



National Association of State Mental Health Program Directors

# **Strategies to Enroll Uninsured People with Mental Health Conditions under the Affordable Care Act**

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## Executive Summary

Under the Patient Protection and Affordable Care Act (ACA), states are responsible for conducting outreach and enrollment for vulnerable and underserved populations eligible for the new Medicaid Expansion, as well as for enrolling people in State Health Insurance Exchanges, also called State Health Insurance Marketplaces.

Targeted outreach and enrollment is essential and necessary to reaching newly-eligible adults with mental illness and substance use disorders, and identifying specific barriers relevant to outreach and enrollment for persons with a mental illness.

### Reaching People Who Are Homeless and with a Mental Illness

Raising awareness among providers of services to homeless individuals and discussing the benefit of having access to health insurance for people who are homeless or at risk of homelessness will be critical to ensuring that eligible individuals enroll.

It may take multiple contacts with a homeless person with a mental illness in shelters, libraries, encampments, food kitchens, and other places where people congregate to develop sufficient trust before they are willing to engage in care.

Once trust is established, education and enrollment is next. Many homeless people are unaware of new programs or the new insurance coverage opportunities made available through health reform. To reach them quickly, those engaging people who are homeless should try discussing their immediate mental illness or medical problem or what services they want to access.

To allow for more effective outreach and enrollment to address the needs of people who are homeless and have a mental illness, it is important for health centers to have the infrastructure to accommodate the extra demand to utilize these strategies:

- **Tailor pamphlets and other educational materials.** Ensure they include information on Medicaid and that they use language that clients understand.
- **Hire in-person assisters and certified application counselors.** These positions can be used to conduct both “in-reach” with existing clients and outreach with new clients.
- **Leverage group sessions.** Add discussions and question and answer sessions about coverage opportunities under the ACA and Medicaid to group sessions already scheduled.
- **Set aside one-on-one time.** Give patients a chance to talk about income eligibility, affordability concerns, and personal circumstances in a private setting.
- **Create electronic alerts.** Set up your medical records to automatically notify you when a client can apply for Medicaid.
- **Partner with shelters and other providers.** Staff an on-premises “enrollment table” that includes familiar and trusted shelter personnel.
- **Invest in a tablet computer.** Take it to the shelters, parks, soup kitchens and encampments.

- Learn about the state's plans for conducting outreach to people that will become eligible for Medicaid as a result of the expansion, particularly people who are homeless.
- Explore the possibility of a Health Care for the Homeless grantee or other homeless outreach agency becoming an agency authorized to conduct Medicaid enrollment activities.

State Behavioral Health Agencies should offer to help states design enrollment processes for vulnerable mental health populations. For example, people who are homeless with mental health conditions and substance use disorders may be particularly disenfranchised. Proxy enrollment procedures may be necessary for these populations.

### Reaching County Jail Populations

According to experts in the field, the first step in developing a health care enrollment program for individuals in local justice systems is to identify the optimal location for enrollment. A provision of the ACA prohibits treating an incarcerated individual as eligible for exchange coverage, other than under an incarceration pending disposition of charges. An incarcerated individual is permitted to enroll in the Medicaid program, but may not receive benefits while incarcerated. Given these restrictions, the best sites for enrollment of the population would include:

- Shortly after arrest for diverted individuals or individuals cited out;
- At the county jail, during initial intake;
- At the county jail, post-arraignment and pre-trial; or
- At the county jail, pre-release;

**Marin County, California**, has initiated an innovative reentry program whereby the sheriff takes custody of the prisoners who will be on Post-Release Community Supervision (PRCS) 60 days before their release. The prisoners will spend the end of their term in the county jail, where the jail's reentry coordinator and probation officers work closely with them to prepare for their reentry into the community, including enrolling them in health insurance coverage. To determine the best time and location for enrollment, county justice officials can collaborate with county health officials to understand each individual's considerations and needs.

Justice system officials should work with county and state health officials to explore ways to use technology to streamline enrollment. County jails that have already collected information needed to make eligibility determinations for a health plan can explore with the state or county health department the possibility of making that data available to automate eligibility determinations.

State Behavioral Health Agencies (SBHAs) should advocate for the enrollment needs of individuals moving from jails and prisons to community-based settings in order to prevent discontinuity of care. SBHAs also should engage with state Medicaid programs to determine how best to address enrollment for individuals who are transitioning between correctional systems to Medicaid to ensure these individuals have consistent access to mental health services.

## Reaching Medicaid-Eligible Youth in Correctional Systems

The time of transition from an institutional setting to the community or home is a critical time for juvenile justice-involved youth with mental health conditions. As they move through the juvenile justice system – sometimes bouncing between settings multiple times before leaving the system completely – there are many opportunities for them to lose their Medicaid eligibility.

Presumptive eligibility is a Medicaid option that allows qualified entities to determine, based on a simplified calculation of family income, whether a child is likely to be eligible for Medicaid. States have the flexibility to deem agencies that provide services, such as juvenile justice programs, as qualified entities. Youth can receive temporary Medicaid eligibility pending a final eligibility determination by the Medicaid agency. This is important because the faster youth get enrolled into Medicaid, the more quickly they will be able to access services after they leave the system.

The **New Hampshire** Department of Health and Human Services reported the Department of Children, Youth and Families (the agency in charge of determining Medicaid eligibility) fiscal staff are notified whenever a child's placement changes. When a youth leaves detention to go to a group or residential placement, the fiscal staff immediately determines Medicaid eligibility.

Few juvenile justice agencies screen at intake to identify Medicaid-eligible youth. SBHAs should allow juvenile justice agents, such as case managers or probation, to screen children for Medicaid eligibility and assist with the application process, which would help ensure continuity of care and allow juvenile-justice involved youth to access medical care once they leave an institution.

## Reaching Uninsured Veterans with a Mental Illness

Beyond the Medicaid expansion, the health insurance coverage and mental health care access of veterans will likely be affected by other policy changes in the coming years. Provisions such as the “no wrong door” policy, whereby applications to Medicaid, CHIP, or exchange coverage can be screened for a variety of health insurance programs; the individual mandate; and the use of trained navigators to assist individuals who are seeking health insurance coverage could increase veterans' awareness of and interest in VA services, facilitating their enrollment. The addition of screening questions about veteran status on Medicaid/exchange applications and the use of data matches to identify and enroll eligible veterans could increase take-up of coverage among veterans.

## Reaching Minority Populations

Outreach to minority populations should be by trusted messengers, including health care providers, promoters and community health workers, community members and others that the potential enrollees know and trust.

Effective outreach must be in the community and reach people where they are through trusted messengers. Enrolling on-site in the immigrant communities, farm worker

communities, rural residents, and tribal areas where people live and work is essential. Locations for effective outreach can include community centers, day care centers, schools, grocery stores, pharmacies, libraries, senior centers, and health care providers.

Messaging and outreach needs to occur at flexible times: before and after standard work hours and on weekends, as well as during the weekday.

## Reaching Men of Color

Men of color should be a critical target for states and new Medicaid coverage because this population has historically lower rates of health care coverage, poor health outcomes, and disproportionate rates of poverty and homelessness than the general population.

Outreach to this population will take concerted and coordinated efforts on the part of multiple stakeholders working at multiple levels. Assisters' and Navigator Outreach Programs are a critical component, but their efforts need to be supplemented and supported by many other organizations. Community outreach and enrollment efforts need to be on-going and widespread and involve others beyond the officially certified Assisters. Community members need to be pro-active in their outreach efforts and target places where men of color are most likely to be present. These locations might include:

- Churches and faith-based organizations;
- Affinity/associational groups of all types: immigrant associations, college fraternities, sports leagues;
- Pharmacies, recreational centers, gyms, and barbershops;
- Ethnic restaurants and grocery stores; and
- Soup kitchens, food pantries, homeless shelters.

With any difficult to reach population, community-based outreach and education efforts should be a critical complement to broader marketing campaigns. Moreover, hands-on application assistance using trusted community groups and providers are most effective in reaching the "hard to reach".

Policy-makers appear to be heeding the lessons of Medicaid and CHIP in designing outreach campaigns that combine both broad efforts to raise public awareness and community-based efforts to reach the outliers. Furthermore, outreach campaigns are being supported by extensive application assistance programs, designed to provide consumers with direct, hands-on help in completing the application process.

Regardless of the size, breadth, and depth of investments in outreach and application assistance, the State Children's Health Insurance Program (CHIP) taught policy-makers that it takes considerable time to achieve broad participation among eligible consumers in coverage.

## **I. Introduction**

This issue paper highlights strategies for states to enroll vulnerable and difficult to reach populations eligible for the new Medicaid Expansion, and is the first in a series of eight related to ACA implementation.

Under health care reform, states are responsible for conducting outreach and enrollment for vulnerable and underserved populations eligible for the new Medicaid Expansion, as well as for enrolling people in state health insurance exchanges also called health insurance marketplaces.

States are required to adopt simplified enrollment procedures and to coordinate Medicaid enrollment with other coverage options, such as enrollment through health insurance exchanges or the State Children's Health Insurance Program (CHIP). The challenges facing states in outreach and enrollment for people with mental illness reflect those they face for other populations. States face language and geographic barriers and must educate those with limited familiarity or experience with Medicaid to reach the newly eligible adults in the Medicaid Expansion population. These barriers exist and are made more complex in enrolling people with mental illness and substance use disorders.

Targeted outreach and enrollment is essential and necessary as is identifying the specific barriers relevant to outreach and enrollment for the population with mental illness.

### **Education about the Shift from a Service Delivery Model to a Health Insurance Model**

Many people with mental health disorders – particularly severe disorders – are often connected to service delivery systems or state services in some way. It is more likely that newly eligible persons with mental illness will be enrolled through providers when they access services than that they will learn about their eligibility through general outreach campaigns.

Since many of these providers operate as direct service providers, rather than through insurance models, these efforts will require education about the shift from a service delivery to insurance model. Reaching the population with mental illness may also require restructuring the relationships between Medicaid and community mental health centers, substance abuse providers, and criminal justice systems, all of whom may have limited experience with Medicaid eligibility and enrollment systems.

The development of information technology systems to facilitate data sharing between Medicaid, mental health and substance abuse providers, criminal justice, and other relevant systems is critically important to reaching individuals with mental illnesses.

## **II. How Health Care Reform Strengthens Medicaid's Role in Ending and Preventing Homelessness**

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). Under pre-ACA rules, single adults without disabilities or children were usually not eligible for Medicaid but that all changed on January 1, 2014 when states were granted the option to expand Medicaid to those earning at or below 138 percent of the Federal Poverty Level (FPL) regardless of their disability status.

This historic piece of legislation presents significant opportunities to improve access to quality, affordable health care for all Americans. This is particularly true for people who are homeless or are at risk of homelessness whose options for accessing behavioral and physical health care services, mental illness prevention and mental health promotion services, and chronic disease management programs have historically been limited.

In connecting people to health insurance, community mental health centers, health care centers, and other community-based providers will likely be tasked with reaching populations that are hardest to reach such as people who are homeless and have a mental illness.

Community health centers collectively served just over 21 million people in 2012, 36 percent of which were uninsured. Of all of these patients, just over 1 million were documented as homeless.

### **Importance of Medicaid**

For many people who are homeless, the lack of access to health insurance can mean a constant struggle to obtain and maintain affordable housing. As a result of not having health insurance, people who are homeless often forgo treatment for mental illness, substance use, chronic health conditions, acute care and injuries – making it difficult to focus on the goal of finding housing.

Without health insurance, mental health and medical crises and ongoing related costs can lead a lower-income household down the path to homelessness. In providing a safety net of needed services, insurance coverage plays a critical role in helping a person who is homeless access those services needed to regain stability – mental, physical, and residential.

Linking people who are homeless to Medicaid – the health insurance program for lower-income Americans – has become an increasingly important federal priority. Beginning in 1999, Congress and the U.S. Department of Housing and Urban Development (HUD) required homeless planning groups to strengthen linkages between people who are homeless and mainstream resources, including

Medicaid. Medicaid – and the expansion of the program – is the secret weapon in the fight against homelessness.

Many policy observers and federal officials have long recognized that bad health outcomes and homelessness are often connected. The lack of affordable health insurance often forces people who are sick to choose between paying for necessary treatment and paying for a place to live. The lack of treatment for health problems often contributes to or extends the episode of homelessness. The lack of stable, safe, housing tends to exacerbate any physical and/or behavioral health problems.

In recent years, homeless providers and advocates have also recognized the importance of securing health insurance through the Medicaid programs in addressing homelessness. In many communities, *Health Care for the Homeless* grantees and other outreach providers have utilized Medicaid to support engagement of chronically homeless people living on the streets, in cars, in parks, under bridges, etc.

Shelter providers have begun implementing systems to proactively link people who are homeless to Medicaid and other mainstream benefits while in shelters. Innovative transitional and permanent supportive housing providers have partnered with Medicaid agencies to support ongoing services needed to keep people housed. Agencies that receive federal homelessness prevention funding have created strategies to link at-risk households to Medicaid and other critical benefits as a comprehensive effort to stabilize housing situations.

Homeless planning groups across the nation – known as Continuums of Care (CoC) – have also begun to explore systematic ways to develop linkages between people who are homeless and Medicaid. Recent legislation reauthorizing federal homeless funding made available by HUD has highlighted the role of CoCs in monitoring the ability of providers to help people who are homeless access Medicaid as well as other mainstream benefits such as Children’s Health Insurance Program (CHIP), Supplemental Security Income (SSI), and Supplemental Nutrition Assistance Program (SNAP). In recent years, HUD funding awards have been directly linked to how well a CoC can demonstrate and measure these linkages.

With the enactment of the Affordable Care Act in 2010, changes to the Medicaid program will increase the value of this resource in meeting the mental and health needs of homeless people and people at risk of homelessness. The changes described below will:

- Allow more people who are homeless and at risk of homelessness to access health insurance coverage;
- Allow providers of services to people who are homeless to address the mental health needs of more people who have lower incomes;

- Enable some agencies to shift the cost of providing critical support services for people who are homeless to Medicaid; and
- Help CoCs better address and end homelessness in communities across the nation.

### **Changes to Medicaid Enrollment and Access to Services**

While the changes to Medicaid under the ACA will make many more people *eligible* for Medicaid who were previously ineligible, this change does not mean these people will automatically receive health insurance coverage. To receive Medicaid services a person must first take the initiative to apply and enroll in the program.

Raising awareness among providers of homeless services and discussing the benefits for people who are homeless or at risk of homelessness of having access to health insurance will be critical to ensuring that eligible individuals actually enroll.

Promoting understanding about the changes to Medicaid eligibility rules among outreach workers, primary care providers, shelter staff, and others will also be important as they are key allies in ensuring that people who are homeless are made aware of their eligibility and are helped with the enrollment process. There are several provisions in the ACA that are intended to simplify enrollment and minimize administrative barriers that in the past have made the Medicaid eligibility determination process particularly difficult for people who are homeless. The ACA requires states to streamline Medicaid enrollment procedures in a variety of ways.

States are required to use a “user-friendly” application form that has been developed by the U.S. Department of Health and Human Services (HHS). This form will allow people to apply for all available health insurance programs offered by a state (e.g. Medicaid, CHIP, etc.) in person, via phone, online, or via mail. States will have the flexibility to design their own form that can be more comprehensive than the form designed by HHS.

For example, a state may design a process that allows people to complete one application for multiple assistance programs, such as SSI and SNAP, in addition to Medicaid. Additionally, ACA provisions require states to use technology to simplify and reduce the need for documentation required to establish eligibility, and adhere to rules making the counting of income easier – further reducing historical barriers to enrollment for people who are homeless.

Also as part of the ACA reforms, in 2014 any hospital that is a participating Medicaid provider can elect to make presumptive Medicaid eligibility determinations. This provision allows hospitals to make a ‘temporary’ Medicaid eligibility determination based on information available at the time of treatment,

avoiding the need for people who are homeless and in need of treatment or emergency care from having to wait for needed services.

This temporary eligibility determination can be in place for a certain period of time and follows the person. For example, if a person who is homeless visits a hospital emergency room, the hospital could make a presumptive eligibility determination. If the person is then referred for follow-up care to a mental health clinic, s/he would be able to receive care at the clinic and the clinic would be able to bill Medicaid for the cost of services.

To better understand the challenges and explore solutions in connecting people who are homeless to health insurance through the ACA, we have examined the literature and interviewed experts in the field.

### **The first task is you have to find them.**

While current patients will get enrollment assistance within the usual clinic operations, outreach is a critical element to reaching people in the community who need care but are not likely to enter a health center on their own.

It typically takes multiple contacts with a homeless person with a mental illness to develop sufficient trust for them to be willing to engage in care. These contacts can take place in shelters, libraries, encampments, food kitchens, and other places where people congregate.

People who are homeless may not be easy to find or may reject help initially. Even in the age of technology, cell phones are not always reliable for this population. Ten years ago, very few clients had phones. Now, they might have several phones, all of which lack minutes of service. If they are moving around from place to place, it is difficult to do follow-up care.

Experts in the field indicate that good old-fashioned word of mouth can be effective. People who are homeless will often share information among themselves using informal networks.

Another method is regular clinical outreach. Social workers and counselors can be sent to parks and shelters to contact people and do health education and enrollment activities. These workers should have tablet computers to allow for on-the-spot enrollment.

### **Next, you have to enroll them.**

Once workers locate someone who is homeless and has a mental illness, a second tier of obstacles arises. Sometimes physical challenges prevent people from being mobile enough to come to an enrollment center. Mental illnesses or

substance use issues (or both) can impede decision-making and create barriers to follow through on enrollment, even if someone is willing to participate.

In addition, a person who is homeless and has a mental illness may have been told he or she was eligible for different programs only to later discover he or she was not. The person may have also been treated poorly by people in the system. Over time these inconsistencies in information shared and poor treatment creates a level of distrust that can make outreach more difficult.

Further, there is an overall distrust of public systems (e.g., social services offices, benefits offices, etc.) by people who are homeless because often these locations are not always welcoming to them. As a result, you may have to repeatedly assure and convince the person who is homeless that this new program will include them.

Once trust is established, education and enrollment is next. Many people who are homeless are unaware of new programs or insurance opportunities through health reform. To reach them quickly, those engaging people who are homeless should try talking about their immediate illness or medical problem to help identify what services they want to access. A provider should link treatment of the illness with enrollment and services. For example, a provider may say, “We can get your feet treated if we enroll you in this program.”

Still, not all people will be wary. Some individuals want health insurance coverage and have been waiting for this opportunity to enroll so they can address their mental health and medical conditions. If mental health conditions or injuries can get addressed properly, they can return to work and exit homelessness.

### **Finally, you have to connect them.**

Observers point out some of the provisions in the ACA that will help to streamline and speed up the Medicaid enrollment process for people who are homeless, as well as broaden their access to coverage.

***Reduced reliance on paper documentation*** – The ACA requires states to first use electronic systems to verify identity, citizenship, and income – rather than use paper documents like social security cards or birth certificates. Paper documentation need only be provided if electronic data matches contradict the enrollee’s attestation. This policy is especially helpful for patients who are homeless and have a mental illness who may not have paper documentation immediately available.

***Auto-renewal*** – Periodic re-enrollment under Medicaid obviously has been difficult for people with no stable address to receive notices that their eligibility was about to expire, which contributed to “churn” (moving in and out of health

insurance coverage). Now the ACA allows continuous enrollment for up to 12 months as long as there is no change that affects eligibility.

**Online real time eligibility** – Being able to conduct online enrollment and select a plan and a provider in one step with an immediate (or very short delay) will help connect clients to services more quickly without risking the long follow-up process that is more difficult when someone is living on the street or in a shelter.

### Prepare in advance.

To allow for more effective outreach and enrollment to address the needs of people who are homeless and have a mental illness, it is important for community mental health centers to have the infrastructure to accommodate the extra demand.

infrastructure to accommodate the extra demand to utilize these strategies:

- **Tailor pamphlets and other educational materials.** Ensure they include information on Medicaid and that they use language that clients understand.
- **Hire in-person assisters and certified application counselors.** These positions can be used to conduct both “in-reach” with existing clients and outreach with new clients.
- **Leverage group sessions.** Add discussions and question and answer sessions about coverage opportunities under the ACA and Medicaid to group sessions already scheduled.
- **Set aside one-on-one time.** Give patients a chance to talk about income eligibility, affordability concerns, and personal circumstances in a private setting.
- **Create electronic alerts.** Set up your medical records to automatically notify you when a client can apply for Medicaid.
- **Partner with shelters and other providers.** Staff an on-premises “enrollment table” that includes familiar and trusted shelter personnel.
- **Invest in a tablet computer.** Take it to the shelters, parks, soup kitchens and encampments.
- **Learn about the state’s plans for conducting outreach** to people that will become eligible for Medicaid as a result of the expansion, particularly people who are homeless.
- **Explore the possibility of a Health Care for the Homeless grantee** or other homeless outreach agency becoming an agency authorized to conduct Medicaid enrollment activities.

### Looking ahead

It will also be important to have mechanisms in place to ensure that once enrolled in Medicaid, people who are homeless are able to maintain access to their services and benefits over time. Under the current Medicaid rules, states must re-determine a person’s eligibility for the program at least annually; however some states may conduct this review more often. Putting in place

systems to assist individuals in the timely completion of “eligibility re-determinations” will be as important as promoting first-time enrollment.

The ACA simplifies some of the re-determination process, but there may continue to be individuals who lose Medicaid coverage because redetermination paperwork was not completed correctly or on time. This situation is particularly true for people who are homeless because they lack a permanent address and frequently move making it difficult to receive and retain administrative documents.

For people who are chronically homeless and have a mental illness and/or substance use disorder, symptoms often impede their ability to respond quickly, jeopardizing their Medicaid coverage. Some strategies for reducing the likelihood of unintentional disenrollment include:

- Co-locating eligibility specialists at shelters and community health centers who can help facilitate the enrollment and redetermination processes;
- Advocating to the Medicaid agency to conduct eligibility re-determinations only once per year;
- Advocating to the Medicaid agency to combine applications for other benefits (e.g., SNAP) with the Medicaid application;
- Encouraging people who are homeless to identify an eligibility representative who can receive information and notices from Medicaid on their behalf; and
- Ensuring that the Medicaid application includes a data field for housing status, allowing for targeted outreach to facilitate the re-enrollment process.

### **Next Steps and Opportunities for SBHAs**

The expansion of the Medicaid program presents a significant opportunity to help people who are homeless and other low-income adults gain access to important health care services and assist them in gaining residential stability. With state officials currently redesigning their Medicaid programs to incorporate the ACA changes, SBHA advocates who work on behalf of people who are homeless, CoCs, and other stakeholders can take the following steps now:

- Gather information about Medicaid in your state. For more information about the Medicaid program in your state go to:  
[www.cms.gov/MedicaidEligibility/downloads/ListStateMedicaidWebsites.pdf](http://www.cms.gov/MedicaidEligibility/downloads/ListStateMedicaidWebsites.pdf).
- Identify the key state Medicaid officials. These officials are listed online at:  
[www.kaisernetwork.org/health\\_cast/uploaded\\_files/State\\_Medicaid\\_Directors\\_List\\_from\\_NAS\\_MD.pdf](http://www.kaisernetwork.org/health_cast/uploaded_files/State_Medicaid_Directors_List_from_NAS_MD.pdf).
- Request a meeting with state Medicaid officials to educate them regarding the benefits of having access to health insurance among people who are

- homeless and other low-income persons and the barriers and proposed solutions to ensuring this access.
- Assist the state in designing enrollment processes for vulnerable behavioral health populations. For example, people who are homeless with mental health conditions and active substance users can be particularly disenfranchised populations; proxy enrollment procedures may be necessary for people who are homeless.
  - Learn about the state's plans for conducting outreach to people who will become eligible for Medicaid as a result of the expansion, particularly for people who are homeless. Explore the possibility of a Health Care for the Homeless grantee or other homeless outreach agency becoming an agency authorized to conduct Medicaid outreach and enrollment activities.
  - Encourage the state to combine the Medicaid application and enrollment process with applications for other benefits such as SSI, CHIP, and Temporary Assistance for Needy Families (TANF), SNAP, etc.
  - Discuss the Medicaid re-determination process to identify possible barriers and to ensure that the needs of people who are homeless are considered. Encourage states to conduct eligibility re-determinations only once per year to minimize the risk of losing coverage.
  - Encourage hospitals to make presumptive Medicaid eligibility determinations.
  - Begin public awareness campaigns to make people who are homeless and providers of services to this population aware of the changes in Medicaid eligibility processes.
  - Work to influence the decision around the benefit design for the expansion population to promote access to Medicaid services that will best meet the needs of people who are homeless.

### **III. Enrolling County Jail and Probation Populations in Health Coverage**

As we have highlighted, beginning in 2014, the ACA expands Medicaid eligibility to include all individuals under age 65, including adults without children who have incomes up to 133 percent of the federal poverty level (FPL). Many individuals involved in the criminal justice system will fall into this category of adults who will be newly eligible for Medicaid because a large majority of jail inmates are young, lower-income males who did not previously qualify for the program. However, unless future administrative actions change existing federal rules while these individuals will be eligible to enroll in the program, they will not be able to receive Medicaid benefits in 2014.

This section of the issue paper examines ways that counties may be involved in eligibility determination and enrollment processes for newly eligible individuals, focusing particularly on issues related to enrolling qualified individuals held in county jails as pre-adjudicated detainees and inmates preparing to reenter the community.

There is a specific ACA provision related to the state health insurance exchanges that could significantly impact county jails, which states that “an individual shall not be treated as a qualified individual, if at the time of enrollment the individual is incarcerated, other than incarceration pending disposition of charges.” This provision will likely allow eligible individuals in custody pending disposition of charges to enroll in a health insurance plan offered through an exchange prior to conviction, or maintain coverage if they are already enrolled.

A substantial number of individuals that enter into county jail custody have serious medical and behavioral health needs and would benefit greatly from treatment to address these conditions. As counties are responsible for providing healthcare services for county jail inmates and the overwhelming majority of individuals in jails lack any type of health insurance coverage, this provision could potentially reduce county jail health costs.

The Affordable Care Act specifically requires states to provide targeted outreach to facilitate the enrollment of underserved and vulnerable populations in Medicaid and CHIP. While regulations have not yet specified who comprises “vulnerable populations,” some jurisdictions have estimated that there will be a considerable amount of newly eligible individuals who have been “*justice-involved*.”

Of the arrestees who have health insurance coverage, many are enrolled in Supplemental Security Income (SSI), a federal income supplement program designed to help older persons, people who are blind, and people with disabilities who have little or no income. Once incarcerated, most people lose their SSI and Medicaid benefits.

Terminating coverage disrupts access to health care and makes it more difficult to achieve “continuity of care” -- the delivery of care, without disruptions, where ongoing treatment is coordinated between providers.

### **Prevalence of Health Problems in the Justice System**

**The need for health insurance among people in the justice system is acute.** This population is more likely to suffer from mental health and/or behavioral conditions, and physical health conditions, than the general population. A nationally representative, cross-sectional survey comparing the incarcerated population to other adults found that **jail inmates had a significantly higher prevalence of certain chronic diseases**, including depression and other mental health disorders; hypertension; diabetes; asthma; arthritis; cervical cancer; and hepatitis.

There is also a high prevalence of mental health challenges among people in jails:

- A 2009 survey determined that the prevalence rate of serious mental illness for recently booked jail inmates was 16.6 percent – **almost three times the rate found in the general population.**
- Less acute mental illness is even more common. The U.S. Bureau of Justice Statistics reported that 64 percent of jail inmates had a recent “mental health problem.”
- Many people in the justice system are suffering from addiction issues at much higher rates than the general population. Data collected in 2009 by the **Office of National Drug Control Policy’s Arrestee Drug Abuse Monitoring** program showed that males 18 years and older in the justice system tested positive for recent use of drugs and admitted to that use at a far higher rate than is found in general population surveys, with **anywhere from 52 percent** (Washington, DC) **to 80 percent or more** (Chicago and Sacramento) of arrestees testing positive for the presence of at least one drug.
- A federal report indicated that across the United States, **almost one in three probationers’ reports abusing alcohol, and one in six admits abusing methamphetamines.**

Once in jail, people with mental health problems tend to stay longer and are less likely to be placed on community supervision (in lieu of incarceration) than others charged with similar offenses. Longer lengths of stay are one factor that makes incarceration of people with mental health conditions significantly more expensive than incarceration of people in the general population.

### **Health Coverage Rates in the Justice System**

Compounding the fact that people in jails and on probation are less healthy than the general population, they are also far more likely to be uninsured:

- **Nine out of 10 people** detained and incarcerated in jails do not have health insurance or the financial resources to pay for medical care upon release; and
- Almost **three out of four** people on probation have no health insurance. This lack of health insurance means that the uninsured are more likely to forego needed care and less likely to receive preventative services.

### **Identify Sites to Enroll and the Stage at Which to Enroll**

According to policy experts, the first step in developing a health care enrollment program for individuals in local justice systems is to identify the location of enrollment, which can include:

- Shortly after arrest for diverted individuals or individuals cited out;
- At the county jail, during initial intake;
- At the county jail, post-arraignment and pre-trial;

- At the county jail, pre-release;
- In a pre-trial supervision program;
- In a diversion program;
- Through the probation department initial assessment;
- Through a Day Reporting Center during the period of probation; and/or
- Through a health clinic or treatment center where people receive care while on probation.

Counties throughout the country are implementing enrollment programs at different stages:

- **Alameda County, California** is currently operating a pilot program under a Medicaid Demonstration waiver that focuses on enrolling individuals in MediCal and the county Low-Income Health Program (LIHP) just after their release from jail to probation.
- **Marin County, California** has initiated an innovative reentry program whereby the sheriff takes custody of individuals who will be on Post-Release Community Supervision (PRCS) 60 days before their release. They will spend the end of their term in the county jail, where the jail's reentry coordinator and probation officers will work closely with them to prepare for their reentry into the community, including enrolling them in health insurance benefits. To determine the best time and location for enrollment, county justice officials can collaborate with county health officials to understand these entities' considerations and needs.
- **New York City, New York:** The Department of Health and Mental Hygiene with assistance from the local department of social services invests substantial resources into Medicaid eligibility screening and pre-enrollment services for inmates with a mental illness, who account for about one-third of the New York City jail population, totaling approximately 30,000 admissions per year.
- **Oklahoma:** A program implemented in 2006 to improve discharge planning for inmates with mental illnesses involves the use of "integrated services discharge managers." Findings from an evaluation of the program suggest that the intervention significantly increases Medicaid enrollment and service use.
- **King County, Washington:** King County also has a strong release planning program that engages key partnerships and processes to facilitate pre-release public benefit enrollment for reentering offenders.
- **Allegheny County, Pennsylvania** established the Allegheny County Jail Collaborative (ACJC) to better coordinate reentry services for county jail inmates. The Collaborative is comprised of representatives from the Allegheny County Jail, the county Department Human Services (DHS) the

Court of Common Pleas (criminal division) and the county Health Department the Jail Collaborative have initiated comprehensive planning that includes reentry programming which begins when individuals enter the county jail.

The wide range of service coordination provided to incarcerated individuals includes helping them apply for Medicaid and connecting them to substance abuse treatment and/or mental health services. Social workers at the jail assist in completing Medicaid enrollment applications and supporting documentation prior to a planned release and sending the information to the local County Assistance Office.

Allegheny County DHS Justice Related Services and community-based service coordinators may then also assist or accompany individuals to an appointment with the local County Assistance Office to complete the application process for Medicaid and to coordinate appropriate treatment and support services post-release. In addition, the Allegheny County Jail has developed a “Discharge Center” where staff helps individuals with their release by assisting with items such as medications, transportation, and appropriate clothing.

- **Salt Lake County, Utah:** The Division of Behavioral Health Services within the Department of Human Services has helped lead efforts to plan for how the justice-involved population within the county will be affected by the Medicaid Expansion and creation of health insurance exchanges.

By actively communicating with their state Medicaid office, they were able to gather information demonstrating that most inmates in the county’s jail system will fall into the new Medicaid expansion population category. To develop strategies for enrolling these newly eligible individuals, they have created a health care services integration coordinator position. Additionally, the county is currently actively enrolling eligible inmates in Medicaid so they will be able to receive benefits on their release. This process has been facilitated by the county directly employing state Medicaid eligibility determination workers by paying the Medicaid administrative match rate as well as by working with other community partners.

- **Massachusetts:** Massachusetts’ (MA) electronic “virtual gateway” application made a significant improvement in the rates of MA inmates leaving with Medicaid coverage. Since the MA system began with a manual application, it has seen its rates climb from 40 percent to 90 percent of offenders leaving incarceration with Medicaid coverage in place. MA’s electronic system has assisted in identifying the underlying rationale for the 10 percent who remain without access. The 10 percent fell into groups that either 1) refused participation, 2) had plans to live

outside of the state, 3) were already enrolled, 4) had issues with immigration status, or 5) were included in a group of parolees that the state is now actively targeting. The state has identified the components critical to success including use of a Medicaid new member booklet, a strong relationship with the Medicaid program, and outreach to inmates prior to release. Released probationers became more favorable clients for community providers to serve given that they had already established insurance coverage.

Within MA, data has shown that 22 percent of people with substance use disorders are not enrolled in health programs, in comparison with a 2 percent statewide non-enrollment rate. This data indicates that targeted Medicaid enrollment efforts in the criminal justice system to focus on people with substance abuse disorders may be useful towards narrowing such enrollment gaps.

### **Staffing Up Smartly**

States are creating a process for conducting background checks of individuals who seek to assist with enrollment and may exclude those with a demonstrated history of abuse of personal information or other criminal offenses that may indicate a propensity to abuse such information.

Staff who interact with inmates in correctional settings and know about eligibility guidelines and behavioral health options (i.e., ones covered by the county LIHP or other health plans) can act as invaluable intermediaries, encouraging inmates accustomed to self-medicating or suffering in isolation on the outside to seek services from culturally competent providers in the community upon release.

Examples of people who can staff an enrollment initiative include:

- Contracted mental health counselors and social workers;
- Reentry staff;
- Probation officers;
- County health staff;
- Staff of nonprofit social services agencies; and
- Trained probationers.

If staffing is a concern, consider **some states have used the ACA's Navigator and Assister Enrollment Entity** programs. Both programs provide funding to entities that have the capacity to provide outreach and assistance with applications for Medicaid and Health Insurance Exchange plans. Organizations eligible for funding include county human service agencies, nonprofits, and other community entities with experience enrolling individuals into federal programs. These groups could potentially assist with enrolling eligible individuals in jails or on probation.

It will be important to keep in mind that some serving as Assister Enrollment Entities may lack experience working with justice populations, making it critical to forge working relationships between these entities and public safety officials. County public safety agencies in several states may also want to consider applying to become Assister Enrollment Entities themselves.

Separate funding opportunities may also be available to help pay for Medicaid enrollment, which is not provided through the Navigator and Assister Programs.

Finally, county probation departments might consider working with a community partner to run a vocational education program to train and certify probationers to help enroll people as “assisters.”

#### **Key Considerations: Staff**

- Targeted and sufficient staff training based on sound information;
- Familiarity and rapport with the people in the justice system (language barriers and trust issues can stand in the way of securing cooperation and consent)
- Location of facilitators (logistically station and equip staff at opportune points of contact to maximize jail referrals and enrollment figures)
- Utilize the Navigators and Assisters Programs

#### **Key Considerations: Take Advantage of Technology**

Prior to the ACA, enrollment in publicly supported health care systems was cumbersome and involved heavy paperwork. Part of the vision of the ACA was to not only expand the number of people with health care coverage but also streamline and simplify the application process. The revised system allows people to apply online, in person, by phone, and by mail for Medicaid or exchange coverage using an application that requires an average of 15-20 minutes. Jails and probation departments should be able to assist people in applying for health plans online through State Health Insurance Exchange programs and receive real-time eligibility determinations, rather than sending paper applications to the county social service department and waiting anywhere from weeks to months for a decision.

Justice system officials should work with county and state health officials to explore ways to use technology to streamline enrollment. Examples might include:

- County jails utilizing collected information to help automate eligibility determinations; and
- County jails that have tablet computers and/or laptops with wireless capabilities to assist inmates in applying online even when security issues make inmate movement difficult.

## **Key Considerations: Tracking Enrollment**

In addition, developing a system to track enrollment and outcomes on a consistent basis will enable public safety officials to evaluate the success of an enrollment initiative and make improvements. Here are some examples of how enrollment tracking can occur:

- The sheriff or probation department can track who applies for coverage as part of the enrollment initiative and the outcome of each application. The sheriff or probation department can collect and analyze data on what refusal rates are, what the rate of successful applications is, how long the process takes, and what the recidivism rates are for people who are or are not enrolled.

“With approximately 85 percent of our sentenced population struggling with addiction and/or mental illness...leaving the jail with health care coverage and a mental health care provider can mean the difference between maintaining a healthy path of rehabilitation, or reoffending due to a lack of mental health treatment.”

– *SHERIFF KOUTOUJIAN OF MASSACHUSETTS*

## **Next Steps and Opportunities for State Behavioral Health Agencies**

SBHAs should consider advocating for the enrollment needs of individuals moving from jails and prisons to community-based settings to prevent discontinuity of care. SBHAs also should engage with their state Medicaid programs to determine how best to address enrollment for individuals who are transitioning between correctional systems to Medicaid to ensure that these individuals have continuous access to mental health services.

### **IV. Ensuring Medicaid-Eligible Youth are Enrolled as They Transition from Correctional Systems**

The period of transition from an institutional setting back to the community or home is a critical time for a juvenile justice-involved youth with a mental health condition. As youth move through the juvenile justice system – sometimes bouncing between settings multiple times before leaving the system completely – there are many opportunities for them to lose their Medicaid eligibility.

Some states are paying special attention to this critical time and have established policies to identify children in the system that are eligible for Medicaid, but not yet enrolled. States are also using enrollment procedures that will allow youth to quickly and easily enroll into Medicaid. These procedures include presumptive

eligibility, suspending eligibility rather than terminating it when the youth is incarcerated, and establishing special enrollment procedures, like requiring case managers or probation officers to fill out Medicaid applications for youth who are about to leave an institution.

At the other end of the continuum, only 12 of 28 juvenile justice agencies (or 43 percent) reported they screen or identify youth at intake to identify youth who may be eligible for Medicaid. Identifying youth with mental health conditions *eligible* for Medicaid is an important first step to enrolling them in Medicaid. The juvenile justice agency can play a role in identifying (and even enrolling) these youth.

### **Juvenile Justice Agents and Presumptive Eligibility Applications**

Presumptive eligibility is a state option in Medicaid that allows qualified entities to determine, based on a simplified calculation of family income, whether a child is likely to be eligible for Medicaid. States have the flexibility to deem agencies that provide services, such as juvenile justice programs, as qualified entities. Youth can receive temporary Medicaid eligibility pending a final eligibility determination by the Medicaid agency.

This is important because the faster youth get enrolled into Medicaid, the more quickly they will be able to access services after they transition away from the system. About 20 Medicaid agencies have adopted presumptive eligibility for children. Presumptive eligibility can also be implemented in state-financed health programs that do not use Medicaid funds, or even other benefit programs.

Some juvenile justice agencies report they allowed juvenile justice agents, such as juvenile justice agency staff, detention facility staff, or probation officers to complete presumptive eligibility applications, although not necessarily within Medicaid programs.

For example, the New Mexico Medicaid agency allows staff from the Children, Youth and Families Department to make Medicaid presumptive eligibility determinations for juvenile justice-involved youth.

However, none of the Medicaid agencies with presumptive eligibility that responded to our questions reported that they specifically allow juvenile justice agents to complete presumptive eligibility applications. There was no overlap in the state representation of juvenile justice agencies that reported that juvenile justice agency staff completed presumptive eligibility applications and the Medicaid agencies who reported they did not allow juvenile justice agents to fill out presumptive eligibility applications.

Most juvenile justice agencies said they had special procedures to facilitate Medicaid enrollment for youth transitioning from the system. Twenty-three of 30

juvenile justice agencies (or 77 percent) reported they have special procedures to facilitate Medicaid enrollment for youth when they transition from a public institution to the community (such as moving from detention or secure corrections to home or community-based treatment). Eighteen juvenile justice agencies (or 60 percent) reported special procedures for youth leaving the juvenile justice system completely (such as being released from parole).

The procedures most often cited involved tasking case managers or other agency staff with helping youth re-enroll. However, the level of assistance varied among agencies. Some juvenile justice agencies reported simply giving the child or child's family a Medicaid application. Some reported explaining to youth the potential of enrolling in Medicaid. Other agencies reported having a formal process for agency staff filling out Medicaid applications for every youth leaving custody.

Particularly strong agency procedures include:

- The Texas Juvenile Probation Commission, the state agency overseeing local juvenile probation departments, collaborated with five local juvenile probation departments and the State Medicaid office to create the Institutional Transitional Medicaid Program (ITMP).

In the ITMP, youth are screened for Medicaid eligibility at intake to the facility and again no later than 45 days prior to the projected date of discharge. If the family to which the youth is returning is eligible or the family is already enrolled in Medicaid, an application or renewal form is submitted by the juvenile probation office to the state Medicaid office on behalf of that youth and family.

- The New Hampshire Department of Health and Human Services reports the Department of Children, Youth and Families (the agency in charge of determining Medicaid eligibility) fiscal staff are notified whenever a youth's placement changes. When a youth leaves detention to go to a group or residential placement, the fiscal staff immediately determines Medicaid eligibility.
- However, most Medicaid agencies report they do not have special procedures to facilitate Medicaid enrollment when youth leave an institution or when they are released from parole. Only eight of 23 Medicaid agencies (or 35 percent) have special procedures to help youth enroll in Medicaid when they transition from a public institution to the community. Nine Medicaid agencies (or 39 percent) report they have special procedures for youth leaving the juvenile justice system completely.

Like the responses from juvenile justice agencies, most of the special procedures reported by Medicaid agencies involve assisting youth in applying for Medicaid,

ranging from the agency facilitating enrollment for the child to giving the youth's family a Medicaid application. Examples of agency procedures include:

- The Washington State Health and Recovery Services Administration says that youth at both transition points can apply for Medicaid up to 45 days prior to release and there is an expedited eligibility determination process in place.
- The Arizona Health Care Cost Containment System reports they have an agreement with the Department of Juvenile Corrections to predetermine Medicaid/CHIP eligibility so enrollment can be posted the day of release. The agency also has a process in participating counties where county detention staff reinstates suspended Medicaid or CHIP eligibility on the day of a youth's release.
- In Colorado, legislation enacted in 2008 requires juvenile justice commitment facility staff to assist the youth's family in applying for Medicaid coverage no later than 120 days before the youth's release date.

#### **Juvenile Justice Agencies and Special Policies to Meet Youth's Mental Health Needs**

Many juvenile justice agencies have special policies or procedures to screen youth with physical or mental health needs. Thirteen of 18 juvenile justice agencies (or 72 percent) reported have these special policies for youth moving from a public institution to the community.

Seven juvenile justice agencies have special policies for youth leaving the juvenile justice system completely. However, many of these agency procedures are the same as the procedures reported for facilitating Medicaid enrollment without regard for special health needs (see page 10). Examples of special procedures reported by juvenile justice agencies include:

- The North Dakota Department of Corrections and Rehabilitation, Division of Juvenile Services will not discharge youth leaving a less restrictive level of care from custody until a case plan is in place that takes their mental and physical health needs into consideration.
- The Oregon Youth Authority evaluates all children for every possible program or benefit for which they may qualify. All "special needs" youth are known to the Oregon Youth Authority disability analysts and the Medicaid eligibility specialist. This agency staff stays in close contact with the probation/parole officers to keep track of where youth are in the system.

## Suspending Medicaid Eligibility

As discussed in the previous section, Federal law prohibits Medicaid payments for care or services for certain inmates of public correctional institutions. States can either terminate or suspend an individual's Medicaid eligibility when the agency learns that an enrollee in the juvenile justice system has been incarcerated. If a state terminates eligibility, the youth must reapply for Medicaid upon release and wait for an eligibility determination before accessing Medicaid services.

Suspending Medicaid eligibility allows the state to restore Medicaid benefits relatively quickly -- and allows the youth to quickly access services -- upon release. Although suspension still requires a Medicaid agency to re-determine eligibility prior to putting the youth back on Medicaid, it can reduce the burden of reapplying for coverage on the youth and family.

- Among 25 responding Medicaid agencies, the **Arizona** Health Care Cost Containment System reported that in most counties it suspends, rather than terminates, eligibility when a youth enters a public correctional institution.
- The **New York** Department of Health suspends eligibility for youth who are incarcerated in a New York State Department of Correctional Services or local correctional facility but not in a juvenile justice facility.
- The Oregon Medicaid agency suspends Medicaid eligibility for juvenile justice-involved youth. When they leave the institution, the agency reinstates coverage for individuals, including juvenile-justice involved youth, who were enrolled at the time of incarceration.
- Three Medicaid agencies—the **California** Department of Health Services, the **Colorado** Department of Health Care Policy and Financing, and the **Florida** Agency for Health Care Administration are in the process of implementing policies and procedures to allow for the suspension of Medicaid eligibility when a youth enters a public correctional institution.
- Two other state Medicaid agencies reported that they were looking at the feasibility of instituting a suspension policy.

Most states that do not suspend eligibility refrain due to technology or fairness concerns. They report they do not suspend eligibility because it would be difficult to do under their current Medicaid Management Information System (MMIS) or because they want to maintain consistent practices across all enrolled populations.

## **SBHA Opportunities to Ensure Eligible Youth Enroll in Medicaid as They Transition Back to the Community**

Enrollment procedures could be more effective for the juvenile justice population in the following ways:

- **Identify Youth Who Qualify for Medicaid but Who Are Not Yet Enrolled.** Agencies could allow juvenile justice agents, such as case managers or probation officers, to screen children for Medicaid eligibility, and then assist with the application process, which could help ensure continuity of care and allow youth to access medical care once they leave an institution. Medicaid eligibility questions also could be integrated into standardized screening tools that are already being used to identify youth with mental health or chemical dependency issues.
- **Adopt Specialized Outreach Designed to Reach Youth in the Juvenile Justice System.** Allowing quick Medicaid enrollment when youth are preparing to return to the community or home makes it more likely they will be able to continue treatment or care that was begun while in an institutional setting. Although presumptive eligibility for children is only currently used by a few agencies, it is one enrollment measure that could be very effective for juvenile justice-involved youth.
- **Suspend Eligibility.** States are increasingly using this mechanism, but few Medicaid agencies reported having such policies currently in place. By suspending, rather than terminating eligibility, the state enables the youth to not have to reapply for Medicaid and access benefits and needed care more quickly once the youth returns to the community. Suspension policies can also benefit both the youth and the state by reducing the paperwork burden on the Medicaid agency, as well as the child or family. However, suspending eligibility still requires the Medicaid agency to re-determine eligibility prior to re-instituting youth's Medicaid coverage. Suspension may also require changes to Medicaid data systems that may be both expensive and time-consuming for agencies to implement.

### **V. Helping Those That Have Fought For Us: Enrolling Veterans with a Mental Illness**

Nationally, an estimated 535,000 uninsured veterans have incomes below 138 percent of FPL and could qualify for coverage under the ACA if their state expands Medicaid. Three-quarters of these -- over 400,000 -- have incomes below 100 percent of FPL and would not be eligible for new exchange subsidies; that group would qualify for new coverage options under the ACA only if their state expands Medicaid eligibility for at least 100% FPL. About one-third of this population has a mental illness such as post-traumatic stress disorder, depression and other serious mental health condition.

However, over half of these uninsured veterans live in states in which the governors have indicated that they are not intending to expand Medicaid in 2014 or are undecided about whether to expand. If all states were to expand Medicaid under the ACA, four in 10 uninsured veterans and one in four uninsured spouses of veterans could gain Medicaid coverage.

Beyond the Medicaid expansion, the health insurance coverage and mental health care access of veterans will likely be affected by other policy changes in the coming years. In particular, the implementation of other ACA provisions – such as the “no wrong door” policy, where applications to Medicaid, CHIP, or exchange coverage can be screened for a variety of health insurance programs; the individual mandate; and the use of trained navigators to assist individuals who are seeking health insurance coverage – could affect veterans’ enrollment in VA services by increasing their awareness of and interest in VA services and making it easier to enroll.

The inclusion of screening questions about veteran status on Medicaid/exchange applications and the use of data matches to identify and enroll eligible veterans could increase take-up of coverage among veterans. It remains to be seen the extent to which uninsured veterans would seek coverage through Medicaid, the VA, or other options under the ACA, and whether and how this would vary across states.

It is possible that some veterans now enrolled in VA care will also enroll in Medicaid and use care through Medicaid in addition to or instead of VA coverage. It is common for VA users to have other sources of coverage, and while concerns have been raised about care coordination and continuity of care for veterans with dual coverage, having both Medicaid and VA care could promote greater provider choice and convenience for veterans.

Participation in Medicaid could increase access to care, particularly for those in more remote areas without a VA facility nearby. At the same time, being in the VA system could connect veterans with other benefits, such as job placement services, educational assistance, and housing assistance, and increase the likelihood that their care meets their specific needs, particularly mental health and behavioral health needs. The VA is currently exploring how to help veterans successfully navigate the changing health care landscape under the ACA.

Given the uncertainty regarding how demand for VA services could change under the ACA and the likelihood that the share of veterans with dual coverage might grow, it will be important to assess the extent to which VA provider supply meets the demand for care, and to implement efforts to reduce fragmentation of mental health care among veterans enrolled in both VA and other coverage through such methods as electronic medical records sharing.

VA care is not an option for most uninsured family members of veterans. Enrollment in Medicaid and CHIP has already increased among those who were already eligible for coverage. This eligibility could address coverage gaps for some family members, particularly uninsured children.

However, uninsured low-income spouses will not have new public coverage options in those states that choose not to expand the Medicaid program. An additional complication for some veterans is the fact that VA care only covers the veteran and not additional family members, which may be an issue for some families who prefer having coverage that includes all family members.

Those with family incomes between 100 percent and 138 percent of FPL in states without a Medicaid expansion, as well as many with incomes above 138 percent of FPL but less than 400% FPL, will qualify for subsidies for coverage in new health insurance exchanges. However, eligibility is conditional on not having access to “affordable” employer-sponsored insurance (ESI), which is defined as having an offer of coverage for the worker that costs less than 9.5 percent of family income, even if the cost of family coverage is higher. Thus, even among veterans and their family members who could qualify for subsidized coverage, some could remain uninsured if they do not purchase available ESI for themselves or their families. In addition, exchange coverage has higher premiums, deductibles, and out-of-pocket cost-sharing than is required under Medicaid.

The Medicaid Expansion Program could help address coverage gaps for veterans and their family members in many states. As with the general population, lack of insurance among veterans and their family members is related to greater challenges accessing care. For veterans, enrollment in Medicaid would increase the likelihood of their health care needs being met.

## **VI. Outreach Strategies for Other Hard-to-Reach Groups: Hispanics Native Americans, Rural Residents**

In states like New Mexico, nearly 40 percent of uninsured adults have never had health insurance before. The majority of the people eligible for coverage are Latino/Hispanic or Native Americans – in communities that have historically faced significant disparities with health care coverage due to enrollment barriers and a lack of information about the options that are available.

According to surveys, Latino/Hispanic individuals and families, including recent immigrants, primarily get their health information from the following sources:

- A healthcare professional (doctor, nurse, or a Community Health Worker);
- Family and trusted friends;
- Television and radio, with radio as the strongest point of contact for immigrants.

Native Americans primarily get their health information from:

- Local radio, which is the strongest media point of contact;
- A “trusted messenger” family/ friend/ community leader who is known; or
- Television and newspapers.

Latino/Hispanic individuals and families are concerned about:

- Affordability;
- Documentation; and
- Risk of deportation if eligible children and family members get coverage.

Native Americans are concerned about:

- Affordability;
- Confusion about the nature of Medicaid;
- Why would someone use Medicaid instead of HIS;
- What is covered by Medicaid (or health insurance) and what is not;
- Whether nearby providers will take Medicaid (or health insurance).

Rural residents are concerned about:

- Access to providers and in-person enrollment locations; and
- Transportation to and from enrollment and services.

Ways to Reduce Barriers to Reach Underserved Communities

- Bilingual and culturally appropriate messaging and materials.
- Plain language, reading level appropriate messaging and materials (a significant portion of the population has not completed high school). Research shows that health insurance jargon, including common terms related to insurance like “co-pay” are confusing and may not be understood well.
- Access/Transportation: In rural areas and tribal areas, many rural residents cannot drive to their nearest service agencies or health providers. In some areas, the nearest health care providers and agencies may be several towns away.

#### **What Are The Most Effective Outreach Strategies?**

- Outreach to underserved communities should be done by trusted messengers, including health care providers, promoters and community health workers, community members and others that people know and trust.

- *Effective outreach must be community-based.* Enrolling on-site, in the immigrant communities, farm worker communities, rural residents, and tribal areas where people live and work is essential. Meeting people where they may go during the day will likely be effective for doing outreach: community centers, day care centers, schools, grocery stores, pharmacies, libraries, senior centers, and health care providers and service agencies.
- Messaging and outreach needs to occur at flexible times: before and after standard work hours and on weekends, as well as during the day.
- In rural, immigrant and Native American communities, heavy investment in in-person, radio and local newspaper strategies will likely bear the strongest results. In urban areas, engaging Hispanic and Native American populations should involve in-person, radio and television strategies.
- Reaching younger eligible enrollees across all of these populations will necessitate use of digital and social media, specifically text messaging and text message platforms like Twitter as well as websites and Facebook pages. Multiple language options should be available for all digital media.
- The messaging in outreach materials should address the concerns of uninsured populations – affordability, the ability to make informed decisions about coverage, and why healthcare coverage through the Exchange or Medicaid is important. Messaging should emphasize the ability of many family members in immigrant households to safely get coverage even if not all family members are eligible. Available access to healthcare providers is key.
- All materials and messages must be provided in multiple languages, and must be culturally and reading-level appropriate. Materials should be in plain language, short and to the point, with as many visuals as text in print materials and presentations. Individuals from the community should review and test materials before they are distributed to ensure translation accuracy, appropriateness, and effectiveness.

## **VII. Strengthening Enrollment Efforts to Increase Health Insurance for Men of Color**

The Affordable Care Act offers an historic opportunity to expand health insurance coverage and address health disparities among people of color through its mandate that states create new health insurance marketplaces that offer affordable coverage to all residents. The ACA also gives states the option of

filling gaps in coverage for the poorest Americans by expanding eligibility for their Medicaid programs.

Black males and other men of color should be a critical focus for states and new Medicaid coverage because this population has historically lower rates of health insurance, poor health outcomes, and disproportionate rates of poverty rates and homelessness compared to the general population.

Nevertheless, enrolling more men of color in health insurance will require targeted, aggressive outreach from trusted sources, effective messaging, and personal assistance in the enrollment process. It will take concerted and coordinated efforts on the part of multiple stakeholders working at multiple levels. Assisters' and Navigator Outreach Programs will be a critical component, but their efforts need to be supplemented and supported by many other organizations.

### **Enrollment Challenges and Barriers for Men of Color**

Reducing racial health disparities is one of the ACA's explicit goals. Race is an important factor that affects the likelihood of having health insurance and seeking care outside of emergency rooms.

Lack of health insurance is not the only reason for health disparities, but it is a critical component in addressing them. Ensuring that men of color are enrolled in health insurance will take the combined efforts of many organizations working at a number of levels. It will require outreach efforts that are intentional, widespread, and targeted specifically to this demographic group.

Providing health insurance is not a cure for all health problems, but it is a critical step in reducing health disparities. Without health insurance, lower-income clients are more likely to delay or forgo necessary health care services or seek costlier emergency room care in hospitals.

Many men of color currently lack any kind of health insurance, public or private. Many are unemployed or work in lower-paying jobs that do not provide employer-funded health insurance. Even when health insurance is free, it is not always accessed or utilized. Historically, many people do not register for public health insurance, even when they are eligible for it. Men of color are also more likely to be significantly disadvantaged in other ways that will make participation in the new insurance marketplace challenging.

Many individuals are unaware of or misinformed about the provisions of the Affordable Care Act. Many are daunted by the enrollment procedures and the complexity of choosing a health plan, or unsure whether they qualify for free or subsidized health insurance. For men of color, these issues may be compounded by other everyday realities.

Many men of color may find it particularly difficult to enroll or may be reluctant to enroll because they have:

- Have literacy and numeracy problems that make it difficult to manage the enrollment process.
- Suffer from mental health or substance abuse problems that can impede their ability to complete the enrollment process and/or maintain their eligibility. In Connecticut, for example, about 19 percent of the adults who will newly qualify for Medicaid are estimated to have some mental illness. Estimates are that about a third of those in Connecticut who have a serious mental illness and would qualify for Medicaid coverage under the ACA in Connecticut are people of color.
- Experienced multiple barriers in accessing health care in the past and/or are accustomed to seeking health care only in crises or on an emergency basis.
- Had difficult past experiences with enrollment and eligibility processes for public benefits.

All of these social factors contribute to health disparities and will make it more difficult for men of color to learn about the new Medicaid coverage opportunities and to complete the complicated insurance enrollment process. These issues also suggest that men of color will need targeted assistance to ensure they enroll in significant enough numbers to reduce historical racial disparities in health care access and improve health outcomes.

### **Recommendations for Outreach to Community-Based Groups**

Outreach and personalized assistance from trusted sources have been shown to boost enrollment rates in numerous public health insurance programs. As we have discussed in this paper, In-Person Assister programs provide opportunities for staff of grassroots community organizations to become certified Assistors in the enrollment process. Assistors are being trained in the enrollment procedures and health insurance options available through the ACA and will be involved in education, outreach, and enrollment efforts in their communities.

Navigator organizations can coordinate and support Assister efforts. These programs are following best practice by focusing on personal assistance to enrollees, reaching out to community-based groups and local enterprises that serve men of color and have strong foundations in a neighborhood, and targeting neighborhoods with high concentrations of uninsured individuals.

Nevertheless, community outreach and enrollment efforts need to be on-going and widespread and involve others beyond the cadre of officially certified

Assisters. Community members need to be pro-active in their outreach efforts and target places where men of color are most likely to be present in significant numbers as venues for disseminating information about the ACA, health insurance, and health care. These locations might include, for example:

- Churches and faith-based organizations;
- Affinity/associational groups of all types: immigrant associations, college fraternities, sports leagues;
- Pharmacies, recreational centers, gyms, and barbershops;
- Ethnic restaurants and grocery stores; and
- Soup kitchens, food pantries, homeless shelters.

Community groups will not have the detailed information that trained Assisters will have. But they can do much to inform people, raise their interest in health insurance and health care, and make referrals to others who can provide them more specific help. Community groups can also help craft effective outreach and informational messages for men of color.

Community groups can:

- Send as many staff and volunteers as possible to the training opportunities available to community members through the Navigator and In-Person Assister Programs;
- Make additional efforts to inform their staff, members, and volunteers about the ACA and encourage them to spread the word about the ACA;
- Use informal conversations, public events, social hours, meetings, newsletters, and other opportunities to provide information about the ACA to community members and encourage men of color to enroll in health insurance, utilize health care, and engage in healthy life styles.
- Provide information about the ACA in the languages community members speak and read.
- Refer individuals who have more questions to others – such as local Assisters—who can give them more specific information and assistance.
- Encourage female members to spread information about the ACA's enrollment options and urge the men in their lives to sign up for insurance coverage and utilize health services.
- Family members, spouses, partners, and friends are also important in getting the message to men of color and encouraging them to enroll in health insurance or Medicaid and seek health care once they have coverage. Evidence about the effectiveness of media efforts and public

education campaigns alone is mixed, but it is clear that more targeted and personalized outreach and enrollment efforts can be very effective.

### **Recommendations for Non-Profit Service Providers**

Poor health affects so many aspects of a person's life - employment, education, housing, and parenting – and so many other aspects of life affect a person's health status that client health is a significant concern for all service providers who work with low-income men of color. It would be beneficial for these organizations to provide information about the ACA to their clients, encourage them to enroll in health insurance, and urge them to seek health care for their medical needs. In addition, given the high incarceration rates of African American males, non-profit organizations that work with the reentry population can be critical sources of information about health care and enrollment under the ACA.

Community-based programs that work on adolescent health issues, mental health, and substance abuse can also play a critical outreach role. Further, since many young men of color are noncustodial, single parents, local fatherhood programs can be important points of contact.

Staff at non-profit service providers can:

- Familiarize themselves with the provisions of the ACA and what is required to enroll in Medicaid or a plan available in the state health insurance exchange;
- Encourage their clients to enroll in Medicaid or a health insurance plan;
- Know who the local Assisters and Navigators are and refer clients to them for more detailed information about enrollment and insurance choices;
- Post information about the ACA in waiting rooms and offices and provide written materials that explain enrollment procedures and eligibility criteria for expanded Medicaid and subsidized care;
- Provide information about the ACA in the languages clients speak and read;
- Encourage trusted messengers to talk with their male friends, partners, family members, and relatives about the ACA and healthcare and encourage them to enroll in a plan; and
- Co-ordinate dissemination strategies and share information with other non-profit organizations that work with men of color.

### **Recommendations for Community Health Centers**

Community-based health centers are a key source of health care for communities of color. They can also play a critical role in ensuring that people who are eligible for public health insurance receive and maintain coverage. Research shows when health centers invest in outreach they benefit financially

from having more patients covered by health insurance, and their patients benefit from having continuous access to care and coverage.

To facilitate enrollment of men of color in Medicaid or a health plan offered by a health plan in the state exchange, community health centers can:

- Map areas with high concentrations of uninsured and Medicaid-eligible individuals and target outreach and enrollment efforts to these areas.
- Build eligibility screening into all center functions, including patient care, billing, translation services, and transportation services.
- Train health center workers in application procedures and outreach techniques, and provide them with eligibility screening tools, promotional materials, and policy-related information.
- Designate outreach staff to actively reach out to and engage with uninsured individuals, enroll them in health coverage, and maintain eligibility for those already enrolled.
- Research the communities in which they are working and build relationships with community-based organizations, faith-based organizations, local resident associations, and other key groups.

Other state agencies play a critical role in setting policy and administrative procedures that affect enrollment in public health benefits and the new exchanges.

To facilitate the enrollment of men of color, state departments of Social Services can:

- Take advantage of federal opportunities that allow automatic or simplified enrollment in Medicaid for certain groups, such as recipients of the Supplemental Nutrition Assistance Program (SNAP) and parents with children enrolled in Medicaid/Husky A & B (Children's Health Insurance Program). These options are time limited, and states must submit waiver applications to utilize them.
- Have DSS eligibility workers available in community health centers to enroll patients in public healthcare benefits.
- Work to strengthen cross-agency connections and coordinate policies and practices to ease barriers to enrollment. For example, work with the Department of Corrections to enroll men in health insurance when they leave the criminal justice system.

## **Keeping Men of Color Eligible and Enrolled in Health Insurance**

There is an additional challenge in not just getting men of color enrolled in Medicaid or private health insurance, but also maintaining their eligibility once they are enrolled. It's important to reduce the "churning" that occurs when individuals cycle on and off coverage. In the Medicaid system, this churning can happen because of fluctuations in income or failure to comply with administrative requirements such as providing timely notification about changes in status. Even a temporary loss of coverage can cause low-income patients to delay or forgo necessary health services or seek care only in emergency situations.

### **Recommendations for Community Health Centers and Community-Based Organizations (CBOs)**

Community health centers and CBOs can take a number of simple actions to help their clients and patients maintain eligibility for public health insurance. For example, they can add a tickler or alert to the patient's/client's file to automatically send a reminder postcard, email, or text message close to renewal time to remind them to renew or they can proactively call clients whose eligibility is about to expire. Further, they can place "apply and renew" posters in public waiting spaces, providing the information to connect people to outreach and eligibility workers:

Organizations should make special efforts to keep particularly vulnerable populations, such as individuals with mental health or substance abuse problems, aware of eligibility requirements and the consequences of not responding. The health problems and frequent changes in address that are typical of this population can make it difficult for them to receive notifications or submit forms and documentation within a short time frame. As a result, notifications and reminders should be transmitted well in advance.

### **Recommendations for Departments of Social Services**

Administrative regulations and practices can make it difficult for Medicaid beneficiaries to maintain eligibility over time. Seemingly small scale changes in enrollment rules can have a large impact on actual enrollment. For example, when **Texas** required enrollees in the State Children's Health Insurance Program (SCHIP) to renew eligibility every six months instead of every 12 months, enrollment dropped substantially. In contrast, when **Georgia** allowed on-line applications and loosened renewal requirements, enrollment increased. Easing requirements and lengthening the application and recertification period can also ease the administrative burden of processing applications.

To reduce churning, Departments of Social Services should:

- Utilize the new federal option that allows states to provide 12 months of continuous coverage;
- Simplify application, recertification, and eligibility policies and procedures;
- Make special efforts to keep particularly vulnerable populations, such as individuals with mental health or substance abuse problems, enrolled. For example, develop policies designed to maximize continuity in coverage and minimize unnecessary enrollee response requirements; and
- Develop customized enrollment and recertification training for providers that serve behavioral health patients who are not insured.

### **VIII. Conclusion**

This issue paper highlighted several areas of opportunities and strategies for states to enroll newly eligible, uninsured, and difficult-to-reach populations under the ACA, including people with mental health and substance use disorders who are homeless, transitioning from jails into the community, veterans and/or special minority populations.

Much of the success of the Affordable Care Act will depend on the degree to which states and the federal government can enroll these historically underserved and vulnerable populations of newly eligible, uninsured persons into health coverage. The law is currently projected to provide health insurance—and by extension, improved access to comprehensive care—to 14 million individuals in 2014 after coverage expansions are first implemented, and to an estimated 25 million by 2016.

Such gains are to occur as a result of the ACA's provisions to expand Medicaid to cover poor and near-poor adults, and to create new health insurance marketplaces where individuals will be able to shop for insurance among competing health plans and receive federal subsidies – in the form of premium tax credits and cost-sharing reductions – to help pay for coverage, depending on their level of income.

Meeting enrollment goals will hinge on multiple factors, including whether the new streamlined eligibility and enrollment systems called for in the ACA are implemented successfully, and whether eligible populations find marketplace premiums affordable.

Equally important, however, are two precursors to the ultimate goal of enrollment:

- Outreach and marketing campaigns that effectively raise the eligible populations' awareness of the availability of new coverage options and inform them of how to access that coverage; and

- Enrollment assistance structures that meet the unique needs of diverse populations with a variety of ways to obtain assistance with the application process.

It will be important that community-based outreach and education efforts are a critical complement to broader marketing campaigns. Hands-on application assistance using trusted community groups and providers must be incorporated to put real “teeth” into outreach.

Regardless of the size, breadth, and depth of investments in outreach and application assistance, it will take considerable time to achieve broad participation among newly eligible consumers in coverage.

Although CHIP had strong bipartisan support and children were viewed as a high priority population by policymakers of all political perspectives, states adopted CHIP coverage in just over two years and the program *still* did not achieve its enrollment goals in the early years of the program.

The ACA, in contrast, enjoys little of CHIP’s advantages – in terms of widespread political support or uniform adoption across the states – suggesting that enrollment for the 2014 coverage expansions could climb even more slowly, perhaps over many years. 00

State and federal policy-makers appear to be heeding the lessons of Medicaid and CHIP in designing outreach campaigns that combine both broad efforts to raise public awareness and community-based efforts to reach the “hard to reach.” Furthermore, outreach campaigns are being supported by extensive application assistance programs, designed to provide consumers with direct, hands-on help with completing the application process.

States and the federal government have taken many of the steps necessary to successfully promote insurance affordability programs, educate the public about new coverage options coming available under health care reform, and creating new infrastructures for providing consumers with enrollment assistance. Policymakers are launching multi-pronged campaigns that combine broad marketing with grass-roots outreach based on lessons learned from previous expansions of coverage under Medicaid, CHIP, and other state coverage initiatives.

Critically, they are equipping community-based outreach entities with the tools and training to also provide hands-on application assistance to consumers who need help navigating the enrollment process, typically building on existing networks of application assistors that have operated for years within Medicaid and CHIP programs.

The most impressive efforts have involved diverse stakeholders from the beginning of the planning process, to gain their early input and buy-in, and to create long-term outreach partners that can help spread the word as expansions are implemented. What is striking, however, is that while state and federal policy-makers are both taking many of the right steps, they are doing so at different levels of intensity. These differences are likely to result in state-to-state variation in terms of the ultimate measure of success: consumer enrollment into coverage.