



Ensuring Timely Access to Medicaid and SSI/SSDI for People with Mental Illness Released from Prison

Four State Case Studies

OF THE 2.1 MILLION PEOPLE INCARCERATED IN US PRISONS, an estimated 8 to 16 percent have mental illness.^{1,2} Immediately prior to their incarceration, many are enrolled in (or are eligible for) Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) and Medicaid to support their medical treatment. Corrections and mental health administrators agree, however, that few are enrolled in these federal benefit or entitlement programs upon release.³ As a result, their access to medications and treatment—elements typically essential to compliance with conditions of release for people with mental illness—is severely limited, presenting a significant obstacle to their successful transition back to the community.⁴

To learn more about opportunities and challenges facing states grappling with this issue, the Council of State Governments (CSG), which coordinates the Criminal Justice/Mental Health Consensus Project and the Re-Entry Policy Council, worked with officials from four states: Texas, Pennsylvania, New York, and Minnesota. Officials from state corrections and mental health agencies and state agencies that administer Medicaid and other health benefits participated in a two-day forum and contributed to written case studies. Understanding the steps these states have taken, and the challenges that continue to impede their progress, could inform related efforts in other states seeking to ensure seamless and successful re-entry for people with mental illness.

I. ELEMENTS OF SUCCESS COMMON TO FOUR STATES

- **Interagency agreements:** Staff or administrators from at least two different relevant agencies have made formal cooperative efforts to address the problem.
- **Targeted initiative:** Each state focused attention on the distinctive needs of offenders with mental illness by creating a new agency or program and/or by assigning staff members specialized caseloads.
- **Timely initiation of enrollment process:** All four states have sought to identify prisoners with mental illness and

to initiate discharge planning for these individuals at least one to three months before their expected release.

II. HIGHLIGHTS FROM STATE CASE STUDIES

• Charge one agency with coordinating efforts

The Texas legislature created a specific agency, the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), to meet the needs of offenders with mental illness. Responsibilities of this agency include providing assistance with enrollment in benefits programs. TCOOMMI reached a formal agreement with the Social Security Administration, which created a streamlined process for the review and approval of applications submitted on behalf of people with medical or mental illnesses who are about to be released from prison.

• Use technology to share information

In Pennsylvania, the Department of Public Welfare has developed a web-based application (COMPASS) which allows trained non-specialists to enter information on any computer on which COMPASS is installed and to electronically submit one collective application for multiple types of benefits (excluding SSI/SSDI) to the appropriate offices. Correctional health care administrators have been trained on COMPASS, and it is now being piloted for Department of Corrections (DOC) use in two facilities.

• Provide coverage while applications are pending

The New York State Office of Mental Health (OMH) operates a Medication Grant Program (MGP) for offenders with mental illness whose applications for Medicaid are being processed. Applicants must submit combined Medicaid/Cash Assistance/Food Stamp applications up to 45 days before or up to seven days after release; OMH provides each participant with an MGP card which can be used to pay for psychiatric medications in the community until the applicant's Medicaid eligibility is determined.

Support for this project is provided by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS), a division of the US Department of Health and Human Services; the MacArthur Foundation; and the New York Community Trust.

- **Begin discharge planning well in advance of release**

Minnesota has passed legislation directing the Department of Human Services and the DOC to assign specialized case workers to initiate discharge planning for prisoners with mental illness who qualify and who volunteer to participate beginning 90 days prior to release, and lays out a detailed timetable for such planning.

III. CONTINUING CHALLENGES TO STATE EFFORTS

- **Insufficient staff with specialized training to assist inmates with applications**

Corrections officials and administrators of agencies that administer mental health services, Medicaid, and other benefits programs agree on the need for specialized staff to manage these cases, which requires expertise on both benefits application procedures, behavioral health matters, and issues unique to people who are incarcerated. No one agency employs staff with expertise in such a diverse range of issues, and there is disagreement about who should create and who should fund these positions, for whom such staff should work, and where their offices should be.

- **Wide variation and lack of communication among county systems**

Medicaid and other benefits are generally disbursed by county agencies that use state requirements to make eligibility determinations. Counties have their own unique agency structures, processes, and timetables for administering benefits, which state officials note can make it very hard to implement programs uniformly. In addition, the capacity of counties to process benefits applications may vary widely due to size and economic factors in each county. Further, in some states, participation in benefits programs can require financial participation from county governments.⁵ In those cases, individual counties may promulgate additional requirements for eligibility.

- **Inadequate follow-up, particularly for people who complete their maximum sentences while incarcerated**

Nearly one in five US prisoners completes his or her sentence while incarcerated, and is released to the community

with no supervision.⁶ This phenomenon is particularly common among offenders with mental illness, who typically serve more of their sentences than other prisoners. In these instances, few mechanisms exist to provide follow-up on benefits applications or to ensure access to services for these individuals. Even in jurisdictions where community corrections plays a role, relationships between correctional and community-based health providers and benefits administrators may not be strong, and mechanisms to ensure follow-up may be lacking.

- **Difficulties identifying offenders who need release planning or benefits**

Screenings and assessments conducted upon admission to prison do not always identify which offenders need mental health treatment. Assessments conducted as the release date approaches often identify a range of problems that must be addressed in a short span of time. Corrections officials' immediate concerns are sometimes given priority over applications for entitlements and benefits.

- **Confusion over federal benefits and entitlements eligibility rules**

In some states, enrollment of offenders in benefit and entitlement programs is impeded by confusion over federal agency guidelines. For example, state Medicaid directors have formally requested clarification regarding a recent recommendation from CMS that states suspend (rather than terminate) Medicaid enrollment for people who are incarcerated. Officials in some states report that applications prepared for people prior to their release are routinely denied by Medicaid or SSI/SSDI administrators the first time they are submitted, because they do not meet a complicated set of requirements. Representatives of the four state teams have asked CMS and SSA for checklists of these requirements, to boost the rate of successful applications.

- **Other challenges:** States report various other resource and procedural problems, including the difficulty of initiating timely release planning when the releasing authority assigns only an approximate release date and security restrictions complicating the use of technology such as web-based applications or other types of information-sharing.

1. Paige M. Harrison and Allen J. Beck, *Prisoners in 2003*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2004), NCJ 205335.

2. Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 1999), NCJ 174463.

3. Of the federal programs named here, SSDI is an entitlement program: recipients must have paid into the program through payroll taxes over at least 10 years in order to qualify. Medicaid and SSI, by contrast, are benefits programs, which do not require a history of contributions to establish eligibility.

4. The much larger number of people with mental illness released after short-term jail stays also face challenges in maintaining continuity of care, though their enrollment in benefits is less likely to be terminated during their incarceration.

5. In 1996, county associations reported financial participation in Medicaid in 27 states, according to a survey conducted by the National Association of Counties. Available online at www.naco.org/cnews/1996/96-04-29/28medsur.htm

6. Timothy A. Hughes, Doris James Wilson, and Anthony J. Beck, *Trends in State Parole, 1990–2000*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2001), NCJ 184735.

7. Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 1999), NCJ 174463. Additionally, the Pennsylvania DOC reports that inmates with serious mental illness are three times as likely as other inmates to serve their maximum sentences (from unpublished description of Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders program, courtesy of Angela Sager, grants manager, May 12, 2002).