ISSUE BRIEF: CONTINUITY OF CARE FOR JUSTICE INVOLVED INDIVIDUALS WITH MENTAL ILLNESS

Background

Individuals returning to communities upon release from jail and prison face numerous barriers to successful transition including limited access to subsidized housing, job prospects, educational opportunities, and health insurance.[i] Many individuals with criminal records do not have access to employer-based health insurance through work and must rely on public funding for medical care. [2] Given the importance of these issues, an increasing number of legislatures, advocates, community-based health providers, and corrections officials are focusing on removing barriers that impede successful "re-entry".

As the number of individuals with criminal records in the United States continues to rise, there is a proportionate increase in the number who have mental health and/or substance use disorders. In many cases, the reason for their arrest is associated with "their lack of income and their unmet need for services, such as mental health and addiction treatment, and supports, such as housing and employment that are essential to life in the community."[3] **The National Council is concerned with this alarming trend and urges states to adopt laws that ensure that individuals with mental illness and substance use disorders are linked with appropriate services before release in order to assist their re-entry into the community and to reduce recidivism.**

Termination of Benefits

Regrettably, many individuals are released without access to Medicaid benefits due to the fact that they enter jail or prison without benefit eligibility or their eligibility is terminated upon incarceration. A central issue is conflicting guidelines between different levels of government and agencies that render the system complex and difficult to navigate. Federal law prohibits State Medicaid agencies from using federal funds to pay for services " . . . for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[4] Federal policy does not delineate, however, how states should execute this requirement. **Termination of Medicaid eligibility is not required and states have the option of suspending their eligibility while individuals are incarcerated.** The Department

of Health and Human Services has issued directives in recent years urging states to suspend rather than terminate Medicaid eligibility for incarcerated individuals. A memo[5] sent to all state Medicaid directors in 2004 by the Acting Director of the Centers for Medicare and Medicaid Services (CMS) encouraged suspension of Medicaid benefits while a person is housed in a public institution citing the importance of "establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later."[6] The memo suggests that when the inmate's release is imminent, "[...] the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility."[7]

Despite such recommendations, barriers persist:

- Many states do not have information management systems that allow for the suspension of benefits.
- States may terminate Medicaid to ensure that claims are not inadvertently filed for incarcerated individuals.
- The number of states and localities that have implemented procedures to help individuals with mental illness and/or substance use disorders claim or retain their benefits upon release is low.[8] This includes providing assistance from "jail personnel or community mental health providers to file an application."[9]
- The Social Security Administration (SSA) provides financial incentives (up to $400 per case) for reporting incarcerated persons in receipt of federal benefit payments so that SSI/SSDI benefits can be suspended or terminated.[10] But no incentive is provided to notify SSA when such persons are released so that benefit eligibility can be reinstated.[11] This program can be detrimental to inmates with mental illness since Medicaid benefits are tied to these federal income programs.[12]

Mental Illness and Addiction Among Justice Involved Individuals

There are more than 2.2 million people held in federal and state prisons or in local jails in the United States.[1] The U.S. Department of Justice estimated in 2005 that more than half of all individuals in both prison and jail had a mental problem[1] and that in 2002 more than two thirds of inmates in jail were dependent on or abusing alcohol or drugs.[1] Based on these figures, it follows that many of the 95% of individuals released each year[1] will have mental illness and/or addiction. Incarcerated individuals with mental illness have higher rates of homelessness, unemployment, past physical and sexual abuse, and substance abuse and dependency than those without mental problems.[1]

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Accessing Health Services Upon Release

While access to treatment in correctional settings varies by state and facility, many inmates with mental illness receive assessment and treatment while incarcerated. When released, this population usually accesses mental health treatment through federal entitlement programs, principally Medicaid. Many of these individuals are also entitled to income supports through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs, which are often linked with Medicaid. Unfortunately, federal policies currently prohibit people with chronic substance use disorders from qualifying for SSI/SSDI. In most states, those who receive SSI are automatically eligible for Medicaid coverage. In others, filling out a separate application will permit most to get Medicaid coverage. SSDI recipients are eligible for Medicare after a 24-month waiting period.

Federal SSI/SSDI benefit eligibility for inmates is determined by the amount of time an individual is incarcerated, thus affecting Medicaid eligibility since they are often connected. It is important to underline the difference between prisons and jails since the average duration of confinement varies by type of correctional facility. Jails are short-stay facilities, designed to hold persons convicted of a crime "sentenced to a year or less on misdemeanor offenses"[13] as well as persons awaiting trial. Prisons are long-stay facilities for those who have been convicted of a felony. Practically all prison inmates lose their SSI benefits (and often Medicaid benefits) due to the long stays,[14] yet this is not the case for jail inmates (See text box). SSDI benefits, on the other hand, are suspended after a 30 day incarceration period, but are never terminated.

For inmates who are eligible for Medicaid through SSI, their Medicaid eligibility will be lost if SSI eligibility is terminated. Moreover, many states automatically terminate Medicaid benefits upon incarceration, even if SSI hasn't been terminated. For inmates whose Medicaid eligibility is not connected to SSI, the state has the option under federal Medicaid law to suspend Medicaid eligibility during incarceration rather than terminate it. However, in practice, Medicaid eligibility is often terminated despite the option for suspending benefits, even if the inmate is confined for a short period of time. (For more information on the SSI, SSDI, and Medicaid rules for incarcerated individuals with mental illness, see the Bazelon Center for Mental Health Law's report, "Finding the Key to Successful Transition from Jail to Community")

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Implications of Benefit Disenrollment for Incarcerated Individuals with Mental Illness

How Time in Jail Affects Eligibility for SSI Benefits

In jail less than one calendar month: Inmate remains eligible for SSI and should receive the full cash benefit.

♦ For example, someone who enters jail on February 10 and is released before midnight March 31 should lose no cash payments.

In jail throughout a calendar month: Inmate will have SSI payments suspended but not terminated. This means that an inmate who is in fail on the first of the month and stays the whole month is not eligible for a cash payment for that month.

♦ For example, someone who enters jail on February 10 and is not released until April 1 will not lose February's payment (not being in jail for the whole month) but will lose the March payment.

In jail at least one month and then released after the first of another month: Inmate can receive an SSI cash payment for part of the month in which he or she is released.

♦ For example, someone who enters jail on February 10 and is released May 15 the same year will not lose the February payment, but will lose March and April benefits. In May, the person will be eligible for half of the monthly benefit. While this will be paid eventually, it could be delayed if the Social Security Administration (SSA) is not informed promptly that the individual have been released.

In jail for 12 consecutive calendar months: Inmate's eligibility is terminated. Technically, termination occurs after 12 continuous months of suspension. Only full months count.

♦ For example, someone who enters jail on February 1st of one year and is released on February 10th the following year will have SSI eligibility terminated because benefits were suspended for 12 continuous months. This person will have to file a new application and resubmit evidence of disability.

♦ But someone who enters jail on February 10th of one year and is released on February 10 a year later has benefits suspended for March through January and prorated for February of the second year. This person's eligibility will not be terminated because benefits were not suspended for 12 continuous months.

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Corrections facilities spend substantial amounts of money to provide mental health services and medications to incarcerated persons, yet due to a lack of coordination, many are released without access to services in the community, compromising their recovery. For newly released inmates seeking medical coverage, applications for Medicaid enrollment can take up to 3 to 5 months for approval.[15] As a result, the released person is likely to enter the community without access to mental health and addiction services for 90 days or more, increasing the risk of relapse, re-hospitalization, and recidivism.

Medicaid coverage upon release increases the likelihood of persons with mental illness receiving continuity of care. A study conducted by Morrissey et al. (2006) found that persons enrolled in Medicaid upon release are more likely "[...] to receive services more quickly, and to receive more days of service than those without Medicaid in the 90 days after their release from jail."[16] In a second study, Morrissey et al. (2007) found that inmates with mental illness who are enrolled in Medicaid at the time of release have fewer detentions in the following year than those

released without enrollment in Medicaid,[17] thus indicating reduced recidivism rates.

Continuity of Care

Several strategies can be employed to ensure continuity of care. These include, but are not limited to:

- *Suspension of eligibility instead of termination.* As suggested previously, state Medicaid policy could allow incarcerated individuals—where applicable by Federal law—to maintain Medicaid eligibility, to ensure continuity of care. Released individuals would then be able to go directly to a Medicaid provider, demonstrate eligibility, and receive services, without interrupting access to medications and other treatment. *This is the most desirable approach since it does not require that a new application be filed and benefits can be restored with minimal delay.*
- *Pre-release planning.* For those whose benefits were terminated or who were not previously enrolled, a desirable option is to ensure that an application for Medicaid, SSI and other benefits are submitted well in advance of release (at least 1 to 3 months prior) so that assistance is available upon release. A variety of Federal, state, and local funds and grants support enrollment in public programs as part of the discharge planning process. Pre-release planning varies by the length of an individual's incarceration period, the size of the correctional facility, and the resources available. Planning programs can include ensuring that the individual has identification cards (i.e. for Medicaid), a supply of medications, and community resource supports (i.e. food stamps, cash assistance, and housing) upon release. Co-locating relevant specialized staff (i.e. trained social workers) or local Social Security Administration staff at the institution to facilitate the process is advisable. A case study from Texas indicates that having a single agency with responsibility for discharge planning (especially assisting with benefit enrollment) is most effective.[18]
- *Having a pre-release agreement.* The Social Security Administration recommends establishing an agreement between a correctional institution and the local Social Security office. The agreement outlines responsiblities for each party to "streamline the process for starting/restarting benefits promptly after an inmate is released"[19], but only "if the inmate is likely to be eligible for benefits within 30 days of his or her scheduled release date."[20] Under the agreement, the SSA agrees to provide a contact in the Social Security office and to teach the social service and institutional staff about the federal benefit application process.[21] The Social Secuity office is also responsible for timely processing of the application and prompt notification when a decision has been made.[22] The responsibilities of the correctional institution

include collecting the relevant information to complete the claim, providing the Social Security office with the anticipated release date, and notifying them when inmate is released.[23] This agreement is often included as part of pre-release planning.

- *Payment by the state.* States could temporarily cover individuals with mental illness released from jail or prison who are awaiting approval of Medicaid or SSI/SSDI eligibility in the interim. For the majority who will receive eligiblity, states can claim reimbursement from the federal government retroactively.
- *Diversion programs.* These programs divert individuals with mental illness and/or substance use disorders to community-based services as an alternative to incarceration to prevent them from cycling in and out of the criminal justice system and their community services. Providing appropriate services and addressing the complex needs of diverted individuals enables them to live successfully in the community, thereby reducing the risk of homelessness, recidivism, and institutionalization.
- *Re-Entry Programs.* These programs are designed to connect individuals released from incarceration with supports and services that foster effective integration into the community. Evidence-based programs are comprehensive in nature and include a range of services designed to reduce recidivism, particularly pre-release programs, mental health and drug treatment, transitional housing support, and vocational training/placement.

These strategies, while not mutually exclusive, can be utilized to facilitate access to federal benefits for inmates with mental illness and substance use disorders. Three strategies in particular –legislation for suspension of eligibility, the adoption of diversion programs, and the implementation of re-entry programs—have received more attention recently and will be highlighted below in more detail.

Suspension of Benefits Legislation: New York State

Several states have passed legislation to bridge the gap between federal and state funding. Some introduced legislation *requiring* that Medicaid benefits be suspended during incarceration (Colorado, New York, passed & adopted; Illinois, in progress; Florida, failed) while other states, such as Iowa, have introduced legislation *recommending* suspension, yet passage was not successful. For example, New York state law was changed to require that Medicaid eligibility for inmates be suspended. The administrative directive (ADM) reads:

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> "[…] a State Department of Correctional Services or local correctional facility inmate in receipt of Medicaid immediately prior to incarceration on or after April 1, 2008, shall have eligibility maintained during incarceration."[24]

This legislation is beneficial for those who have Medicaid eligibility upon admission to prison/jail (which is an estimated 20-30% of their booked inmates[25]) and requires that the effort be a shared responsibility between state and local departments of social services. However, although the law clearly requires the suspension of eligibility, the reinstatement process is less explicit and there are several barriers that must be clarified. In order for individuals to have their benefits reinstated upon release, the state must be able to check whose Medicaid eligibility was suspended against who is released from jail. Although state law requires coordination between the Department of Corrections (DOC) and the Office of Temporary and Disability Assistance to identify those who need Medicaid suspended upon entering correctional facilities, many states, including New York, do not require that correctional facilities report information about an inmate's release to the State, thus rendering information about incarcerated individuals incomplete and hindering reinstatement of Medicaid coverage. Many State agencies issue a "Memorandum of Understanding" (MOU) that specifies requirements and responsibilities for information exchange between the two entities. However, this approach is largely relationship-based and can be problematic. Outcomes related to this legislation are not yet known, as it was enacted in April of 2008.

Diversion Program: Colorado

The Partnership for Active Community Engagement (PACE) in Boulder County, Colorado is a non-residential diversion program that has had marked success and shows promise for future state-wide adoption. Funded by a grant from the Department of Corrections, PACE offers coordinated and integrated services provided by a team in one location for members of the probation population with co-occurring mental health and substance use disorders. Acceptance into the program is determined by a range of criteria including presence of a major mental illness, status of supervised probation, if the client is at a "manageable risk level", and the likelihood that the individual will benefit as determined by the PACE treatment team. PACE seeks to connect participants with the supports they need, including assistance with medical/dental care, housing, and employment. Those who completed the program had lower recidivism rates than those "those on probation, those on parole, and those in community corrections programs."[26] Participants in PACE showed encouraging rates of recovery from addiction: while 88% entered the program substance dependent, 67% were sober during treatment.[27] In

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addition, the program demonstrated considerable cost savings: the cost to keep a person in jail in Boulder County is $23,000 per year, or $61.50 per day.[28] The PACE program costs $6,000 per year or $15 per day per client—one quarter of the daily cost of one day in county jail.[29]

Re-Entry Program: Arizona

The Co-occurring State Incentive Grant (COSIG) Services Pilot Project (funded by a SAMHSA-COSIG grant) is an integrated re-entry program for prisoners operated by the Arizona Department of Corrections (ADC) in Tucson. The program provides addiction and mental health treatment during incarceration (pre-release) and case management following release to ensure the continuity of mental health and addiction treatment services (post-release). The overarching goal of the program is "to increase opportunities for successful re-entry into the community"[30] for individuals with co-occurring diagnoses, thereby reducing recidivism. Services in prison are delivered by a team consisting of licensed substance abuse counselors, mental health staff, parole officers, re-entry case managers, and correctional officers. In addition to residential treatment in prison, an Individualized Transitional Release Plan (IRTP) is prepared for each participant to establish measurable objectives and determine resources needed for re-entry into the community. Participants receive education on mental illness and substance abuse with the rationale that increasing their knowledge base and life skills will encourage acceptance, management, and adherence. Following release from prison, individuals received case management and subsidized housing for 6 months, and are also offered continuing "alumni support groups". Although the COSIG Services Pilot Project has experienced staffing shortages and participant sampling problems, the results show potential. Of the 36 participants released as of March 2008 into the community, 19 (53%) completed the 6 months of aftercare. Nine of the 36 (25%) participants were either returned to custody or absconded. The evaluators note that although this program had "some shortfalls in implementation, it is uncertain if the shortfall is serious enough to impact the re-entry outcomes."[31] Indeed, many of the program's participants are "reported to be doing well" and continuation of the program could provide more conclusive outcomes.[32]

Recommendations

As the number of incarcerated individuals continues to rise each year, so does the number of those with untreated mental illness and/or addiction. A significant number of individuals are arrested for reasons relating to their illnesses and insufficient access to effective and appropriate community-based services. For those who enter the correctional system with benefits, many find them terminated during

the period of incarceration. If individuals are enrolled in federal and state benefit programs upon release, they are more likely to achieve successful re-entry into the community and less likely to be re-incarcerated.

Federal policy has encouraged states to suspend SSI and Medicaid benefits during incarceration, yet many states continue to terminate eligibility for these programs. Clearly, this discrepancy needs to be addressed in order *to ensure that incarcerated individuals receive federal benefits and are able to access the necessary services the day they leave jail or prison.* **As permitted by federal policy, the National Council urges that legislation be adopted by states to suspend, rather than terminate, the Medicaid benefits of eligible individuals during incarceration.** To implement legislation successfully, state governments and local correctional facilities need to work in partnership to integrate their systems and communicate effectively to ensure individuals have access to benefits when released. In the interim, state and local agencies should work with correctional facilities to identify those who are eligible upon release, quickly reinstate benefit eligibility, and utilize strategies to ensure continuous care.

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