

# Facilitating Medicaid Enrollment for People with Serious Mental Illnesses Leaving Jail or Prison: Key Questions for Policymakers Committed to Improving Health and Public Safety\*

*State policymakers and corrections and mental health officials recognize the importance of improving public safety and public health outcomes for the large numbers of people with serious mental illnesses (SMI) transitioning from incarceration to the community. Improving access to Medicaid and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits can help achieve these outcomes, but enrollment in these benefits can become mired in the complexity of state and federal rules and regulations. The key questions below can help policymakers facilitate or strengthen effective collaboration among corrections, health, and mental health agencies to identify and enroll eligible individuals with SMI in these programs.*

## BACKGROUND

Millions of individuals with SMI are admitted to local jails and state prisons each year.<sup>1</sup> Their involvement in the corrections system presents a crucial opportunity to improve public and individual health outcomes and reduce recidivism by ensuring their enrollment in federal benefits. Medicaid, Medicare, and SSI/SSDI may be the best opportunities for individuals involved, or at risk of involvement, with the criminal justice system to access health care, housing, and other essential supports.<sup>†</sup> Enrollment in these federal benefits programs enables continuity of care from incarceration to the community, which is thought to play a role in promoting public safety by reducing returning individuals' future contact with the justice system.<sup>2</sup>

With the 2010 passage of healthcare legislation,<sup>3</sup> Medicaid eligibility criteria have been simplified for many adults with SMI. Whereas members of this group were previously eligible for Medicaid only if they had a disability that met explicit criteria, eligibility will now be based on whether their income falls below 133 percent of the federal poverty guideline or if they meet disability criteria.<sup>4</sup> As such, more individuals with SMI will qualify for Medicaid and the opportunity for states to share this group's healthcare costs with the federal government will be greater. Although the legislation does not change the prohibition on receiving

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<sup>†</sup> People with SMI who are transitioning from incarceration to the community have multiple needs beyond continuous health care; many will also have difficulty obtaining and maintaining employment. SSI/SSDI will remain essential supports to help these individuals access housing, income supplements, and other services.

Medicaid if an individual has been incarcerated for more than a year, it will make access to Medicaid more likely upon release.

If current practice is any indication, corrections systems will need to augment their discharge planning procedures and better collaborate with Medicaid and Social Security agencies to maximize enrollment rates for individuals with SMI after their release. Many corrections agencies are not equipped to identify people who were enrolled previously in Medicaid or SSI/SSDI, or who are likely to be eligible upon release—regardless of their mental health status. This is the case for both local jails and state prisons, which face different challenges conducting reentry planning.<sup>5</sup>

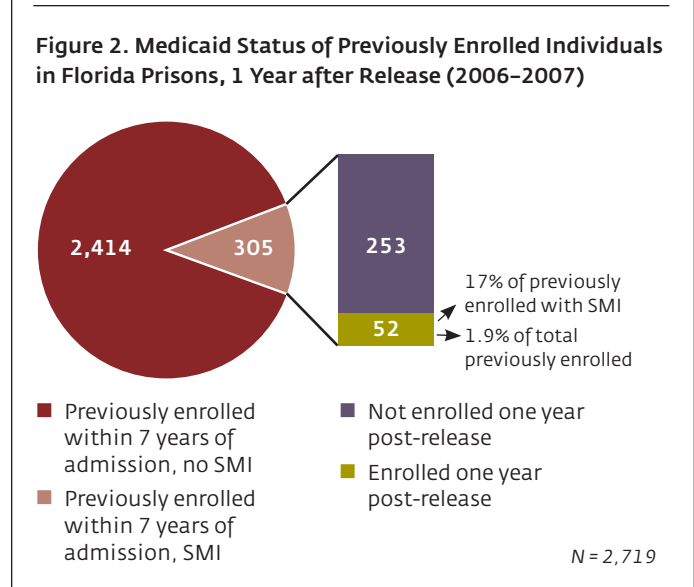
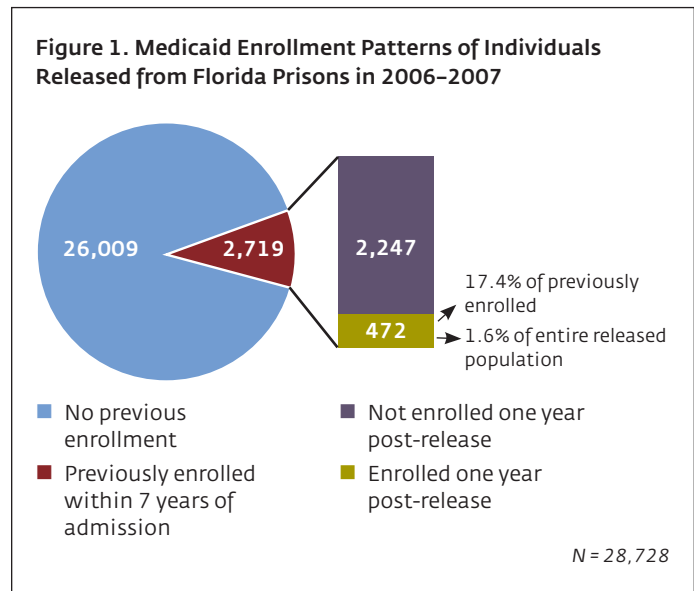
In Florida’s state prisons, for example, 28,728 people were released in 2006-07. Of the 2,719 individuals who had been enrolled in Medicaid at some point in the seven years prior to their admission, only 17.4 percent were re-enrolled at any point within a year after their release (see Figure 1).<sup>6</sup>

For the 305 releasees with SMI who were enrolled in Medicaid at some point in the seven years prior to their admission, the re-enrollment rate after release was similarly low (see Figure 2).

In Oklahoma, less than 17 percent of Medicaid-eligible prisoners with SMI were enrolled within 90 days of their release.<sup>7</sup> After policymakers implemented an enhanced transition planning program for this population, the enrollment rate rose to nearly 38 percent.<sup>8</sup>

With the passage of health reform, the federal government will begin to reimburse up to 100 percent of state Medicaid expenditures for newly eligible participants in 2014. In light of this significant development, legislators and officials in corrections, health care and mental health should start planning now for this expansion of eligibility for people with SMI who have been in correctional facilities. With increased attention to Medicaid enrollment, policymakers should also use the opportunity to look at SSI/SSDI enrollment for individuals with SMI returning to their communities from local jails and state prisons.

Seeking answers to the questions below can help corrections and mental health systems professionals determine where they stand with regard to enrollment rates for people with SMI. The process of answering these questions can also help policymakers set goals for increasing enrollment as health reform is implemented. Each key question includes an explanation of why policymakers should care about the issues raised, and how to determine the answer—particularly if the information is not readily available.



## KEY QUESTIONS



### What percentage of the total corrections population is eligible for Medicaid?

- Of those eligible for Medicaid, what percentage has SMI?
- Of those with SMI, what percentage is eligible for SSI/SSDI?

#### Why policymakers should care

Corrections agencies are likely missing large numbers of people potentially eligible for Medicaid. Knowing the estimated percentage of people admitted to jail or prison who are eligible for Medicaid will provide a target figure that offers a point of comparison for examining actual enrollment rates. Accordingly, it helps officials gauge the scope of work needed to implement enhanced transition planning and estimate the potential cost-shifting impact of this work. Having a sense of the size of the Medicaid-eligible population with SMI will also provide jail and prison administrators with information that can be used to initiate discussions with health and mental health policymakers and state Medicaid and Social Security officials about improving collaboration to increase enrollment rates. Similarly, knowing the percentage of individuals with SMI who are eligible for SSI/SSDI can promote comprehensive transition planning. Gathering this data will ideally prompt corrections officials and their partners to examine the state's current approach to identifying and enrolling the corrections population in income support and entitlement programs.

#### How to determine the answers

Whereas eligibility criteria before the passage of healthcare legislation may have been prohibitively complex for corrections agencies to routinely identify individuals with SMI who were eligible, new criteria based on federal poverty guidelines make the task much easier. As a result of new healthcare legislation, all individuals who have an income equal to or below 133 percent of the federal poverty guidelines are eligible for Medicaid.\* This will simplify the process of estimating the number of people eligible. To estimate the percentage of a corrections population who are at or below 133 percent of federal poverty guidelines, it is reasonable to use community averages available from U.S. Census data, which are easily accessible online.<sup>9</sup> Individuals incarcerated in jails and prisons tend to have a lower socioeconomic status than the general population;<sup>10</sup> thus, local Census data will provide a conservative estimate for the number of people who are likely to be eligible for Medicaid. (If more sophisticated demographic analyses have been conducted for a given corrections population, then these figures should be used instead.)

Next, officials must determine what percentage of the Medicaid-eligible group (those with incomes at or less than 133 percent of federal poverty guidelines) is likely to have SMI. National estimates suggest that the overall prevalence of SMI in jails and prisons is roughly 16.9 percent (but jurisdiction-specific estimates should be used if available).<sup>11</sup> It is reasonable for policymakers to assume that the prevalence of SMI among incarcerated people who are at or below federal poverty guidelines will be similar to—if not greater than—the overall prevalence of SMI among the corrections population. In other words, if 16.9 percent of the overall corrections population has SMI, then *at least* 16.9 percent of individuals below the federal poverty guidelines will have SMI. This estimate is fair (and likely conservative) because epidemiological research consistently shows that the prevalence of SMI is actually higher among groups with low socioeconomic status,<sup>12</sup> and there is no reason to believe that people with SMI have greater incomes than people without SMI.

There is no simple way to determine the percentage of people with SMI who meet disability criteria for SSI/SSDI.<sup>13</sup> One way to obtain this figure is for corrections, mental health, and federal benefits administrators to match records of individuals involved with their systems to determine who among the previously eligible are now incarcerated. If such information is not readily available, policymakers may need to facilitate information-sharing agreements among corrections, mental health, and state Medicaid and federal Social Security agencies and work with research and information technology staff to implement such agreements. Alternatively, those individuals with SMI can be formally assessed to see if they meet the criteria for SSI disability.

\* Some individuals with SMI who do not meet income criteria will still be eligible for Medicaid based on their SSI/SSDI disability status.



## How does a corrections system identify individuals at intake who meet new Medicaid income guidelines and have SMI?

### Why policymakers should care

Policymakers should know if corrections agencies are taking advantage of the opportunity to identify and enroll individuals with SMI in federally reimbursable services. Research suggests that this group's access to Medicaid and SSI/SSDI improves individual and system-wide outcomes. Specifically, having income support allows access to food and housing, which may reduce their future contact with the criminal justice system and unnecessary use of the most costly health care resources, such as emergency rooms. Enrolling individuals with SMI in Medicaid and SSI/SSDI requires determining an individual's income level upon admission, which is likely not standard practice and will require changes to existing intake procedures. Current correctional practices for identifying people with SMI are likely designed with a focus on the safety of the correctional population and stabilization of individuals who are actively symptomatic, and are not optimized for achieving the goal of connecting this group to community-based services upon release or determining their disability status.

### How to determine the answer

As of this writing, the process of determining whether an individual has an income at 133 percent or below the federal poverty level has not yet been established. Corrections departments should establish a process during intake to routinely ask about income prior to incarceration. Following screening, the individual will then need to provide documentation of their income.

To determine whether an individual entering jail has SMI and/or may be eligible for SSI/SSDI, corrections agencies should use standardized screening procedures, with instruments that have been developed and validated specifically for use in correctional settings. It is important for jail and prison administrators to coordinate their screening and assessment procedures with community treatment providers. To improve the detection rate, departments can also check whether an individual has been diagnosed with SMI by determining who was enrolled previously in SSI/SSDI. Coordination and information sharing facilitates ongoing identification of people who are eligible for Medicaid and those who were or were not enrolled previously in SSI/SSDI but who were flagged by corrections agencies' screening and assessment procedures as possibly eligible because they were identified as having SMI.

### Suspension vs. Termination of Benefits

Federal policy allows states to suspend, rather than terminate, SSI and SSDI benefits when an individual has been incarcerated for 12 consecutive months or less. Currently, termination also ends the health insurance associated with these programs. Once an individual's eligibility is terminated, re-establishing benefits can be a long process. The impact of the new federal health reform legislation on the ability of states to suspend, rather than terminate, Medicaid enrollment is yet to be determined. States should consider the long-term implications of the decision to suspend rather than terminate benefits, as state health expenditures associated with uninsured populations can be significant.



## At what point prior to individuals' release does the corrections system begin the application process for Medicaid and SSI/SSDI?

### Why policymakers should care

To ensure continuity of care for individuals with SMI who are released from jails and prisons, officials should see that benefits are reinstated as close to an individual's release date as possible. To do this, the application process must be initiated as early during the term of an individual's incarceration as is feasible. In principle, such release planning can begin at intake. In practice, jurisdictions initiate and engage in pre-release planning at different times before the release date (e.g., one year, six months)—but the earlier, the better, especially when the timing of Medicaid and SSI/SSDI reinstatement is uncertain.

Discharge planning will, of course, differ for local jails and state prisons, whose populations have drastically different lengths of stay—the former measured in a matter of days and the latter measured in terms of years. In Oklahoma, where state prison officials implemented a successful program to increase federal benefit enrollment, the application process took at least six to nine months.<sup>14</sup> For local jails, rapid screening and assessment for SMI and benefits eligibility is possible—and recommended—but the application process will likely not be completed for any but the longest-stay individuals; therefore, a seamless handoff to community providers, who will initiate and shepherd the application process, is paramount. With the passage of federal healthcare legislation, planning work is in process in most states as they seek to address requirements by 2014.

### How to determine the answer

Corrections, mental health, and state benefits administrators should develop formal agreements to expedite income and disability determinations for individuals being released from jail and prison. These agreements should ensure the following:

- 1) corrections officials will submit all necessary documentation;
- 2) state benefits agency personnel will accept applications from individuals who are still incarcerated;
- 3) guidelines will be developed for the estimated length of processing time that such applications will require; and
- 4) the methods for obtaining benefits upon release are made clear to the applicant.

For local jails, a mechanism should be established that “flags” individuals who are likely to be eligible for federal benefits for community-based providers, who can oversee the application process for these individuals after their relatively short lengths of stay in jail. For individuals staying longer in local jails, jail staff should initiate the application process but plan for community providers to follow up immediately upon release.

## CONCLUSION

For individuals with SMI in correctional facilities, transitioning from incarceration to the community is even more complex than for inmates in the general jail or prison population. If they do not have sufficient supplies of medication, connections to mental health services, housing, and other supports they are almost certain to decompensate. This may result in behavior that constitutes a technical violation of their release conditions or a new crime. Ensuring that these individuals are enrolled in federal benefits such as Medicaid and SSI/SSDI is critical for continuity of care and a successful reentry process. As a result of the 2010 health reform legislation, new Medicaid eligibility criteria will make it easier to enroll individuals with SMI returning to their communities from county jails and state prisons. With the legislation bringing increased attention to Medicaid enrollment, policymakers are presented with an opportunity to increase this group's enrollment in SSI/SSDI. These disability benefits provide critical income support that, coupled with Medicaid, can improve the likelihood of an individual with SMI succeeding in the community and avoiding future contact with the justice system.

Asking the key questions above can help policymakers stay in front of the implementation of new healthcare legislation without becoming mired in intricate regulatory rules and procedures. The questions can kick-start discussions among corrections, health, mental health, and benefits officials to determine how they will 1) estimate how many people with SMI entering jails and prisons are eligible for Medicaid, 2) modify procedures to identify eligible individuals with SMI upon intake, and 3) ensure that this process begins as early as possible during a person's period of incarceration. Planning around these issues now can help position states to share a greater portion of the healthcare costs of people with SMI with the federal government and promote continuity of care for this high-needs population.

### Justice Center Resources

The Council of State Governments Justice Center has developed a number of resources and online tools on federal benefits/criminal justice issues generally ([http://reentrypolicy.org/fedbens\\_pubs\\_tools](http://reentrypolicy.org/fedbens_pubs_tools)) and for people with SMI involved in the justice system specifically (<http://www.consensusproject.org/>).

## NOTES

1. According to the best estimates, the prevalence of serious mental illness in jails and prisons is roughly 17 percent. Using 2008 data from the Bureau of Justice Statistics, this represents 1.53 million of the 9 million people arrested, 133,000 of the 785,556 jail inmates, 258,000 of the 1.52 million prison inmates, and 858,000 of the 5 million individuals under community corrections supervision had SMI. (Sources: H. J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services*, 60 (2009): 761–65; William J. Sabol, Heather C. West, and Matthew Cooper, "Bureau of Justice Statistics Bulletin: Prisoners in 2008," December 2009, NCJ 228417, available online at <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1763>.)
2. For more information, please see Council of State Governments Justice Center, *How and Why Medicaid Matters for People with Serious Mental Illness Released from Jail: Research Implications* (New York: Council of State Governments Justice Center, 2005), [http://www.reentrypolicy.org/jc\\_publications/how\\_why;file](http://www.reentrypolicy.org/jc_publications/how_why;file).
3. The Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).
4. For more on current eligibility criteria, see <https://www.cms.gov/MedicaidEligibility/>. The federal poverty guidelines are the official federal poverty measure used for administrative purposes, such as determining financial eligibility for federal programs. The federal poverty guidelines vary by family size. For more information, see <http://aspe.hhs.gov/poverty/09poverty.shtml>.
5. For examples of the different issues and challenges that county jails and state prisons face conducting reentry planning, see <http://www.urban.org/projects/tjc/background.cfm>.
6. Florida figures are adapted from a 2009–2010 internal study conducted by the Florida Mental Health Institute, University of South Florida and the Council of State Governments Justice Center.
7. Bob Mann, Henry T. Ireys, and Seth Prins, "Ensuring Access to Medicaid for Individuals with Mental Illnesses Reentering Their Communities from Prison: A Program Model from Oklahoma" (Webinar presentation, Council of State Governments Justice Center, October 29, 2009), <http://consensusproject.org/features/webinar-oklahoma-medicaid>.
8. Ibid.
9. See <http://factfinder.census.gov>.
10. Caroline Wolf Harlow, *Education and Correctional Populations Bureau of Justice Statistics Special Report* (Washington, D.C., Bureau of Justice Assistance, 2003), NCJ 195670. Doris J. James, *Profile of Jail Inmates, 2002* (Washington, D.C. Bureau of Justice Statistics, 2004), NCJ 201932.
11. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates"; Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers* (Washington, DC: Bureau of Justice Statistics, 1999).
12. Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States Since 1950* (New York: The Johns Hopkins University Press, 2006), 14–15.
13. See the U.S. Social Security Administration's website for more information on current eligibility criteria: <http://www.ssa.gov/>.
14. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions* (Rockville, MD: SAMHSA, 2010), <http://download.ncadi.samhsa.gov/ken/pdf/SMA10-4545/SMA10-4545.pdf>.