Partnership Marketplace.<sup>30</sup>

States must adopt a simplified application that assesses both eligibility for Medicaid and subsidies for health plans offered in the Marketplace. Marketplaces must allow applications to be submitted online, by mail, in-person, or on the telephone.<sup>31</sup> States must automatically initiate annual re-determinations of eligibility for Medicaid, using data that can be accessed through data-matching technology. States may request additional information from beneficiaries only if eligibility cannot be determined through use of federal and state data records.<sup>32</sup>

The ACA requires Marketplaces to provide enrollment assistance programs that help people apply for the new health insurance options. It establishes several different enrollment assistance programs for the Marketplaces, including health insurance Navigators, Certified Application Counselors, and In-Person Assistance Personnel.<sup>33</sup>

Health insurance “Navigators” are responsible for enrollment outreach as well as helping individuals choose among and apply for insurance coverage under Medicaid, CHIP, and the Marketplace insurance plans—called Qualified Health Plans (QHPs).<sup>34</sup>

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<sup>28</sup> 42 C.F.R. § 435.907.

<sup>29</sup> 42 U.S.C. § 18041.

<sup>30</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310, 18325-26 (Mar. 27, 2012).

<sup>31</sup> 42 C.F.R. § 435.907.

<sup>32</sup> 42 C.F.R. § 435.916.

<sup>33</sup> There is a non-Marketplace-based enrollment program authorized by Section 1002 of the ACA, called the Consumer Assistance Programs (CAPs). CAPs are state-agency-based programs that “assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance.” 42 U.S. Code § 300gg–93. CAPs must also provide other consumer protection services such as helping consumers file complaints and appeals related to adverse determinations by health insurers and group health plans, and educate consumers about their rights and responsibilities with respect to group health plans. The initial round of CAP funding was announced in 2010, with CMS ultimately awarding grants to 36 states and the District of Columbia. The Affordable Care Act authorized necessary appropriations for CAPs to continue indefinitely. The Henry J. Kaiser Family Foundation, FOCUS ON HEALTH REFORM, CONSUMER ASSISTANCE IN HEALTH REFORM 4-6 (Apr. 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8434.pdf>.

<sup>34</sup> 42 U.S.C. § 18031(i), 45 C.F.R. § 155.210.

They are responsible for providing accurate and impartial information about these various coverage options.<sup>35</sup> All Marketplaces must have Navigators.<sup>36</sup>

Certified Application Counselors (CACs) perform many of the same duties as Navigators.<sup>37</sup> The primary differences between Navigators and CACs are that: (1) Navigators are funded through federal grants from the Department of Health and Human Services, whereas CACs must seek other funding, (2) Navigators are required to conduct outreach and education, whereas CACs are not, and (3) the Navigator program has more stringent conflict of interest requirements.<sup>38</sup> All Marketplaces must have CACs.<sup>39</sup>

Finally, In-Person Assistance Personnel (IPAPs) provide over-the-phone assistance with applications for health care coverage. State Partnership Marketplaces must use IPAPs. State-Based Marketplaces can choose to use them, and Federally-Facilitated Marketplaces do not use them.<sup>40</sup>

CMS has created trainings to ensure that these enrollment assistance programs are implemented effectively. The federal training for Navigators and CACs is mandatory in Federally-Facilitated Marketplaces and State Partnership Marketplaces, although State Partnership Marketplaces can supplement the Navigator training with any additional requirements they desire.<sup>41</sup> State-Based Marketplaces are required to provide training for their outreach and enrollment personnel, but can use the federal standards or develop their own standards.<sup>42</sup> State Partnership Marketplaces are required to use the training for IPAPs and must use federal materials, supplemented however the State Partnership Marketplace thinks necessary.<sup>43</sup> State-Based Marketplaces choose whether or not to

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<sup>35</sup> 45 C.F.R. § 155.210.

<sup>36</sup> 45 C.F.R. § 155.205.

<sup>37</sup> 45 C.F.R. § 155.225.

<sup>38</sup> Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, Common Questions and Answers on Designation of Certified Application Counselor (CAC) Organizations in Federally-Facilitated Marketplaces, Question 45, available at <http://marketplace.cms.gov/help-us/common-qandas-about-cac-designation.pdf>.

<sup>39</sup> 45 C.F.R. § 155.225(b).

<sup>40</sup> 45 C.F.R. § 155.205.

<sup>41</sup> Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Navigators and Other Marketplace Assistance Programs* (May 2013); Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, *Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace* 12 (Jan. 2014), available at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/marketplace-ways-to-help.pdf>.

<sup>42</sup> *Id.*

<sup>43</sup> Patient Protection and Affordable Care Act; *Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors*, 78 Fed. Reg. 42824, 42826 (July 17, 2013); 45 C.F.R. §§ 155.205, 155.210, 155.225. See also, Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, *Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace* (Jan. 2014) available at

have IPAPs and “CMS training standards would apply if paid for with federal Exchange Establishment grant funds.”<sup>44</sup>

Trainings for all of these enrollment assistance programs are required to ensure that the programs are accessible to individuals with disabilities.<sup>45</sup> Navigator training must “ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.”<sup>46</sup> CACs must provide “information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et seq. and section 504 of the Rehabilitation Act, as amended, 29 U.S.C. 794,” either directly or through referral to a Navigator, Exchange call center, or other assistance personnel.<sup>47</sup> In-Person Assistance Personnel must be trained to ensure that all “[i]nformation must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to . . . [i]ndividuals living with disabilities [...] in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.”<sup>48</sup>

The success of the first enrollment period demonstrates the importance of enrollment assistance programs in maximizing enrollment in health care coverage. Allocation of sufficient resources to these programs during future enrollment periods is critical. It is equally critical to ensure that these programs are conducted in a way that any programs funded are meeting the legal obligations, and workers are trained to provide individuals with mental illnesses with an equal opportunity to participate, in the ways discussed below.

The Robert Wood Johnson Foundation has funded a National Disability Navigator Resource Collaborative to help develop cross-disability competence among Navigators and other enrollment specialists. The project, conducted by seven national disability organizations, has developed materials including a technical assistance guide, fact sheets, and issue briefs. These materials and other information are available at <http://www.nationaldisabilitynavigator.org>.

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<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/marketplace-ways-to-help.pdf>.

<sup>44</sup> *Id.*

<sup>45</sup> Patient Protection and Affordable Care Act; *Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors*, 78 Fed. Reg. 42824 (July 17, 2013).

<sup>46</sup> 45 C.F.R. § 155.210(e)(5).

<sup>47</sup> 45 C.F.R. § 155.225(d)(5).

<sup>48</sup> 45 C.F.R. § 155.205.

## **Federal Law Requires Reasonable Modifications that Offer Individuals with Disabilities an Equal Opportunity to Participate**

Title II of the ADA prohibits state and local government entities from discriminating based on disability in their programs, services and activities.<sup>49</sup> They must afford people with disabilities an equal opportunity to participate in or benefit from aids, benefits and services.<sup>50</sup> They must not use methods of administration that have the effect of discriminating on the basis of disability, or of “substantially impairing accomplishment of the objectives of the public entity’s program with respect to individuals with disabilities.”<sup>51</sup> To these ends, state and local government entities must make reasonable modifications in policies, practices and procedures to ensure equal opportunity for individuals with disabilities.<sup>52</sup> Section 504 of the Rehabilitation Act imposes parallel requirements on federal agencies and on any program or activity receiving federal funds.<sup>53</sup>

Courts have required the Social Security Administration, for example, to make reasonable modifications to its benefits programs in order to ensure that individuals with disabilities have equal opportunities to participate in these programs. In *American Council of the Blind v. Astrue*, a federal court required the Social Security Administration to

**State Medicaid Expansion programs and state and federal Marketplaces are required by the ADA and/or Section 504 to make reasonable modifications to ensure that individuals with serious mental illnesses have equal opportunities to apply for and receive insurance coverage.**

develop a Braille alternative and a navigable Microsoft Word CD alternative to all of its communications with SSI and SSDI beneficiaries and offer such alternatives to all beneficiaries and representative payees known to have a visual impairment.<sup>54</sup> In a settlement in another federal case brought under Section 504, the Social Security Administration agreed to make reasonable modifications for two benefits recipients with mental illnesses and intellectual disabilities, including having specific SSA staffers assigned to the individuals to meet with the individuals upon request, explain SSA communications to them, and help them respond to SSA communications; providing summaries of the meetings in simplified

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<sup>49</sup> 42 U.S.C. § 12132.

<sup>50</sup> 28 C.F.R. § 35.130(b)(1)(ii).

<sup>51</sup> 28 C.F.R. § 35.130(b)(3).

<sup>52</sup> 28 C.F.R. § 35.130(b)(7). A modification is not reasonable if it would fundamentally alter the service, program or activity. *Id.*

<sup>53</sup> 29 U.S.C. § 794(a).

<sup>54</sup> Findings of Fact and Conclusions of Law, *American Council of the Blind v. Astrue*, Case No. 05-04696, 39 (N.D. Cal. Oct. 3, 2008)

language; requiring the SSA staffers to meet with the individuals' treatment professionals and caregivers to discuss how to effectively communicate with the individuals; and including a notation in SSA files requiring other SSA staff involve the specially assigned staff in any substantive discussions with the individuals.<sup>55</sup>

Similarly, state Medicaid Expansion programs and state and federal Marketplaces are required by the ADA and/or Section 504 to make reasonable modifications to ensure that individuals with serious mental illnesses have equal opportunities to apply for and receive insurance coverage.<sup>56</sup> For example, reasonable modifications must be made to ensure that they have equal opportunities to enroll in these programs. Reasonable modifications might involve having a Navigator, Certified Application Counselor, or staff administering the Medicaid program or Marketplace provide extra assistance in order to help an individual gather the necessary information to apply, ensure that the individual meets requisite deadlines, and explain the process in understandable terms.

### **Federal Law Requires that Services Be Administered to Individuals with Disabilities in the Most Integrated Setting Appropriate**

The ADA also requires state and local governments to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. This requirement—sometimes known as the “integration mandate”—reflects one of the core purposes of the ADA, to promote integration of individuals with disabilities into all aspects of mainstream society.<sup>57</sup>

The ADA’s “integration mandate” was recognized by the United States Supreme Court in the landmark *Olmstead v. L.C.* decision, which held that the needless segregation of individuals with disabilities is a form of discrimination under the ADA.<sup>58</sup> The *Olmstead* decision requires public entities to offer services in the most integrated setting to individuals with serious mental illnesses, unless doing so would fundamentally alter their service systems.<sup>59</sup> The Justice Department, which enforces Title II of the ADA, has clarified that the most integrated setting is one “that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”<sup>60</sup> For virtually all

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<sup>55</sup> Stipulation for Compromise, Settlement, and Releases, *Davis v. Astrue* and *Doe v. Astrue*, Case No. 06-6108 & No. 09-980, 4-8 (N.D. Cal. Jun. 19, 2012), available at <http://www.pwdf.org/wp-content/uploads/2013/11/Stip-for-Com-Settlement-signed-by-Judge-Chen.6.19.12.pdf>.

<sup>56</sup> State Medicaid Expansion programs, State-Based Marketplaces, and State Partnership Marketplaces, as state programs, services and activities, are covered by Title II of the ADA. They are also covered by Section 504 due to their receipt of federal funds. Federally-Facilitated Marketplaces, as programs or services of a federal agency, are covered by Section 504.

<sup>57</sup> Section 504 imposes a parallel requirement.

<sup>58</sup> 527 U.S. 581 (1999).

<sup>59</sup> 527 U.S. at 604-07.

<sup>60</sup> 28 C.F.R. Part 35 App. § 35.130(b)(4).

individuals with disabilities, this setting is their own home or apartment.<sup>61</sup>

The ACA is an important tool that may be used to help states comply with the integration mandate.<sup>62</sup> Even without the Medicaid Expansion, states may offer Medicaid services such as supported housing, assertive community treatment (ACT), intensive case management, mobile crisis services, supported employment, and peer supports that enable Medicaid recipients with serious mental illnesses to avoid needless institutionalization.<sup>63</sup> States that adopt the Medicaid Expansion can provide these services to millions of additional individuals with serious mental illnesses, essentially at federal expense. Similarly, the availability of insurance

coverage to individuals with serious mental illnesses through the Marketplaces will reduce the needless use of segregated service settings such as hospitals, emergency departments, and shelters and will help states comply with the ADA.

Thus, increasing enrollment and fully capitalizing upon the opportunities afforded through the Medicaid Expansion and the Marketplaces to individuals who were heretofore uninsured can significantly improve states' abilities to meet their ADA obligations to people with serious mental illnesses.

**Increasing enrollment and fully capitalizing upon the opportunities afforded through the Medicaid Expansion and the Marketplaces to individuals who were heretofore uninsured can significantly improve states' abilities to meet their ADA obligations to people with serious mental illnesses.**

## **The ACA Also Prohibits Disability-Based Discrimination**

Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in "any health program or activity" established or supported by the ACA.<sup>64</sup> HHS's Office of Civil Rights is developing proposed regulations to

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<sup>61</sup> U.S. Senate Health, Education, Labor and Pensions Committee, SEPARATE AND UNEQUAL: STATES FAIL TO FULFILL THE COMMUNITY LIVING PROMISE OF THE AMERICANS WITH DISABILITIES ACT 4 (Jul. 18, 2013), available at <http://www.harkin.senate.gov/documents/pdf/OlmsteadReport.pdf>.

<sup>62</sup> This is discussed in detail in the Bazelon Center for Mental Health Law publication, WHEN OPPORTUNITY KNOCKS . . . HOW THE AFFORDABLE CARE ACT CAN HELP STATES DEVELOP SUPPORTED HOUSING FOR PEOPLE WITH MENTAL ILLNESSES, available at <http://www.bazelon.org/portals/0/Where%20We%20Stand/Community%20Integration/Olmstead/When%20Opportunity%20Knocks.%20Bazelon%20Center%20for%20Mental%20Health%20Law.pdf>.

<sup>63</sup> See, e.g., U.S. Dept. of Justice, QUESTIONS AND ANSWERS ON THE ADA'S INTEGRATION MANDATE AND OLMSTEAD ENFORCEMENT, Question and Answer 15, available at [http://www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf) (remedies for needless institutionalization should include supported housing, ACT teams, crisis services, case management, peer support services, supported employment and other services).

<sup>64</sup> 42 U.S.C. § 18116.

implement this provision, but at a minimum, the ACA's non-discrimination provision requires that ACA programs—including the Medicaid Expansion and the Marketplaces—provide reasonable modifications needed to ensure equal opportunity for individuals with disabilities to participate and benefit, and afford them the opportunity to receive services in the most integrated setting.

## Strategies for Maximizing Enrollment of Individuals with Serious Mental Illnesses

### Building on Existing Outreach and Enrollment Programs

There are a number of highly successful programs that provide outreach and enrollment assistance targeted to individuals with serious mental illnesses who are homeless. While generic outreach and enrollment programs have typically not been adept in engaging these individuals, these targeted programs have a proven track record of significantly increasing enrollment in benefits programs. They offer useful strategies that may be translated to efforts to maximize enrollment of individuals with mental illnesses in the Medicaid Expansion or Marketplace health coverage.

Three established, specialized outreach and enrollment programs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that aim to connect people with serious mental illness who are homeless or at risk of homelessness with benefits are particularly instructive: (1) an early demonstration program called Access to Community Care and Effective Services and Supports (ACCESS), (2) the Projects for Assistance in Transition from Homelessness (PATH) program, and (3) the SSI/SSDI Outreach, Access, and Recovery (SOAR) program.

Additionally, the Outstationed Eligibility Workers program, which aims to increase Medicaid participation among uninsured individuals, is a useful model. Finally, programs that focus on enrolling individuals with serious mental illnesses in benefits upon release from incarceration also offer useful approaches.

These programs, discussed in detail below, serve as important building blocks for outreach and enrollment efforts to connect individuals with serious mental illnesses with ACA coverage.

## Access to Community Care and Effective Services & Supports (ACCESS)

Begun in 1993, ACCESS was a five-year demonstration project sponsored by the US Department of Health and Human Services.<sup>65</sup> The project attempted to address issues identified by the 1992 Federal Task Force on Homelessness and Severe Mental Illness, primarily by “creating integrated service systems that would allow homeless persons with mental illnesses to gain access to the full complement of services they required regardless of their point of entry.”<sup>66</sup> In addition to funding changes to the service system, the program funded all ACCESS locations to conduct “intensive outreach to homeless persons in the community.”<sup>67</sup> This outreach program collected substantial data, including information about the hardest-to-reach individuals and how to best contact them.

ACCESS Outreach focused on providing “basic services” and “building a relationship with the potential client” which was designed to engage individuals over time in case-management services.<sup>68</sup> The program focused on providing outreach to individuals where they are, including both “street outreach,” where the outreach workers met with individuals on the street, and “services setting” outreach, where the outreach workers collaborated with service providers to meet with individuals who came in to receive services from a health or social services provider.<sup>69</sup>

A study surveying the data collected through the ACCESS project determined that individuals in service settings were more likely to enroll in case management services than individuals on the street.<sup>70</sup> Of those individuals contacted on the street, 20 percent went on to enroll in the ACCESS project, while 42.7 percent of individuals contacted in service settings enrolled.<sup>71</sup> The individuals contacted on the street also required additional time to engage, with outreach lasting 101.1 days, in contrast to 47.8 days for individuals in service

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<sup>65</sup> Frances Randolph, et. al, *Creating integrated service systems for homeless persons with mental illness: the ACCESS Program. Access to Community Care and Effective Services and Supports*, 48 *Psychiatric Services* 3, 369-73, 369 (Mar. 1997).

<sup>66</sup> *Id.* at 369.

<sup>67</sup> Frances Randolph, et. al, *Overview of the ACCESS Program*, 53 *Psychiatric Services* 8, 945-48, 946 (Aug. 2002).

<sup>68</sup> Julie A. Lam and Robert Rosenheck, *Street Outreach for Homeless Persons With Serious Mental Illness: Is It Effective?*, 37 *Medical Care* 9, 894-907, 896 (Sept. 1999).

<sup>69</sup> *Id.* at 905.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 899.

settings.<sup>72</sup> Both sets of individuals, however, responded well to the services received from ACCESS, once enrolled, and their improvement on most outcome indicators was equal.<sup>73</sup> As a study of the data concluded: “Street outreach is, thus, well justified because it reaches people who are more severely impaired and less motivated to seek out services, successfully engages the most troubled among this group, and is associated with substantial improvement.”<sup>74</sup>

This location-based outreach model, with a focus on building a relationship with the individual in order to enable them to access services, has been more broadly adopted and defined since ACCESS, in programs like PATH. The PATH program began at approximately the same time as the five-year ACCESS demonstration and over the subsequent years has refined the techniques that worked for ACCESS into a structured, successful program.

### **Projects for Assistance in Transition from Homelessness (PATH)**

The PATH Program is a formula grant to the 50 states and the District of Columbia, providing funding for services for people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at imminent risk of becoming homeless.<sup>75</sup> Part of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990, PATH grants are available to cover a broad selection of services, including specifically “outreach services.”<sup>76</sup> Outreach is “essential to the national PATH program” and “[h]omeless service providers, advocates, and consumers view the process of outreach and engagement as a key component of homeless service delivery.”<sup>77</sup>

PATH defines “outreach” as: “[t]he process of bringing individuals who do not access traditional services into treatment. Effective outreach utilizes strategies aimed at engaging persons into the needed array of services, including

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<sup>72</sup> *Id.* at 902.

<sup>73</sup> *Id.* at 905.

<sup>74</sup> *Id.* at 906; Frances Randolph et al., *Overview of the ACCESS Program*, 53 *Psychiatric Services* 8, 945-48 (Aug. 2002).

<sup>75</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, PATH Essentials*, available at <http://pathprogram.samhsa.gov/Channel/PATH-Essentials-532.aspx>.

<sup>76</sup> 42 U.S.C. § 290cc-21 et seq.

<sup>77</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, PATH Technical Assistance Resource Page: Outreach 4* (2011) available at <http://pathprogram.samhsa.gov/ResourceFiles/Outreach%20Resource%20Page.pdf>

identification of individuals in need, screening, development of rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources.”<sup>78</sup> PATH pays for “active outreach” or “face-to-face interaction with literally homeless people in streets, shelters, under bridges, and in other non-traditional settings” and “in-reach,” when “outreach staff are placed in a service site frequented by homeless people, such as a shelter or community resource center, and direct, face-to-face interactions occur at that site.”<sup>79</sup> The focus on direct, face-to-face interaction is an important element of what constitutes PATH outreach. In addition to face-to-face interaction, PATH also emphasizes that outreach is an interactive process that might take additional time and repeated contact.<sup>80</sup> PATH often makes use of “peers” who have “lived experience” with mental illness and public mental health systems to do outreach.

In 2012, 468 different local organizations used PATH funds to provide Outreach Services—meaning that 92 percent of all providers receiving PATH funds use outreach—an acknowledgement of the important role of outreach.<sup>81</sup> This allowed those organizations to reach 192,299 individuals and, ultimately, to enroll 58 percent of all eligible individuals in PATH case management.<sup>82</sup>

Following use of these successful outreach tools, the next step is enrolling individuals in mainstream benefits, such as Medicaid or other healthcare coverage. Many PATH organizations use the SOAR approach to this enrollment process.

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<sup>78</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, PATH Annual Reporting Guide*, 20-21 (2013) available at [http://pathprogram.samhsa.gov/ResourceFiles/Documents/PATHAnnualReport\\_ProviderGuide\\_2013%20508c.pdf](http://pathprogram.samhsa.gov/ResourceFiles/Documents/PATHAnnualReport_ProviderGuide_2013%20508c.pdf)

<sup>79</sup> *Id.*

<sup>80</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, PATH Technical Assistance Resource Page: Outreach 6* (2011) available at <http://pathprogram.samhsa.gov/ResourceFiles/Outreach%20Resource%20Page.pdf>.

<sup>81</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, Number of Organizations Providing PATH Services by Type of Organization* (2012), available at <http://pathprogram.samhsa.gov/Path/Reports09/ViewReports.aspx?rYear=2012&rpts=DataReport3&noStateOk=1>.

<sup>82</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projects for Assistance in Transition from Homelessness, Percentage of PATH Outreach Contacts who Enrolled in Services* (2012), available at <http://pathprogram.samhsa.gov/Path/Reports09/ViewReports.aspx?rYear=2012&rpts=DataReport4&noStateOk=.1>

## SSI/SSDI Outreach, Access and Recovery (SOAR)

SOAR is a technical assistance initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that is designed to improve access to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) benefits for people with serious mental illnesses who are homeless or at risk of homelessness. Following a 1993 demonstration program in Baltimore, researchers identified three elements required to create a system whereby individuals with serious mental illness who are homeless, or at risk of homelessness, could effectively access benefits: strategic planning meetings of the involved governmental entities, training of front-line staff interacting with these individuals, and accessible technical assistance. These three elements used together, create the SOAR Approach:

First, the state or community holds strategic planning meetings of policy makers, bringing together the relevant agencies that work with the target populations.<sup>83</sup> These partners can include the Social Security Administration (SSA) and Disability Determination Services (DDS); the state's mental health agency and department of corrections leadership; and community homeless, health and behavioral health providers.<sup>84</sup> For instance, "[t]he SOAR approach in correctional settings is a collaborative effort by corrections, behavioral health, and SSA."<sup>85</sup> These stakeholders collaborate to develop an action plan and create a process for increasing the submissions and processing of SSI/SSDI applications for homeless individuals.<sup>86</sup>

Second, a SOAR action plan includes "[t]raining of case managers using SAMHSA's Stepping Stones to Recovery curriculum."<sup>87</sup> The curriculum provides background and up-to-date information on the SSI/SSDI application process, including "a step-by-step explanation of an improved SSI/SSDI application process" that is SOAR-specific.<sup>88</sup> The involvement of case managers in the application process is a crucial element of SOAR's success, since they have relationships with the applicants already.<sup>89</sup> Case managers

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<sup>83</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Admin., SOAR Technical Assistance Center, *SSI/SSDI Outreach, Access and Recovery: An Overview* (Dec. 2013).

<sup>84</sup> *Id.*

<sup>85</sup> Dazara Ware, M.P.C. and Deborah Dennis, M.A., SOAR Technical Assistance Center, *Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings 4* (Jan. 2013) available at [http://www.prainc.com/soar/cms-assets/documents/Best\\_Practices\\_Exiting\\_CJ\\_Systems030413.pdf](http://www.prainc.com/soar/cms-assets/documents/Best_Practices_Exiting_CJ_Systems030413.pdf).

<sup>86</sup> U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Admin., SOAR Technical Assistance Center, *SSI/SSDI Outreach, Access and Recovery: An Overview* (Dec. 2013).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> Rosen, J. and Perret, Y., *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults Who Are Homeless, with Social Security Disability and Supplemental Security Income Applications*. DHHS

work actively with clients one-on-one to help them through the enrollment process. SOAR provides the necessary technical knowledge for case managers to be able to help their clients put together successful applications.

Third, states and localities can use the services offered by the SOAR Technical Assistance Office, including help with “action plan implementation, training observations with feedback, and assistance with tracking outcomes in order to document success and help access additional resources.”<sup>90</sup> There is also a “Leadership Academy” program that helps to train local leaders on how to support SOAR-trained case managers and coordinate local SOAR programs.<sup>91</sup>

The SOAR approach has been used not only to help enroll hard-to-reach homeless individuals in benefits, but also to help prisoners prepare for reentry by ensuring that applications for benefits are done timely to ensure that individuals are connected with benefits promptly upon release.<sup>92</sup> The success rate for SOAR approach applications is astronomical: As of June 2011, 44 states were reporting a 71 percent approval rate, compared to a national approval rate of only 10-15 percent for homeless applicants and only 32 percent for all applicants.<sup>93</sup>

Because the SOAR approach has been so successful, SAMHSA recently announced a new funding opportunity for states to use a similar approach to “enhance or develop the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent housing; peer supports; and other critical services” for chronically homeless individuals with serious mental illnesses, substance abuse disorders, or co-occurring mental health and substance abuse disorders.<sup>94</sup> This program, called “Cooperative Agreements to Benefit Homeless Individuals” (CABHI), is designed to increase the number of these individuals receiving “sustainable permanent housing, treatment, recovery supports, and Medicaid and other

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Pub. No. SMA 05-4051. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

<sup>90</sup> SSI/SSDI Outreach, Access and Recovery: An Overview (Dec. 2013).

<sup>91</sup> *Id.*

<sup>92</sup> Dazara Ware and Deborah Dennis, SOAR, Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings 3-4 (January 2013)

<sup>93</sup> Deborah Dennis and Kristin Lupfer, Policy Research Associates, Inc., *SSI/SSDI Outreach, Access and Recovery (SOAR)*.

<sup>94</sup> Dept. of Health and Human Services, Substance Abuse and Mental Health Services, Administration, *Cooperative Agreement to Benefit Homeless Individuals – States, Request for Applications No. SM-14-010, 2* (2014).

mainstream benefits.”<sup>95</sup> The state must establish an interagency council of agencies and community partners that touch the homeless population and a statewide plan that will “ensure sustained partnerships across public health and housing systems that will result in short- and long-term strategies to support the population.”<sup>96</sup> The program provides funds to “[e]ngage and provide enrollment assistance to the population of focus for Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP, etc.)” including by having front-line staff trained through the SOAR approach.<sup>97</sup>

## Outstationed Eligibility Workers

State Medicaid programs are required to have Outstationed Eligibility Workers (OEWs) at locations other than the usual Medicaid eligibility offices. These locations must include Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals, both of which serve large numbers of individuals who lack healthcare coverage.<sup>98</sup> OEWs can be state employees assigned to these health facilities, employees of the health center or hospital, or employees of other organizations under contract to the state Medicaid program.<sup>99</sup>

The costs of OEWs are shared between federal and state Medicaid programs. To provide additional incentives for states to expand their OEW efforts in anticipation of the opening of the Marketplace, the ACA authorized an enhanced federal match rate of 75 percent for certain types of enrollment assistance, including by OEWs.<sup>100</sup> In addition, 1,159 FQHCs received \$150 million in supplemental funding for OEWs in 2013 and an additional \$58 million in supplemental funding for 2014.<sup>101</sup>

OEWs serve established patients at their health centers and provide outreach and enrollment assistance to underserved populations in their service areas. Because OEWs are integrated with FQHC and DSH operations, they already have the capability to exchange data electronically with Medicaid. In addition,

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<sup>95</sup> *Id.* at 4.

<sup>96</sup> *Id.* at 10.

<sup>97</sup> *Id.* at 11.

<sup>98</sup> 42 U.S.C. § 1396a(a)(55).

<sup>99</sup> 42 C.F.R. § 435.904(e).

<sup>100</sup> *Id.*

<sup>101</sup> Health Services and Resources Administration, HRSA *Health Center Ongoing Outreach and Enrollment (O/E) Assistance, Frequently Asked Questions (FAQs)* (updated May 1, 2014), available at <http://bphc.hrsa.gov/outreachandenrollment/oefaq05012014.pdf>.

at a state's discretion, they may perform all eligibility processing functions, including the eligibility determination for Medicaid.

Historically, uninsured individuals needing primary or acute care have been routed to community health centers since these facilities serve disadvantaged members of their communities. Community mental health providers also serve such individuals, and OEWs could and should be used in connection with these providers. Indeed mental health case managers often provide enrollment assistance and may coordinate with OEWs or Medicaid eligibility workers.

A recent study of OEWs in federally qualified health centers in Connecticut found that they were tremendously successful in enrolling individuals in Medicaid. From July 1, 2012 to June 30, 2013, the FQHCs provided application assistance to 10,322 individuals and almost half—4,770—were granted benefits by June 30th.<sup>102</sup> This number was likely an undercount given delays in the processing of applications.<sup>103</sup>

## **Programs Targeting Incarcerated Individuals with Mental Illnesses**

Some states have developed targeted strategies to facilitate the prompt enrollment of individuals in Medicaid upon their release from jails or prisons. Connecticut, for example, uses a shortened application form for jail and prison inmates who have medical or mental health needs to expedite the process of determining their eligibility for Medicaid and enrolling them immediately upon release.<sup>104</sup> These individuals receive assistance in applying for Medicaid and obtaining eligibility determinations before they are released. Key elements of the program include: discharge planners who are based in correctional facilities and help inmates complete applications; reentry counselors who offer classes on filling out applications; entitlement specialists, based at the Department of Social Services, who determine eligibility for Medicaid; and access to daily electronic feeds from the Department of Correction to identify individuals about to be discharged.<sup>105</sup> The number of applications rose from several hundred in 2006 to more than 4000 in 2013.<sup>106</sup>

Rhode Island has a new eligibility and enrollment system designed to facilitate coverage and continuity of care for vulnerable populations, including individuals in jails. This system features extensive collaboration and data sharing among the Department of Corrections, the

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<sup>102</sup> National Association of Community Health Centers, *Outstationed Eligibility Workers and Community Health Centers: A Connecticut Case Study 1* (Nov. 2013), available at <http://www.nachc.com/client/Spotlight%20on%20the%20States%206.pdf>.

<sup>103</sup> *Id.*

<sup>104</sup> Stephen A. Somers et al., *Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals*, 33 *Health Affairs* 455, 459 (March 2014).

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

state Medicaid agency, and a managed care entity to help jail inmates establish eligibility and enroll three to six months before their release.<sup>107</sup> Former inmates may submit the thirty-day photo ID issued by the Department of Corrections as sufficient identification for enrollment, and the release letter provided to inmates upon release as sufficient proof of income.<sup>108</sup>

## Key Strategies for Outreach and Enrolling People with Serious Mental Illnesses in Healthcare Coverage

### Active and Sustained Engagement

An important lesson from the ACCESS and PATH programs is that active and sustained engagement is an important element of outreach efforts aimed at connecting individuals who have serious mental illnesses, including those who are homeless, with benefits and services. Experience has long shown that for many individuals with serious mental illnesses, successful engagement requires sustained efforts over time in order to build trust. Without such efforts, many individuals will not attempt to enroll in healthcare coverage. A 2013 study found that “...nearly three-quarters of chronically homeless adults with income below the threshold for the Medicaid were not enrolled in Medicaid, including 53 percent who were uninsured or relied solely on state or local assistance.”

### Active One-on-One Assistance

Another lesson learned from the experience with SOAR is that a key strategy that has proven effective is providing active, one-on-one assistance with enrollment. Individuals with serious mental illnesses may need sustained one-on-one assistance and follow-up over a period of time to ensure successful enrollment. This assistance should be offered in locations that are convenient and comfortable for individuals, such as where they live or receive services.

To help individuals with serious mental illnesses successfully obtain and maintain health coverage, states should offer one-on-one assistance to help these individuals with tasks such as the following:

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<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

- **Understanding why coverage is important and obtaining basic information about Medicaid and health coverage through the Marketplace**
- **Collecting personal information needed to complete an application—whether online, on paper, or over the phone**
- **Evaluating and selecting a health plan** Individuals eligible for healthcare coverage through the Marketplace will need to understand what services are covered by the various plans, and how plan policies will affect their out-of-pocket costs.
- **Understanding cost-sharing mechanisms and other plan rules**
- **Understanding requirements for reporting changes in personal information, such as place of residence, household income, and household size**
- **Verifying that the enrollment process was successfully completed** Errors or failure to pay premiums within specified time frames can result in enrollment failures in some states.
- **Selecting service providers**
- **Responding to requests for information in the renewal process** Enrollees may be automatically re-enrolled in coverage annually, but if the Medicaid agency is unable to verify required eligibility information, consumers must respond to requests for additional information within a certain time frame or risk the loss of coverage.

## **Involving Community Service Providers**

Another key strategy that has worked to increase enrollment of individuals with serious mental illnesses is involving mental health providers and other community service providers. These agencies, which routinely work closely with individuals who have serious mental illnesses, have expertise in engaging them and are more likely to succeed in helping individuals enroll than generic outreach and enrollment workers. Many individuals with serious mental illnesses have had negative experiences with public service systems; for them, building relationships of trust is a critical part of that engagement. Outreach and enrollment efforts should involve community providers who already have a relationship with an individual, or who have experience developing such relationships with individuals with serious mental illnesses. Peer-run provider programs, including drop-in centers or peer recovery centers, are particularly effective in developing such relationships.

Outreach and enrollment efforts may also involve providers of services other than mental health services—for example, individuals with substance use disorders—that serve significant numbers of individuals with serious mental illnesses.

Community service providers may work in partnership with outreach and enrollment workers or may themselves serve as outreach and enrollment workers. Some community providers now have staff members who have completed training to become Certified Application Counselors or In-Person Assistance Personnel. Service providers have

incentives to devote staff time to outreach and enrollment of uninsured individuals in healthcare coverage, as they can obtain reimbursement for services provided.

## Involving Peers

In mental health programs, there is growing recognition that *peers*, people who have lived experience with mental illness and public mental health systems, can play important roles in engaging and helping other individuals with mental illnesses. Many people with mental illnesses find particularly helpful the insights of individuals who may have overcome some of the challenges that they are currently experiencing. While mental health programs initially provided peer supports informally, research has since demonstrated their effectiveness in engaging and supporting the recovery of mental health consumers, and states now have the option to provide reimbursement for peer specialist services under Medicaid. As of September 2012, 36 states had established programs that train and certify peer support service providers.<sup>109</sup>

SOAR programs provide an example of how mental health peers can be incorporated into a state's benefit outreach and enrollment efforts. Throughout the nation, these programs rely upon trained peer support workers to engage people with serious mental illnesses in applying for SSI/SSDI benefits and to provide them with ongoing assistance in what is often a complicated and protracted application process. As is the case with other peer services, outcomes are enhanced when peers use their lived experience to develop trusting relationships with individuals and to help them through the process of qualifying for benefit

**Peers—people who have lived experience with mental illness and public mental health systems—can play important roles in engaging and helping other individuals with mental illnesses.**

programs. Peer specialists typically provide outreach and engage individuals in their preferred locations—either in the community or at home. Trained peers also provide direct assistance to help individuals complete forms, compile medical records and other needed documents, accompany individuals to appointments, and help clinicians document functional difficulties that are considered in eligibility determinations.<sup>110</sup>

Oklahoma, an early adopter of SOAR in its corrections programs, employs peers who have personal experience in mental health and criminal

<sup>109</sup> Laura Kaufman et al., *Peer Specialist Training and Certification Programs: A National Overview*. University of Texas at Austin Center for Social Work Research 1 (2012), available at <http://www.dbsalliance.org/pdfs/training/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview%20UT%202013.pdf>.

<sup>110</sup> Kristin Lupfer, *Involving Peer Supports in the SOAR Process 1-2* (Nov. 2012), available at [http://www.prainc.com/soar/cms-assets/documents/peersupports8.5x11\\_110612.pdf](http://www.prainc.com/soar/cms-assets/documents/peersupports8.5x11_110612.pdf).

justice systems to assist individuals leaving prison in applying for benefits. An evaluation of this program found that, for those approved for SSI/SSDI, returns to prison were 41 percent lower than a comparison group.<sup>111</sup>

## Targeting Efforts to Incarcerated Individuals

To ensure that incarcerated individuals returning to the community have timely access to coverage, states should offer enrollment assistance that begins at correctional facilities prior to release, so that individuals may be linked to healthcare coverage and other benefits immediately upon community re-entry. Medicaid agency staff, outstationed eligibility workers, case managers, or other outreach and enrollment assisters may be used to provide this help. States should explore using shortened application processes and accepting documents readily available to inmates as proof of eligibility requirements such as income and identification. For individuals who were enrolled in Medicaid or Marketplace insurance upon entering jail or prison, states should arrange to suspend, rather than terminate, enrollment in these benefits upon incarceration so that they may be promptly restored upon release.

## Other Strategies Authorized by the Federal Government

In addition, CMS has laid out a number of optional strategies for streamlining administrative operations and maximize opportunities to increase Medicaid and CHIP participation rates. These strategies include:

- **Using Supplemental Nutrition Assistance Program (SNAP) data to identify individuals who are income-eligible for Medicaid** The SNAP database is a reliable, verified source for states to use in determining individuals' income eligibility for the Medicaid expansion. To exercise this option, states must obtain a waiver from CMS.
- **Developing a single application for assessing eligibility for state and federal benefits programs** The application could cover SNAP, housing, and energy assistance, as well as Medicaid and subsidies for private health coverage.
- **Using household income information that was used to qualify children for Medicaid** This information is a means to identify parents who are likely eligible for the Medicaid expansion
- **Expanding presumptive eligibility** This allows qualified entities, such as health centers and hospitals, to enroll individuals screened by them before their application has been formally approved

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<sup>111</sup> Dazara Ware and Deborah Dennis, Best Practices for Increasing Access to SSI/SSDI Upon Exiting Criminal Justice Settings 6 (Jan. 2013), available at [http://www.prainc.com/soar/cms-assets/documents/Best\\_Practices\\_Exiting\\_CJ\\_Systems030413.pdf](http://www.prainc.com/soar/cms-assets/documents/Best_Practices_Exiting_CJ_Systems030413.pdf).

- **Establishing a 12-month continuous eligibility for parents and other adults**  
Doing so assures that these individuals are not cycling on and off Medicaid over the course of a year.<sup>112</sup>

Enrollment figures from four states that had adopted the options of using existing SNAP and children's Medicaid/CHIP data sets to identify *income*-eligible people showed that these states were able to quickly reach and enroll a larger proportion of their Medicaid expansion population than would be possible had they not exercised these options. As of November 15, 2013, they had enrolled 223,000 people in Medicaid through fast-track enrollment strategies, well in advance of their coverage start date of January 1, 2014. These fast-track strategies are administratively efficient, eliminating duplicative income eligibility determinations; similarly, they are also less burdensome upon consumers.

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<sup>112</sup> U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014 (May 17, 2013) available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

## Conclusion

People with mental illnesses who have been uninsured generally have not had access to the array of services and supports that allow them to live as envisioned by the Americans with Disabilities Act—as full members of their communities. Instead, they have been at very high risk of recurrent hospitalizations, arrest, incarceration, and homelessness. The Affordable Care Act, particularly its expansions in Medicaid eligibility, holds tremendous opportunities for people with serious mental illnesses who have heretofore not qualified for health insurance to finally secure coverage for the community services they need to be successful. Not only will such coverage help states meet their legal obligations to people with disabilities, but it does so at substantial cost savings.

The Affordable Care Act's initial open enrollment period has ended, with unexpected success. Nevertheless, there is reason to believe that significant numbers of people with mental illnesses remain uninsured. Key to realizing the full benefits of newly available health coverage are states' programs and strategies to effectively enroll these individuals in insurance. The strategies delineated in this report can help states fulfill this critically important responsibility.