
City and County of San Francisco
Mayor Gavin Newsom

# Return on Investment: How SSI Advocacy Became a Standard of Practice in San Francisco

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## Background

In 1998, the San Francisco Department of Public Health (SFDPH) adopted a "single standard of care" as its mental health policy[1]. This provided that uninsured San Franciscans will have access to the same level of mental healthcare as the insured. Additionally, it opened a range of much needed services to San Francisco's hard-to-reach and uninsured homeless population.

In 2002, under the leadership of Dr. Mitch Katz, Director of Health for SFDPH, a citywide workgroup was formed to identify barriers and develop recommendations to assure that SFDPH patients and clients who are eligible for Supplemental Security Income (SSI) benefits attained them. The workgroup included staff from the Social Security Administration (SSA), Department of Human Services, SFDPH, and the public benefits advocacy community. To conduct its research, the workgroup frequently met with the treatment community.

The workgroup identified that to reach such a goal, the recommendations would have to address the SFDPH clinical staff's real and perceived problems with not only the application process, but the entitlement itself:

- The process is complicated, time-consuming, and often futile;
- Advocates try to tell me who is disabled and how to diagnose my clients;
- The benefit is contrary to the "recovery model," it is a permanent label, and the money "enables" clients with their substance addictions.

Recommendations to Dr. Katz included goals, resources, and ways to address the cultural shift needed (Attachment A, page 6).

In 2004 and following the publication of his committee's report "San Francisco's 10-Year Plan to Abolish Chronic Homelessness[2]" wherein SSI Advocacy was identified as an important intervention for ending homelessness (page 13), Mayor Gavin Newsom asked the Citywide SSI Advocacy Workgroup to summarize the benefits, barriers, and recommendations for moving disabled residents onto SSI.

To determine the potential economic benefits to San Francisco for this report, the workgroup researched the lists of enrollees in the County Adult Assistance Program's "SSI Pending Program" (a cash benefit program for those who are presumed disabled) and the uninsured patients of the SFDPH mental health plan who were coded with severe DSM-IV diagnoses.

Results estimated that there were over 5,000 disabled individuals who were potentially eligible for SSI and SSI-linked Medi-Cal: a potential revenue-generating, cost-reducing engine of nearly $27 million.

The Citywide SSI Advocacy Workgroup categorized its recommendations to the Mayor (Attachment B, page 6) as follows:

- Provide Leadership and Training;
- Increase SSI Advocacy Services;
- Advocate for California Legislative Changes;

[1] Available at http://www.sfgov.org/site/uploadedfiles/mental_health/archive/m061098.doc
[2] For complete report, go to http://www.ich.gov/slocal/plans/sanfrancisco.pdf

- Advocate to Reform How the State Agency Adjudicates its SSI Claims;
- Standardize Performance Objectives and Measure Success Citywide.

This report generated significant support to implement an SSI Advocacy Pilot Project for the Mental Health System of Care.

## Mental Health SSI Advocacy Services Pilot Project

The pilot project was implemented over the two fiscal years FY0304 and FY0405 with the community-based organization, Positive Resource Center (PRC). The goal of the pilot was to serve and support mental health clinic staff in getting their selected clients onto SSI; a different model from before, where advocates independently served clients and contacted clinicians on behalf of their clients only for medical evidence. PRC partnered with mental health clinics and provided clinicians with training regarding SSA disability criteria and documentation and consulted with them regarding their individual clients. In conjunction with the clinicians, PRC developed SSI applications, gathered medical evidence, and provided legal services for clients who were referred by these clinics. SFDPH contract objectives for the pilot included targets for satisfaction ratings by both clients and clinic staff. The pilot was doubled in FY0405 based upon positive outcomes from the first year.

At the end of the two-year pilot, SFDPH measured the impact (see Appendix C, page 18). Based on the data gathered from SSI award letters, CalMEDs, SFDPH and EMS billing systems, and Positive Resource Center, we were able to determine:

a. **86% Award Rate**, averaging 12 months of retroactive benefits.
b. **93% brought SSI-linked Medi-Cal benefits**, averaging 10 months of retroactive Medi-Cal coverage.
    - [Note: 45% of the retroactive Medi-Cal months awarded required CCSF staff to *manually* activate them; 14% because Cal-MEDs had not been accurately updated by the Federal SSA data links and 32% via Letters of Authorization because the services occurred over 13 months prior to the billing.]
c. 227 awards are projected to have brought in a total of **$3,173,673 new revenues** during the 2-year period to CCSF (calculated during year-one of each award):
    - $2,734,259 of SSI-linked Medi-Cal revenues to the SFDPH, an average of $12,045 retro dollars per award.
    - $428,406 to CCSF Department of Human Services for reimbursement of cash benefits (Interim Assistance Reimbursement, IAR), an average of $3,150 returned dollars per award.
    - $11,008 of SSI-linked Medi-Cal revenues to EMS for prior ambulance pick-ups.
d. **SSI Advocacy services cost $643,234**, averaging $2,834 investment per award.
e. **5 to 1 hard dollar return on investment in year one alone.**
f. Following the first year, it is expected that the SFDPH will be able to draw-down an average of $4,000 per year of Medi-Cal revenues per SSI-insured client. An amount that would have previously been covered by CCSF general fund. In addition, the Department of Human Services no longer has to pay financial assistance for these clients.
g. Clients have access to the Department of Rehab and are able to access medical care and afford housing.

Other findings:

- Average age of individual awarded was 43.
- 69% were homeless (56% chronically homeless).
- 92% of awards were won at the same application level the provider received the case, 8% were awarded following one appeal.

## Updates

a. Since the pilot, CCSF has been able to draw-down between 50 and 75% of its expenses for SSI-Linked Medi-Cal Advocacy from the Community Services Block Grant (CSBG), a state fund that assists counties in getting individuals on to Medi-Cal. As a result, the first-year return for SFDPH has nearly doubled.

b. However, the California Department of Mental Health is denying payment for mental health services bills that have aged over 13 months. This denial is being challenged in court citing mental health equity laws, as the State will reimburse for *medical* services that have aged over 13 months.

c. To expand Medi-Cal coverage for SSI recipients, we are currently working on a pilot with the San Francisco Medi-Cal Office to adopt the SSI onset date and allow three months prior Medi-Cal coverage. To accomplish this, advocates simultaneously complete SSI applications and Medi-Cal eligibility applications that establish non-medical eligibility for the three months prior to the onset date.

d. With the dollars recouped by the pilot program, SFDPH was able to enact what is now a comprehensive SSI Advocacy Program which offers two models of services: legal and clinical; as well as add community-based rep payee services and administrative personnel. SSI advocates from three programs (Positive Resource Center, Disability Evaluation and Advocacy Program, and Homeless Advocacy Project) now serve all out-patient Mental Health Clinics, jail health, methadone maintenance programs, primary care clinics, and inpatient psychiatric units.

e. In FY0607, SFDPH required as part of the performance objectives for its mental health outpatient programs that SSI applications be submitted for at least 5% of all uninsured active clients with a DSM-IV diagnosis code that likely indicates disability. This objective was achieved and surpassed by the twenty-five outpatient mental health programs working collaboratively with the SSI advocacy groups funded by SFDPH. To further its commitment in assisting and supporting disabled clients in their applications for SSI, the application-rate objective was increased for FY0708 to 25%, and is expected to increase in FY0809.

f. Since FY04, SFDPH-funded SSI Advocates have helped over 2,000 clients get SSI benefits.

# Plan to Implement 9 Recommendations for DPH

Recommendations submitted to Barbara A. Garcia, Deputy Director of Health, July 17, 2002
Draft Implementation Plan submitted to Gregg Sass, DPH Chief Financial Officer, August 1, 2003

**Goal**: Assure DPH patients and clients who are eligible for SSI benefits attain them.
**Objective**: DPH provide leadership, policies, increased efficiencies and dedicated resources as follows:

| # | Recommendation | Draft Implementation Plan |
|---|---|---|
| 1 | Continue to provide leadership and support for Citywide multi-disciplinary focus of SSI. | • Maria X Martinez, Deputy Director of Community Programs to continue to lead Citywide SSI Advocacy Workgroup toward goals |
| 2 | Shift DPH provider philosophy to that of:<br>*"SSI benefits help disabled clients achieve their therapeutic goals by improving access to healthcare and by giving them the financial means to stabilize their living situation and better meet their nutritional needs."* | • Bob Cabaj, Director of Community Behavioral Health Services to provide leadership.<br>• Training / expansion of pilot projects |
| 3 | Set DPH goal:<br>*"All DPH clients will be screened for SSI eligibility. All clients deemed eligible for SSI benefits will be assisted through the application process."* | • Per Dr. Mitch Katz, feasibility to be determined through pilot projects. |
| 4 | Provide SSI Advocacy training to City and CBO staff, including:<br>• Case Management and Outreach Teams<br>• Staff at Access Points<br>• Clinicians<br>• Medi-Cal Eligibility Workers | • **Proposal and budget to be developed.** |
| 5 | Maintain current SSI Advocacy Services and expand to jails, all mental health clinics, and all primary care programs. | • Expand SSI Mental Health Advocacy pilot project (with Positive Resource Center) to add 2 more outpatient clinic sites and the jail. Projected $2.70 return for every dollar invested. **Proposal and budget to be developed.** |
| 6 | Have Medi-Cal Eligibility Workers process SSI applications instead of Medi-Cal applications. | • Per Dr. Mitch Katz, feasibility to be determined through pilot projects. |
| 7 | Integrate SSI eligibility screening questions into DPH clinical screening and intake forms. | • Per Dr. Mitch Katz, feasibility to be determined through pilot projects. |
| 8 | Add SSI eligibility advocacy services to DPH performance objectives; for example, set standards for mental health clinicians to respond to SSI applications and other documentation in a timely and quality fashion. | • Per Dr. Mitch Katz, feasibility to be determined through pilot projects. |
| 9 | Assure timely access to mental health treatment for SSI Advocacy clients. | • Per Dr. Mitch Katz, feasibility to be determined through pilot projects. |

**Purpose of the Citywide SSI Advocacy Systems Workgroup**
San Francisco has unmet need for SSI Advocacy services. There are not enough resources in the system to serve all in need. All in need are not aware of or do not seek services. An overall system approach will enable San Francisco to leverage limited resources, increase client engagement, and improve services.

– DHS County Adult Assistance Programs – San Francisco General Hospital – DPH Community Mental Health Services –
– Homeless Advocacy Project – Positive Resource Center – Social Security Administration – DPH Community Programs –
– SFGH SSI Project – DHS Behavioral Health – DHS Homeless Programs – CJCJ –
– DPH Disability Evaluation Assistance Program – DHS CAAP SSI Project – GAAP SSI Project – Private Attorneys –
– Westside CalWORKs Counseling Services – Conard House –

**Attachment B**

Gavin Newsom
Mayor

# Moving Disabled San Franciscans on to SSI:

# **Benefits, Barriers, and Recommendations for SSI Advocacy**

Requested by and submitted to

Mayor Gavin Newsom

Citywide SSI Advocacy Workgroup

of San Francisco

October 20, 2004

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**Background** _____

There are over 5,000 disabled San Franciscans who are eligible for SSI, but are not enrolled[3].

The Department of Public Health (DPH) estimates that there are over 3,500 uninsured mental health clients who are most likely eligible for SSI. Because SSI enrollees automatically receive Medi-Cal benefits, the City could draw down an estimated $5,700 of revenue per year per client – an estimated $20 million of untapped revenue per year for these clients alone.

Over 1,400 clients a year receive cash benefits through the City-funded Social Security Insurance Pending (SSIP) program at the Department of Human Services (DHS) – an approximate $7 million annual expense plus the SSIP administrative costs could be avoided by the City were these individuals moved on to SSI.

**What is SSI** _____

SSI is a program of the Social Security Administration that provides cash assistance payments to aged, blind or disabled people who have limited income and resources. Although SSI is a federal benefit, some states contribute to the federal benefit rate. California pays the highest rate in the country for SSI beneficiaries. Most states, including California, provide full Medicaid coverage to SSI recipients.

Eligibility includes meeting both medical and non-medical rules:

The medical definition of disabled is as follows:

1. Inability to earn $830/month (as of 2005).
2. Due to a severe, documented medical impairment.
3. Likely to last longer than 12 months or result in death.

Non-medical rules are as follows:

1. Assets < $2000 (some assets are exempt, for example a car and a house if you live in it).
2. "Qualified Immigrant" status or citizen (qualified immigrants may include asylees, refugees, Cuban/Haitian entrants, some battered women and children, those with withholding of deportation status and some Lawful Permanent Residents).
3. No outstanding felony warrants or violations of parole or probation (good cause exceptions apply as of 1/1/05 and new ruling by District Court for Northern California allows for exceptions).
4. Unearned income (Social Security Disability Insurance or gifts, for example) is below the SSI levels (which vary depending on people's living situation and which state they live in).

**SSI Advocacy Services** _____

SSI advocacy services may include one or more of the following:

- Screening clients for eligibility
- Consulting with providers
- Completing applications, including gathering evidence of disability from medical records and various treatment providers
- Providing consultative exams and psychological testing to determine disability
- Scheduling and transporting clients to appointments

[3] This projection considers an analysis of uninsured mental health patients seen at DPH and clients enrolled in SSIP at DHS (of which, only 25% overlap with the mental health patients, resulting in 3,850 total unduplicated clients). It is a conservative estimate that there are at least 1,150 additional San Franciscans who would also qualify, including those who are not served by DPH, patients who have physical-only disabilities, mental health patients who have Medi-Cal without SSI, and those who are incarcerated.

- Representing clients at the initial stage and when applications are denied (first denial is "recon" with the SSA Office, second denials require going before an Administrative Law Judge, and, third denials require going before the Appeals Council)

**Benefits of SSI and SSI Advocacy** _____

Benefits to clients:

- $872[4] per month (over twice their cash benefit from SSIP) means clients are more likely to have access to housing and better meet their nutritional needs.
- Medi-Cal coverage means clients are more likely to become engaged in ongoing and preventive treatment.
- The benefits case management that is provided during the course of advocacy services oftentimes leads to clients become engaged in medical and mental health care.
- Clients are able to access Department of Rehabilitation for vocational assessment and training.

Benefits to the City:

- The City would be reimbursed by Medi-Cal for half of its eligible health service costs. Savings are estimated to be about $5,700 per client, or $20 million total per year, were all 3,500 clients estimated to be eligible were moved on to SSI.
- Moving individuals onto SSI, as opposed to SSIP (a County cash benefit), would reduce $7 million per year of General Fund expenditures, not including staff costs.
- In addition to the projected DPH and DHS ongoing savings, one analysis showed that clients were retroactively enrolled onto SSI an average of 1.5 years. Although total annual figures are not yet available, we do know the individual client return.
  - The federal government reimburses counties for the cash assistance that was provided to clients during the effective SSI dates (known as Interim Assistance Reimbursement, or IAR billings). IAR billings have averaged about $3,000 per client.
  - In addition, Medi-Cal eligibility is also retro-activated, enabling the City to bill for eligible services rendered during the retro-effective dates. Retroactive Medi-Cal billings have averaged about $11,000 per client.
- Only 60-70% of those clients housed in DPH's supportive housing (Direct Access to Housing, or DAH) are on SSI. Clients on SSI are able to make a larger client-share contribution to their supportive housing and residential treatment costs.
- **The estimated return on investment for SSI advocacy services is 5:1 for year one alone[5].**

**Recommendations**_____

## I. Provide Leadership and Training.

### Background

- Applications for SSI are not being activated.
  Eligibility Clerks throughout DPH and DHS help clients apply for Medi-Cal, but not SSI. At SFGH, there is just one staff member who coordinates all SSI applications. Few City employees and providers who work with SSI-eligible clients are trained to assess eligibility.
- Resistance in the treatment community.
  Some mental health clinicians are reluctant to declare their patients "disabled" even though their clients may meet eligibility requirements. The time required to complete the

[4] $872 is the amount for individuals who do not have access to cooking facilities (a stove or refrigerator); i.e., those who are homeless. $790 is the amount for individuals who do have access to these resources.

[5] Conservative estimate based upon advocacy costs averaging $2,500 per client served (CBO rates) versus revenues generated for 85% of the clients who are awarded, totaling $20,000 ($11,000 retroactive Medi-Cal revenue + $5,700 annual Medi-Cal revenue + $3,000 IAR revenues).

application is perceived to be too great given their extremely limited time and the small return (due to belief that most clients will not be awarded). Some clinicians incorrectly believe that substance abuse in itself automatically (or should automatically) disqualify a client from SSI.

**Specific Recommendations**

1. Shift DPH provider philosophy to "SSI benefits help disabled clients achieve their therapeutic goals by improving access to healthcare and by giving them the financial means to stabilize their living situation and better meet their nutritional needs."
2. Set DPH goal that "All DPH clients will be screened for SSI eligibility. All clients deemed eligible for SSI benefits will be assisted through the application process."
3. Train DPH employees to recognize SSI eligibility, to pro-actively help clients begin the application process, and to improve charting so that medical records more effectively establish disability. Prioritize trainings as follows:
    - Mental Health Clinicians
    - Social Workers and Case Managers
    - Eligibility Workers
    - Mental Health Access
4. Maintain a multi-disciplinary and systems perspective of SSI policies and procedures by supporting the continuation of the Citywide SSI Advocacy Workgroup.

## II. Increase SSI Advocacy Services.

### Background

By all accounts, the SSI application process is extremely complicated and difficult to maneuver, especially for clients who are challenged by poverty and severe psychiatric disabilities. Many start but do not complete the process, as supported by the San Francisco Social Security Administration (Market Street Office) findings:

- 50% of scheduled appointments for initial claims do not show up.
- For those who get far enough to be approved by the State Agency for SSI, 25% do not show up for their appointments to finish the processing of their case.
- 92% of initial claims denied for failure to attend a consultative examination or provide additional medical information were for clients who did not have SSI advocacy.

Overall (with or without SSI Advocacy), only 40% of SSI applications adjudicated nationwide are approved, and most of the remaining 60% who are denied do not file an appeal. In contrast, 85-95% of applicants who receive a combination of case management and legal advocacy are approved.

Those who are disabled and homeless, in particular, have difficulty negotiating their way through the SSI application process. Using statistics on the incidence of both mental health and physical impairments among homeless persons from a 1996 Federal survey of homeless assistance providers and their clients, the National Law Center on Homelessness and Poverty estimates that up to 40% of homeless persons may be eligible for SSI - with only 11% receiving it. Of the approximate 120 homeless persons assessed this year in San Francisco's jail, only 12 (or 10%) were on SSI. Of all homeless clients who accessed the Homeless Advocacy Project office this year, 71% were disabled[6] and only 20% were already on SSI.

There are a handful of SSI advocacy programs provided and/or contracted by the City that will serve about 1,400 clients this year. Non-profits include the Homeless Advocacy Project[7] and

[6] Undetermined if all were severely enough disabled to qualify for SSI.

[7] Homeless Advocacy Project (HAP), in partnership with DPH and DHS, HAP was recently awarded a Social Security Administration HOPE grant. This grant targets 50 homeless individuals who are not engaged in treatment. DPH also contracts with HAP to provide legal services to about 300 clients per year.

Positive Resource Center[8]. Civil Service programs include the DHS Disability Evaluation Consulting Unit[9] and the DPH Disability Evaluation Assistance Program (DEAP)[10].

The demand for SSI Advocacy services far exceeds the supply.

**Specific Recommendations**

1. Implement the recommendations included in San Francisco's Ten Year Plan to End Homelessness (attached, page 13) which outlines about $3 million of additional resources as follows:
   - 50 Fulltime Benefits Advocates
   - 3 Fulltime Attorneys
   - 3 Fulltime Medical Records Technicians
   - Psychologist/Physician Consultative Exam Resources
   - Administrative Support
2. Reinvest revenues generated as a result of one year's advocacy services into expanding the next year's advocacy services.
3. Target special populations and design advocacy services to meet these population's special needs as follows:
   - DHS SSIP Program
   - DPH Adult Mental Health
   - DPH Supportive Housing
   - DHS Case Managed SROs
   - Jail Psych (SSI continued and new)
   - DPH Tom Waddell Health Center
   - DHS CalWORKs
   - DPH/DHS Child Welfare Transitional Youth
   - DPH Methadone Maintenance
4. Centralize a Citywide SSI Advocacy Database and Referral Service for clients. One possibility would be with the DPH Placement and Access Program.

## III. Advocate for California Legislative Changes.

**Background**

The state uses the same legal standard to determine disability as SSA and, as such, when the federal government awards SSI benefits, Medi-Cal is automatic. However, the converse is not true, as SSA does not consider Medi-Cal determinations of disability binding, despite the fact that both are determined by the same state agency. Therefore, clients must go through the application process separately and entirely to be considered for SSI.

The state agency has the ability to make presumptive disability findings for SSI. "Presumptive disability" for SSI is currently allowed for certain medical conditions, such as HIV/AIDS and other terminal medical conditions. This means that individuals diagnosed with these conditions are presumed eligible when their applications are submitted and receive immediate proactive cash benefits and Medi-Cal. If upon evaluation by the State Agency the application is disallowed, the client is terminated from SSI and Medi-Cal, but does not have to payback cash payments or medical costs incurred during the period. Medi-Cal applications approved for disability do not currently qualify for SSI presumptive disability, even though – again – both are determined by the same agency using the same legal standard.

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[8] Positive Resource Center (PRC) – 225 clients in the mental health system are being targeted via a DPH contract with Positive Resource Center (PRC), a full-spectrum attorney and benefits case manager program. The objective of the contract is for PRC to train and support staff in five mental health clinics and provide advocacy services and representation at four levels of appeal to their clients. PRC also provides SSI Advocacy services to about 700 people living with HIV/AIDS through a contract with DPH.

[9] DHS has recently been allowed to hire four SSI benefits case managers in the Disability Evaluation Consulting Unit (DECU) which will increase the number of clients it is able to serve (it served about 100 clients last fiscal year).

[10] While the Mayor's budget restored funding in DPH for the Disability Evaluation & Advocacy Program (DEAP) to continue to provide medical and psychiatric evaluations, money for benefits case management was not restored.

**Specific Recommendations**

1. Advocate for legislative changes that require the State Agency to automatically process SSI applications when individuals qualify for disability-related Medi-Cal (for those individuals who wish to apply). Although federal law regulates this, the state could require that Medi-Cal Office staff initiate an SSI application for all disability-related Medi-Cal awards by contacting SSA for a protective filing date. These individuals should then be linked to SSI Advocacy services.
2. Advocate for legislative changes that require the State Agency to presume SSI eligibility when individuals qualify for disability-related Medi-Cal. Legislation that encouraged presumptive disability findings in such instances as when a Medi-Cal disability determination has already been made would facilitate many qualified applicants to receive SSI benefits.

## IV. Advocate Reforming How the State Agency Adjudicates its SSI Claims[11].

### Background

The following issues are based upon the ongoing experience of SSI advocates, as witnessed by their review of documents for those who have made past claims that were denied. This experience also bears out the findings of an in-depth review done in 2000 by the Bay Area Benefits Access Collaborative, a nine-county HUD-funded project designed to identify ways to increase the number of eligible individuals getting on to SSI.

- A significant part of the SSI advocate's role is the gathering of medical records and contacting of a treating source for medical documentation. Both of these tasks are included in the federal regulations that determine how SSI claims should be evaluated and documented by the state agency. However, frequently these tasks are not done thoroughly by the state agency for those clients without SSI advocates.
- Federal law mandates that treating doctors should provide the document of disability. The state agency contracts out to a system of doctors who perform psychological and physical examinations on claimants in order to gather current medical documentation of their disability. When the claimant has a treating doctor who has already provided documentation of disability, the State agency often disregards these documents and orders a consultative exam from their own doctors. These "consultative examinations" are frequently incomplete and inadequate; showing no evidence that the doctor reviewed the existing medical records or even knew what disability should be tested for. Clients report that when seeing one of these doctors, he or she is likely to receive a 10-15 minute exam.

### Specific Recommendations

1. Advocate for the State Agency to form a panel to review the policies and procedures of the state agency in accordance with GAO reports from the federal government[12].
2. Advocate for the State Agency to work openly with the advocacy community to facilitate the application process and establish open communication regarding ongoing issues and obstacles that come up for disabled individuals attempting to access benefits. This could take the form of a quarterly meeting mediated by a third party.

## V. Standardize Performance Objectives and Measure Success Citywide.

1. Implement standard performance objectives for SSI Advocacy Services:
   - SSI Advocacy Award Rates[13]

[11] Members of the Citywide SSI Advocacy Workgroup who are employees of the Social Security Administration abstained from this recommendation.

[12] Government Accountability Office (formerly the General Accounting Office) report entitled "Social Security Administration: More Effort Needed to Assess Consistency of Disability Decisions" (GAO-04-656 July 2004) and "Gaps in key knowledge and skills area of DDS to adjudicate claims" (GAO -04-121, January 2004).

[13] # Applications adjudicated divided by # Applications awarded

- Rate of awards resulting in client becoming permanently housed

2. Measure CCSF performance via SFSTAT:
   - Measures noted above, but aggregated.
   - CCSF Return on Investment[14]
   - Rate of overall targeted populations moving on to SSI:
     a. DHS SSIP Program
     b. DPH Adult Mental Health
     c. DPH Supportive Housing
     d. DHS Case Managed SROs
     e. Jail (SSI continued and new)
     f. DPH/DHS Child Welfare Transitional Youth
     g. DPH Methadone Maintenance
     h. DPH Tom Waddell Health Center

**Attachment**

## SSI Advocacy Excerpts from the 2004 San Francisco 10-Year Plan to Abolish Chronic Homelessness

For complete report, go to http://www.ich.gov/slocal/plans/sanfrancisco.pdf

**Page 28, "Penal System, continued"**

Initiate SSI advocacy and application/reinstatement for all inmates identified with mental health issues prior to release.

**Page 39 through 43, "SSI Advocacy"**

It is estimated that 30-70% of homeless persons in San Francisco have a disability - physical, mental or both. A 1999 federal study indicated that about 40% of homeless people may be eligible for SSI (Supplemental Security Income, or Social Security Disability Insurance for those who have a sufficient work history), yet only 11% were receiving SSI. In our experience, many homeless persons in San Francisco should qualify for federal disability benefits. This is true even for those who have a co-occurring substance abuse or alcohol addiction.

Despite the fact that many persons who are homeless and disabled should qualify for SSI, it is very difficult for such individuals to obtain the benefits without assistance. This is especially true for people who are not stably housed, and who suffer from mental disabilities. According to one study, only 5% of homeless persons with severe mental health problems are successful in obtaining SSI on their own.

SSI benefits amounts for the totally disabled are inadequate to support life in San Francisco and increase the City's cost to provide housing and services. The maximum SSI benefits provided through the Social Security Administration of $564 are the same nationwide and are not currently adjusted for high cost areas. The state augments SSI benefits in California by $226, but it too does not make adjustments for high cost areas. It is cruel and unrealistic to expect someone who is totally disabled, which is what it takes for non-elderly persons to qualify for SSI, to live on $790 monthly in San Francisco where this amount will barely cover the cost to rent the cheapest of rooms leaving nothing for other basic necessities, and it is well below HUD's 2004 fair market rent of $1,084 for a studio apartment in the city. We will not be able to solve the panhandling problem in San Francisco even if we get more of the disabled off the street unless the Social Security Administration provides benefits that will support people's basic necessities.

[14] Retroactive Medi-Cal and IAR Revenues Generated by Awards divided by the Total Cost of SSI Advocacy Services

The benefits of moving disabled homeless persons on to SSI are many:

- The level of benefits, while inadequate, exceeds any other public benefit available for the disabled (with the exception of certain service-connected veterans benefits), with the current rate at $790/month.

- Recipients automatically qualify for MediCal coverage, providing the opportunity for ongoing medical, mental health, and dental care, and substance abuse treatment.

The potential savings to the City and County of San Francisco by moving homeless persons on to federal income and medical benefits are huge. For example, in the past five years, HAP has moved more than 750 persons on to SSI. This represented an infusion of new federal dollars into San Francisco of over $20,000,000 in cash payments alone. Reimbursement to the City from MediCal is harder to calculate specifically, but might very well exceed that.)

The value of effective assistance: with effective advocacy, the rate of SSI approvals for persons who are homeless and have severe mental health disabilities is much higher than the 5% success rate experienced by individuals who attempt to secure benefits on their own. At the Homeless Advocacy Project, the approval rate for clients who are assisted by our project is currently 89%.

**The Benefit:**

Assuming that 2500 persons could be moved onto SSI, what are the benefits to the individuals and to the City and County?

*Federal/state SSI cash benefits*

Monthly (assuming $800/month benefit - some will get more, some slightly less, depending upon whether they have access to cooking facilities): $2,000,000. This represents an annual infusion of $24,000,000 into the San Francisco economy.

Medi-Cal Reimbursements:

Medi-Cal coverage is automatic for all SSI recipients. While the cost of medical care and the amount of MediCal reimbursement varies greatly by individual, some DPH estimates have put the costs for the most frequent uninsured users of City/County healthcare at as high as $50,000 per person. Assuming even a very modest estimate of Medi-Cal reimbursement of $2000 per person, MediCal reimbursement for 2500 individuals per year would total $5,000,000.

Savings in County Assistance:

While not all homeless disabled persons receive County Adult Assistance, even if 1000 of the 2500 do, that would represent a savings to the City and County of $5,400,000 per year in cash benefits.

Other Benefits:

Receipt of SSI and MediCal benefits also provides other benefits to both the individuals and the City/County that are less easily quantified but are nevertheless important.

A regular source of income and access to payment for medical/mental health care is an important component of a strategy to stabilize individuals and move them into more permanent housing. This benefits the individuals, and the City, which has an interest in moving people off the street, to make the City and it's neighborhoods cleaner and more attractive to residents and tourists.

Federal cash benefits are most often infused into low-income neighborhoods, benefiting local businesses and helping to support the economy in depressed areas of the City.

The bottom line - For a cost of approximately $3 million per year, 2,500 disabled homeless individuals can be moved on to Supplemental Security Income and Medi-Cal. This will bring an infusion of at least $30 million in federal and state dollars to San Francisco, and save the City and County over $5 million in County Assistance payments. The City and County comes out over $30 million dollars ahead!

**What is effective advocacy?**

From years of experience, we have found that the most effective approach includes the following components:

- Assistance from the earliest stages of the SSI application process.
- Assistance by trained advocates who are familiar with the applicable laws and regulations. A specific and detailed approach to advocacy.
- The involvement of treating sources who can verify the applicant's disabilities, or the involvement of trained mental health and medical professionals who can provide consultative examinations to support the applications when no treating source is available. A supportive and accessible agency and staff, where clients feel comfortable and are more likely to return and follow through.
- The involvement of social services professionals who assist the applicant with other issues that are barriers to stability (such as housing and treatment), thereby helping to keep clients involved in the process, and better preparing them for a successful transition to stability when benefits are received.
- The use of well-trained and well-supervised volunteers can leverage resources.

The Homeless Advocacy Project (HAP) provides full-representation SSI advocacy to between 250 and 300 clients per year, focusing almost exclusively on individuals who are both homeless and have mental health disabilities. HAP's SSI advocacy component is currently funded through a combination of government grants, including HUD McKinney -Vento funding through the Department of Human Services and the Department of Public Health contracts described below; private foundation funding; and in-kind services provided by the Bar Association of San Francisco.

HAP/DPH projects: The Homeless Advocacy Project (HAP) has a long-standing relationship with the Department of Public Health to provide SSI Advocacy. They currently have two joint SSI projects with the Dept. of Public Health:

Disability Evaluation & Advocacy Program (DEAP) - DEAP provides SSI advocacy for clients through four in-house case managers. Medical staff, including two psychologists, primary care providers and a psychiatrist, have on-site office hours to help connect clients with medical care as well as help to document SSI claims. HAP provides training and technical legal advice regarding SSI issues to DEAP staff. HAP staff also provide SSI advocacy directly to over 100 clients per year through this project, and DEAP staff assist HAP in gathering local medical records and connecting our clients with psychological evaluations.

SSA "HOPE" project - recently funded by the Social Security Administration, the Homeless Advocacy Project will be the primary subcontractor with the Department of Public Health to provide SSI advocacy to the most difficult population of chronically homeless and mentally ill individuals.

The Healthcare Access Collaborative -a joint project between the Homeless Advocacy Project and Haight Ashbury Free Clinics, Inc. (HAFCI). HAP provides SSI advocacy (and handles certain other legal issues), and HAFCI provides a part-time psychologist placed in the HAP office who does consultative

examinations and some treatment, as well as facilitates access to other HAFCI programs. The project was originally generously funded by the California Endowment. That funding has now ended, and the project continues in a scaled-back fashion with support from the California Wellness Foundation.

The Ten Year Council recommends that San Francisco fund SSI Advocacy in an immediate, large scale, and effective manner. SSI advocacy can be an incredibly effective way to help stabilize disabled homeless persons, providing both a source of income and healthcare. It is a particularly effective approach because it more than pays for itself by reducing the costs to the City and County, while at the same time bringing an infusion of federal dollars. Current resources for effective SSI advocacy are inadequate.

The city must increase funding for SSI advocacy to move 2,500 people onto the SSI roles. Because successful models exist, most notably the Homeless Advocacy Project, expanded SSI advocacy could be put into place fairly quickly.

A successful model requires at least three components:

1. Advocates to work with the clients, fill out the forms, assemble the evidence and provide representation to clients with the Social Security Administration (SSA), trained and supervised by legal experts.
2. Psychologists (or psychiatrists) to provide consultative examinations in support of the claims, who are familiar with applicable regulations, and have sufficient time to prepare adequate reports.
3. A method to gather applicable past medical records, from both local and other providers (often out-of-state.)

Estimates of the number of homeless persons who are severely disabled so as to potentially qualify for SSI vary widely. Even assuming that only 30% of the lowest estimate of homeless persons (8500) are potential SSI recipients, the number of homeless persons in need of SSI advocacy in San Francisco would be approximately 2500.

The ideal level of service to truly move approximately 2500 homeless disabled persons on to SSI would require approximately 50 full-time SSI advocates, located in, or regularly traveling to, a number of sites throughout the City, including existing medical and mental health clinics, homeless shelters, San Francisco General Hospital the jail, the County Adult Assistance Office, the offices of community based organizations, and doing some street outreach. The advocates would require training and ongoing technical assistance from legal experts who are completely familiar with the applicable laws and regulations and the most effective advocacy approaches. Existing medical records would need to be gathered for all of the clients. Some clients would likely already be in existing treatment, while others would require consultative examinations. In either case, a provider would need to have the time to document the clients' disabilities. The estimates also assume only salary and benefit costs, or hourly rates for medical and mental health providers. It is assumed that the advocates would be able to make use of existing facilities.

There will be a systematic connection of SSI Advocacy, housing, and services for homeless persons. SSI advocacy and outreach, supportive housing, and discharge planning from all mainstream services will be integrated for efficiency.

Training for all staff providers will be improved and coordinated, with services interfacing with homeless persons, and those who are at risk for homelessness, to improve cross-referrals to services, housing and SSI advocacy. Need for payee services will be identified in clinical evaluations conducted for SSI application; payee services will be offered to ensure SSI benefits are used to cover basic necessities.

**The total cost to implement this plan:**

- 50 full-time advocates (salary and benefits): $2,000,000

- 3 full-time Attorney Experts/Supervisors (salary and benefits): $187,500
- 3 full-time medical records technicians (salary and benefits): $112,500 Psychologist/provider time for onsultative exams or to prepare reports for 2500 clients (assumes 1500 need consultative examinations to 10 hours per client, depending upon the amount of testing needed - and 1000 need reports on ongoing treatment - 1 hour per client to write reports: $612,500
- An undertaking of this magnitude would require some administrative support, some supplies, and the time of some kind of project director, at an additional cost of approximately $54,125.

Total projected cost: $2,966,625. (Compared to $10 million that will be generated.)

**Other potential costs/requirements:**

Some non-invasive way by which clients could be tracked or notified when they access services, so that their SSI advocate can reach them if needed. Ability by providers of consultative exams to make referrals to treatment.

**Two legislative and policy changes are recommended:**

1. To address the underlying structural problem, the federal government must provide incomes for those deemed unable to support themselves as a result of their disabilities that will cover the cost of basic necessities in San Francisco and other high cost areas
2. The State of California must provide cost of living adjustments in the benefit augmentation amounts it provides to those on SSI to help those with disabilities remain stable.

## Appendix C

| Row | SSI Advocacy for DPH Mental Health Clients – Positive Resource Center<br>Two Year Performance SSI Advocacy for DPH Mental Health Clients | | FY0304 + FY0405 | |
|---|---|---|---|---|
| 6 | **ACTIVITY AND CASE STATUS [% of line 6]** | Total Cases Managed: | 376 | 100% |
| 8 | | Cases Determined Ineligible (for non-medical reasons): | 39 | 10% |
| 11 | | CASES DECIDED: | 263 | 70% |
| 12 | **DISABILITY AWARDS [% of line 12]** | **CASES AWARDED:** | **227** | **100%** |
| 13 | | Award Rate (line 12 / line 11): | 86% | |
| 14 | | SSI-only Awards: | 113 | 50% |
| 15 | | SSDI-only Awards: | 39 | 17% |
| 16 | | Blended SSI-SSDI Awards: | 59 | 26% |
| 17 | | Continuances Awarded (Disability Cessation Avoided): | 14 | 6% |
| 18 | | CAPI Awards: SSI not eligible due to immigration status: | 2 | 1% |
| 19 | | Average Number of Benefit Retroactive Months Per Award: | 12 | |
| 20 | **MEDI-CAL AWARDS** | Medi-Cal Benefits Awarded / Re-awarded [% of line 12]: | 210 | 93% |
| 21 | | Average Retro-Active Months of Medi-Cal Awarded: | 10.0 | |
| 22 | | Total Retro-Active Medi-Cal Months Activated: | 1,999 | 100% |
| 23 | | Retro Months Requiring CCSF Admin to Activate (% of line 22): | 905 | 45% |
| 24 | **REVENUE RETURNS [% of line 34]** | Mental Health Revenue Recouped: | 2,521,874 | |
| 25 | | Methadone Maintenance Revenue Recouped: | 57,644 | |
| 26 | | SFGH and Outpatient Revenue Recouped: | 131,407 | |
| 27 | | Mental Health Pharmacy Revenue Recouped: | 23,334 | |
| 28 | | **Total DPH Revenues Recouped:** | **2,734,259** | **86%** |
| 29 | | Average DPH Revenues per Case Awarded (line 28 / line 12): | 12,045 | |
| 30 | | **DHS Interim Assistance Reimbursement (IAR) Recouped:** | **428,406** | **13%** |
| 31 | | Cases Awarded with IAR Histories [% of line 12]: | 136 | 60% |
| 32 | | Average IAR Dollars per Case Awarded: | 3,150 | |
| 33 | | **EMS Recouped:** | **11,008** | **0.3%** |
| 34 | | **Grand Total CCSF Revenues Recouped:** | **3,173,673** | **100%** |
| 35 | **INVESTMENT** | DPH SSI Advocacy Contract: | 550,000 | |
| 36 | | DHS IAR Fees Paid to Contractor: | 93,234 | |
| 37 | | Total Costs: | 643,234 | |
| 38 | | Average Cost per Award (line 37 / line 12): | 2,834 | |
| 39 | **RETURN ON INVESTMENT** | **DPH (line 28 / line 35)** | **$ 5.0** | |
| 40 | | **CCSF (line 34 / line 37)** | **$ 4.9** | |
| 41 | **DEMO-GRAPHICS [% of line 12]** | Chronic Homeless: | 127 | 56% |
| 42 | | Homeless Not Chronic: | 29 | 13% |
| 43 | | Housed: | 71 | 31% |
| 44 | | Average Age: | 43 | |
| 55 | **LEVEL APPLICATION FILED AND WON [% of line 12]** | Filed at Initial Application: | | 63% |
| 56 | | Filed at Reconsideration: | | 22% |
| 57 | | Filed at Hearing ALJ: | | 10% |
| 58 | | Filed at Appeals: | | 0% |
| 59 | | Filed at CDR: | | 4% |
| 60 | | Filed at CDR Hearing: | | 1% |
| 61 | | Awarded at same level application filed: | | 92% |
| 62 | | Awarded at next level of appeal: | | 8% |

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