



Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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Executive Summary

Many low-income individuals with severe mental illness leave state institutions without health insurance and therefore without financial access to the treatment they need to live successfully in their communities. Many of these individuals might be eligible for Medicaid coverage on the basis of their disability or other factors. However, complex eligibility rules for Federal disability benefits and Medicaid as well as complicated application procedures create barriers to ensuring that these individuals have Medicaid coverage after they leave an institution. In states like Oklahoma, where Supplemental Security Income (SSI) recipients are not automatically eligible for Medicaid and must apply separately for the program, people with mental illness may find it particularly challenging to obtain coverage. Reducing barriers to health insurance should increase access to health services and reduce subsequent admissions to prisons, hospitals, or other institutions.

Under contract with the Substance Abuse and Mental Health Services Administration (SAMHSA), Mathematica Policy Research, Inc., (MPR) worked with Oklahoma to develop, implement, and evaluate a model program to ensure that eligible individuals with mental illness were enrolled in Medicaid at discharge from state institutions. As a result of extensive collaboration across state agencies and with MPR, Oklahoma implemented a new program in July 2007 to help inmates with serious mental illness in three correctional facilities complete disability and Medicaid applications. Oklahoma also gathered detailed information on the Medicaid enrollment status of clients entering the state's largest institution for mental diseases (IMD) to determine whether implementing a similar program in IMDs would be beneficial. This

report describes the evaluation of these efforts.

The new program that was implemented in the three correctional facilities aimed to achieve Medicaid enrollment on the day of discharge for all eligible inmates with mental illness. The program involved (1) identifying inmates with severe mental illness who were likely eligible for Medicaid about 6 to 9 months before their release, (2) helping them apply for Federal disability benefits 4 months before their release, and (3) assisting them with subsequent Medicaid applications 2 months before their release. Critical to the success of the program were new appropriations from the state legislature that enabled the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to hire three discharge managers. These managers were hired to

improve discharge planning for inmates with serious mental illness in the three facilities. The evaluation of the program's implementation indicated that staff training, interagency agreements that simplified application procedures, and sustained interagency collaborations also were critical to the program's implementation.

The new program significantly improved access to Medicaid for discharged inmates with mental illness in the three facilities. On the day of release, about 25 percent of eligible inmates at the participating facilities were enrolled in Medicaid, compared with 8 percent of inmates at the same facilities in the 3 years prior to the program. In similar facilities that did not have new discharge managers, only 3 percent of inmates with mental illness had Medicaid at discharge during the program period. Using difference-of-differences methods and adjusting for various inmate characteristics, the study estimates the program increased Medicaid enrollment at discharge by almost 15 percentage points. Furthermore, program implementation improved over the study period. During the last 3 months of the intervention (after discharge managers had been in place for about a year), the program was associated with a 28 percentage point increase in the likelihood that inmates with severe mental illness had Medicaid on the day of release.

The potential for implementing a similar program in IMDs was evaluated using evidence collected at the state's largest IMD, revealing three major findings. First, the median length of stay in this IMD was 8 days, far too short to complete the complex

process of assisting clients with applications for disability benefits. Second, most (98 percent) of the clients who entered this IMD with Medicaid had short lengths of stay, and as a result, left with Medicaid coverage intact. Third, 71 percent of the clients may have been eligible for but were not enrolled in Medicaid, and all but 5 percent of these individuals would need to first receive a disability determination to be considered for Medicaid eligibility. For these clients, applications for benefits could be started in the IMD but would need to be monitored and completed in the community after discharge. Because of these and other factors, no new program was implemented in the IMD. However, efforts were made to improve information sharing between the IMD and a local community mental health center.

Overall, the evaluation of Oklahoma's efforts to ensure Medicaid enrollment for eligible individuals leaving state institutions demonstrates (1) the effectiveness of the state's model program for inmates with serious mental illness and (2) the need for community-based programs to help potentially eligible clients discharged from IMDs to enroll in Medicaid. The evaluation underscores the importance of developing sustained interagency collaboration, obtaining funding to enhance discharge planning for a clearly defined group of individuals with mental illness, and improving data systems to support application tracking and information sharing among state departments. The evaluation also reveals the need for strategic changes in state practices regarding Medicaid and disability applications.



Introduction

Many low-income adults with mental illness who are living in correctional facilities or institutions for mental diseases (IMDs)¹ lack health insurance coverage when they are discharged (Council of State Governments, 2005). Consequently, they may be unable to obtain needed medications and mental health services when they return to the community. Difficulties in obtaining these services place them at high risk for diminished quality of life; increased visits to emergency departments; criminal behavior; and readmission to prisons, hospitals, or IMDs (Carmody & Buchan, 2008; Harman, Manning, Lurie, & Christianson, 2003; Osher, Steadman, & Barr, 2002; Rabinowitz, Bromet, & Lavelle, 2001; Yanos, Lu, Minsky, & Kiely, 2004).

For many of these individuals, Medicaid is the primary source of health care coverage when they reenter their communities (Mallik-Kane & Visser, 2008). Medicaid coverage is important because it can help reduce the risks that arise when an adult with mental illness returns to the community after a stay in a public institution. For example, a series of studies investigating the postrelease trajectory of jail detainees with mental illness found that those with Medicaid were more likely to access community services (Morrissey, Steadman, et al., 2006; Morrissey, Dalton, et al., 2006) and had fewer subsequent detentions (Morrissey, Cuddeback, Cuellar, & Steadman, 2007) than those who did not have Medicaid.

Ensuring access to Medicaid for eligible individuals at discharge from state institutions would appear to be straightforward; in fact, achieving this goal is challenging for several reasons. First, most states consider adults living in public

institutions ineligible for Medicaid and will not accept their applications for Medicaid coverage until they leave the facility. States take this approach because Federal Medicaid law prohibits them from using Federal Medicaid dollars to pay for health services provided to most individuals living in state institutions. Specifically, this exclusion applies to all individuals who are inmates of a public institution and to all individuals aged 22 through 64 who are receiving services in an IMD. In addition, for many individuals with mental illness, the only way to become eligible for Medicaid is to first become eligible for Federal disability benefits. This means they must demonstrate that their condition meets the Federal definition for

¹ An IMD is defined as a facility of more than 16 beds that is primarily engaged in providing treatment services for individuals diagnosed with mental illness (42 CFR (Code of Federal Regulations) § 435.1009).

disability and that they cannot engage in gainful employment, which can be difficult to do from a prison or IMD. Moreover, the procedures involved in applying for Federal disability benefits are complex, and the necessary coordination among local institutions, state agencies and their local offices, and state offices of Federal agencies is often lacking. Completing a Federal disability determination itself can be a lengthy and arduous process (Social Security Advisory Board, 2001). Coordinating this with the Medicaid application process while residing in a state institution may not be feasible unless a state has developed special procedures that help such residents submit their applications for disability and Medicaid benefits well before discharge.

With support from Mathematica Policy Research, Inc., (MPR) made possible through a contract from the Substance Abuse and Mental Health Services Administration (SAMHSA), representatives from multiple agencies in Oklahoma worked together to design a model program to ensure that eligible adults leaving Oklahoma correctional facilities and IMDs have Medicaid at discharge or as soon as possible thereafter. SAMHSA selected Oklahoma for this project because the director of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was especially interested in addressing the issue and the state had been working for many years to develop an integrated, cross-agency database—drawing from the departments of mental health, corrections, and Medicaid—that was used to support the program development process (see Buck, Teich, Graver, Schroeder, & Zheng, 2004; Coffey et al., 2001).

The remainder of this chapter provides background information for the evaluation of Oklahoma's efforts, including a discussion of the scope of the problem, current Federal and state efforts to address the challenges, key implementation issues that similar programs have encountered, and an overview of the study methods.

Chapter II addresses key policy issues related to Medicaid eligibility. Discussion items include (1) policies related to suspending Medicaid eligibility or facilitating Medicaid applications for those entering state institutions with and without Medicaid, (2) the key eligibility groups through which Medicaid is obtained, and (3) the complex interactions between the application process for Medicaid and Federal disability benefits.

Chapters III and IV present the analyses of program implementation and outcomes for the project at correctional facilities and an IMD, respectively. These chapters describe how one state addressed the key policy issues discussed in Chapter II, including strategies used to develop interagency collaboration and data sharing agreements. Chapter V concludes the report with a summary of the study's major findings.

1.1 Scope of the Problem

Ensuring that eligible adults with mental illness have Medicaid coverage and appropriate access to needed treatment services after they leave a state institution has become an important issue for many states. During the past several decades, states have witnessed rapid increases in the number of (1) incarcerated adults with serious mental health problems and (2) adults entering IMDs.

With regard to inmates with mental illness, for example:

- The U.S. Department of Justice (DOJ) estimates that 1.3 million individuals with mental illness were in state or Federal prisons or local jails in 2005. More than half of all prison and jail inmates exhibited symptoms of a mental disorder, and about a quarter had mental health problems diagnosed within the past 12 months (James & Glaze, 2006).
- Rates of serious mental illness are two to four times higher among prisoners than among members of the general population (Hammett, Roberts, & Kennedy, 2001; Harlow, 1998).
- At least 100,000 individuals who left correctional facilities in 2004 had a mental illness (Council of State Governments, 2005).

Adults with mental illness also enter IMDs in substantial numbers. Despite this fact, few studies have examined the effects of Medicaid eligibility on their health or mental health status after their release.

1.2 Federal and State Efforts

The Federal Government has taken several steps to help adults with mental illness obtain Medicaid coverage at discharge from a public institution (these efforts are discussed in detail in Chapter II), and ongoing Federal interest is evidenced by a series of new Federal grant programs. For example, the Second Chance Act of 2007 (H.R. 1593/S. 1934) reauthorized and revised an existing DOJ program that provides money to states to design and implement reentry initiatives. It also created a Federal interagency task force to study and

coordinate policy and commissioned several research projects that included a study of Federal policy barriers to successful reentry. The act authorized DOJ to provide grants to nonprofit organizations for mentoring and transitional programs for adult and juvenile offenders.

State governments have addressed this problem either by developing policies to suspend Medicaid eligibility upon incarceration and then reinstating it at discharge or by implementing programs to help inmates complete Medicaid and disability benefit applications before discharge. For example, New York suspends eligibility indefinitely; whereas, in North Carolina, Medicaid eligibility is suspended until the enrollee's eligibility period ends. Other states, including Maryland, Minnesota, Texas, and Washington, also suspend Medicaid eligibility upon incarceration for varying lengths of time.

Examples of state efforts to assist inmates with mental illnesses in securing Federal benefits upon their release include programs developed by Texas, Pennsylvania, New York, and Minnesota:

- The Texas Correctional Office of Offenders with Medical or Mental Impairments provides discharge planning services through contracts with local mental health and social service providers. A group of at least 12 eligibility benefit specialists supports discharge planning at state correctional facilities. For inmates with mental illness who are eligible for discharge planning, the eligibility benefit specialist starts the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) application

process and submits all applications to the local Social Security Administration (SSA) disability determination office about 90 days before release. Each local SSA office has a designated point person who works with inmate applications. The application process is tracked, and state-funded coverage is arranged to fill any gaps until Medicaid begins (Reentry Policy Council [RPC],² 2005d; D. Kifowit, personal communication, 2004).

- Pennsylvania's program focuses on a Web-based application system for public benefits, including Medicaid and general medical assistance for those not eligible for Medicaid. The Web-based system eliminates barriers associated with residency requirements, and it reflects the state's decision to no longer require an in-person interview at application. Because of resource constraints, the Web-based application is only available at one women's correctional facility and one men's facility (RPC, 2005a; C. McVey, personal communication, 2004).
- In New York, inmates with a severe mental illness who appear to be eligible for Medicaid receive application assistance from the Transition Correctional Unit. Staff members help

the inmate submit benefit applications before his or her release and ensure that the state/county-funded Medication Grant Program (MGP) is in place to provide immediate medication coverage after the person leaves the facility. The MGP provides only interim coverage for medications while the former inmate waits for Medicaid coverage to start. The MGP is optional at the county level and as a result is not available in all counties (RPC, 2005c; D. Abreu, personal communication, 2004).

- Minnesota screens adults entering either an IMD or a correctional facility for receipt of SSI and Medicaid benefits. When a Medicaid enrollee enters an IMD, the state automatically replaces Medicaid with a state-funded health insurance program. Upon the person's discharge, Medicaid is automatically reinstated. Because the state uses the same information system to manage both the Medicaid and state-funded programs, only an eligibility code needs to be updated to reflect the change from one program to the other. Discharge planning for individuals with serious and persistent mental illness in correctional facilities is prescribed in state law, and it must begin at least 90 days prior to release, although the state reports that the process begins about 6 to 9 months before the anticipated release date. Assistance typically includes help with SSI/SSDI applications. For those determined eligible for Medicaid prior to release, the county social service office will mail the Medicaid card to the prison to ensure the inmate has it the day of

² The Reentry Policy Council (RPC) was established in 2001 to assist state government officials grappling with the increasing number of people leaving prisons and jails to return to the communities they left behind. The RPC's goals are to: (1) develop bipartisan policies and principles for elected officials and other policymakers to consider as they evaluate reentry issues in their jurisdictions; and (2) facilitate coordination and information-sharing among organizations implementing reentry initiatives, researching trends, communicating about related issues, or funding projects.

release (RPC, 2005b; S. Autio, personal communication, 2004).

1.3 Key Program Implementation Issues

In reviewing the four state programs described above, the RPC concluded that the key ingredients to success included (1) interagency agreements, (2) designation of special staff, and (3) timely initiation of the application process.

Interagency agreements and collaborations are considered essential to reducing barriers to Medicaid coverage for those with mental illness leaving state institutions. The application processes for Medicaid and Federal disability benefits require the ability to track people with mental illness over time and across agencies. At a minimum, the state mental health and Medicaid agencies must have the ability to share information about potentially eligible people. If the program is designed to help people in correctional facilities, then the department of corrections must be involved as well, and mechanisms must be in place to exchange information about inmates between corrections, mental health, and Medicaid. These mechanisms may require new data systems. The state department that conducts disability determinations and the state and local offices that handle SSI and SSDI applications must also be involved in initiatives that provide assistance with applications for Federal disability benefits. Their involvement frequently includes designating staff to handle applications that come through the program.

The RPC also determined that these initiatives must focus on the distinctive needs of people with mental illness. Serving adults with mental illness typically requires more

time and resources compared with other populations. Individuals with severe and persistent mental illness typically have a complex array of immediate needs, including needs for housing and income support. Their mental illness can also create additional barriers that make it difficult for them to cooperate with staff members who are trying to help them navigate multiple systems. As a result, the Council believes that successful programs typically require the agencies involved to assign staff members specialized duties or caseloads. In many instances, the programs have required new resources such as funding for new positions.

As noted, the application processes for Medicaid and Federal disability benefits are complex and lengthy. Consequently, starting the application process early is critical to ensuring that Medicaid coverage is in place the same day someone returns to the community. Once someone has left a facility, followup and monitoring of the application becomes more difficult because of the challenges associated with tracking people across agencies, particularly if many of them are unable to find stable housing. In addition, many adults with mental illness find the application process, and the associated need to make multiple appointments, too difficult to manage on their own.

1.4 Study Methods

The evaluation of Oklahoma's new programs had two objectives: (1) identify critical components in the process of designing and implementing the programs and (2) assess the extent to which the programs achieved the goal of establishing Medicaid coverage for eligible individuals

with mental illness at discharge from correctional facilities and IMDs.

1.4.1 Program Design Phase

MPR began this project by working with ODMHSAS and the Department of Corrections (DOC) to assemble a steering committee of representatives from Oklahoma state agencies who could collaborate in the design of the new programs and support their implementation. This committee required broad representation because adults with mental illness who leave state institutions are likely to require services from multiple agencies. Individuals from these agencies helped plan the necessary interagency coordination, provided information useful in designing the new programs, and identified state procedures that needed modification.

In addition to staff from ODMHSAS, DOC, and MPR, this committee included representatives from the Oklahoma Health Care Authority (OHCA, the state's Medicaid agency); the Department of Human Services (DHS, which assesses eligibility for Medicaid and other public programs); a state field office of the SSA (which is responsible for final decisions regarding eligibility for SSI and SSDI); and the Disability Determination Division (DDD) of the Oklahoma Department of Rehabilitation Services (which handles the disability determination process for the SSA office). A list of steering committee participants appears in Appendix A.

Between January 2005 and July 2007, Oklahoma designed interventions to facilitate applications for individuals leaving three of the state's largest prisons and the state's largest IMD. Although full implementation was somewhat delayed, a new program was

eventually implemented in three DOC facilities. For the state's IMD, a new program was developed but not implemented for several reasons, as indicated below.

DOC Facilities. New legislative appropriations allowed the ODMHSAS to enhance discharge planning procedures for inmates with serious mental illness in three state prisons, hire new discharge managers to assist inmates with applications, and support the development of a data collection system that the new staff used to manage the application process. Oklahoma staff began developing specific plans for the enhanced discharge planning in mid-2006; the discharge managers began working in January 2007; the designated start date for the program evaluation was July 1, 2007, thus giving the discharge managers time to complete training and orientation.

Supporting the program was extensive interagency collaboration that resulted in simplified and more efficient disability benefit and Medicaid application procedures for inmates leaving the three project facilities.

The IMD. In the IMD, the program that was designed for this project involved (1) a new method for documenting staff efforts to assist clients potentially eligible for Medicaid to begin applying for disability benefits and Medicaid and (2) enhanced communication between the IMD and a community mental health center (CMHC) to which many IMD clients were discharged. Despite extensive planning in 2006–2007, the new documentation method was not implemented for several reasons.

First, as indicated by the data analyses presented in Chapter IV, the median length of stay in the IMD was about 8 days during the study period (July 2007–March 2008). This length of stay usually means that

individuals entering with Medicaid coverage are not likely to lose that coverage before discharge. For those not enrolled in Medicaid, this length of stay is too short to complete the complex application procedures for disability benefits that are necessary for the Medicaid application. These conditions presented (1) major challenges for staff in the IMD with respect to monitoring client applications for Medicaid and disability benefits and (2) the need for substantial coordination between the IMD and community-based agencies to which clients are referred upon discharge (but who often do not appear for post-discharge appointments). Second, no new funds were made available for new staff in either the IMD or the CMHC, and the work of existing staff was not reallocated to permit time to integrate the new documentation method.

Because no program was implemented at the IMD, we changed the purpose of data collection to focus on descriptive analyses of the characteristics, Medicaid status, and post-discharge outcomes for individuals leaving the IMD.

1.4.2 Data Sources

To evaluate Oklahoma's programs, MPR collected qualitative and quantitative data. To assess the implementation of the program at DOC, qualitative information was collected from key informants between March and June 2008. Interviews were conducted with program managers, staff supervisors, and frontline staff who worked directly with the program participants. The implementation analysis also relied on administrative data to obtain information about the size of the program (such as counts of participants).

The quantitative analyses of Medicaid enrollment and other outcomes for people leaving DOC facilities and the IMD utilized administrative records obtained from a variety of linkable data systems. Data were obtained from DOC, ODMHSAS, the Medicaid agency, and the participating IMD. Employment information came from the Oklahoma Employment Security Commission (OESC).³ The Oklahoma State Bureau of Investigation provided arrest data. Oklahoma staff compiled the data and created person-level records. Personally identifying information was removed and the final project database was sent to MPR for analysis.

The evaluation of program effects greatly benefited from data sharing agreements between key agencies. Prior to the study, ODMHSAS periodically assembled data from most of the state's public mental health facilities and merged them with Medicaid records from the OHCA. This provided comprehensive tracking of Medicaid enrollment and service utilization for selected mental health services in the state. A new interagency agreement between ODMHSAS and the DOC enabled ODMHSAS to collect similar information for inmates discharged from Oklahoma prisons. The resulting project database facilitated analysis of Medicaid enrollment, service use, employment, and arrest outcomes for people with mental illness released from DOC facilities and from IMDs.

³ OESC gathers employment information on only those employees who contribute to Oklahoma's unemployment compensation fund. As a result, postdischarge employment outcomes for those in jobs that do not contribute to this fund (such as roofers and painters working as independent contractors) are not captured.

1.4.3 *Analytical Approach*

The outcomes analysis focused on (1) Medicaid enrollment, (2) use of mental health services after discharge, (3) employment after discharge, and (4) recidivism and IMD readmission. For the analysis of the DOC program, the study approximated outcomes that would have occurred in the absence of the program by comparing the outcomes of inmates who participated in the program to the outcomes of similar inmates from a previous period and from other correctional facilities. The methodology compared Medicaid enrollment, mental health care utilization, employment, and recidivism in the group that received program services to the same outcomes of a similar group that was discharged from the same facilities during an earlier period (January 2004 through December 2006). To control for outside factors that may have affected program outcomes between the two periods, the study obtained outcome information for inmates with mental illness discharged from nonparticipating correctional facilities for the

same two periods. The analysis of outcomes relied on regression techniques to adjust for differences in observable characteristics between the intervention and comparison groups.

For the IMD, the study gathered administrative data on clients discharged between July 2007 and March 2008. The study analyzed the rate of Medicaid coverage, mental health service use, employment, arrests, and IMD readmission after discharge and how these outcomes varied by Medicaid status at admission. The study also gathered similar information for clients discharged from the IMD between January and December 2006. Because the study found no substantive differences between outcomes for the 2006 population and outcomes for clients discharged the subsequent year, and because there were substantially more missing and potentially problematic data on clients discharged in 2006, the study's analyses focused on the group leaving the IMD between July 2007 and March 2008.



Barriers to Ensuring Medicaid Eligibility for Adults Leaving State Institutions

To policymakers unfamiliar with the intricacies of the Medicaid program, ensuring Medicaid coverage for individuals with mental illness who leave state institutions may seem easily accomplished. For those with Medicaid coverage at entry, an obvious solution might be to suspend eligibility at entry and reinstate it at discharge; for those without Medicaid coverage at entry, an obvious solution might be to ensure that they apply for Medicaid while still institutionalized and, if eligible, enroll on the day of discharge. However, implementing either solution is more complex than it appears:

- Maintaining eligibility for adults entering these institutions who are already enrolled in Medicaid depends heavily on their length of stay and other factors, such as the need for periodic redetermination of Medicaid eligibility.
- Federal rules allow suspension of Medicaid eligibility for adults who are already enrolled in Medicaid when they enter state facilities, but most states have not implemented such procedures.
- The specific rules and practices governing Medicaid application procedures require a sequenced set of activities that often depends on the timing and outcome of an application for Federal disability benefits.
- For adults with mental illness, Medicaid procedures are shaped by Federal rules and state choices regarding mandatory and optional eligibility groups.
- Federal policies affecting the determination of disability for adults with mental illness are complex and vary depending on whether an individual enters an institution already receiving such benefits.

This chapter describes the Federal rules that govern Medicaid eligibility of adults residing in state institutions, addressing each of the issues described above.

2.1 Federal Rules Governing Medicaid Eligibility of Adults Residing in State Institutions

Some adults with mental illness enter state institutions already eligible for and enrolled in Medicaid, and most states have policies that allow them to terminate Medicaid eligibility for these individuals. One reason why states have these policies involves rules about Federal reimbursements for services to individuals in public institutions.⁴ Under Federal law, states cannot obtain Federal financial participation (FFP) for services provided to individuals in correctional facilities or to individuals between age 21 and 64 in IMDs (42 CFR § 435.1009).⁵ This rule restricts only a state's capacity to obtain FFP but does not address whether Medicaid-eligible individuals who enter these institutions remain eligible during their stay or can be enrolled in Medicaid.

To clarify the implications of this rule, Federal officials have emphasized that Medicaid eligibility need not change when someone enters these institutions (see Exhibit 1). As a whole, Federal transmittals and rules provide a reasonably clear policy foundation for states, if they wish, to develop strategies

for maintaining Medicaid eligibility for Medicaid-enrolled individuals entering public institutions by, for example, suspending eligibility at entry and reinstating it at discharge. A few states have implemented methods for suspending rather than terminating Medicaid benefits. New York, for example, recently passed legislation that suspends Medicaid coverage for prisoners during their incarceration and then reinstates it at their release (Feldman, 2007). Texas and Washington suspend Medicaid eligibility for individuals who enter jails if they remain in jail for less than a month (Bazelon Center for Mental Health Law, 2006). According to Eiken and Galantowicz (2004), the Maryland Medicaid agency maintains incarcerated individuals on its enrollment list even if they have been incarcerated for more than 30 days.

Most states, however, have interpreted the regulation prohibiting FFP for these individuals to mean that all Medicaid-enrolled individuals who enter these institutions become ineligible for Medicaid. Analysis of data from a 2000 survey showed that all states had policies terminating Medicaid eligibility upon incarceration (Lackey, 2000; Morrissey, Dalton, et al., 2006). From a state's perspective, terminating eligibility or allowing it to lapse after entry into an institution provides an unambiguous designation and avoids the potential for (1) erroneous payment for non-FFP Medicaid services for which the state would be fully responsible or (2) erroneously billing the Federal government for Medicaid services provided to individuals who were not eligible for Federal matching payments at the time of the service.

Furthermore, states have not pursued the option of suspending eligibility of Medicaid

⁴ According to 42 CFR § 435.1010, "public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This report uses the term to refer to correctional facilities and state-licensed IMDs that are governed by Medicaid and SSA policies.

⁵ The Federal regulation prohibiting FFP for individuals in state institutions has two important exceptions. First, it does not prohibit FFP for Medicaid-covered services when individuals residing in state institutions are admitted as inpatients to a hospital, nursing facility, or intermediate-care facility (assuming either that the individual's Medicaid enrollment has not lapsed or that he or she has been newly enrolled). Second, the regulation does not apply to IMD residents over age 65 or under age 21 (42 CFR §§ 440.140, 440.160).

Exhibit 1. Federal Rules and Allowances Regarding Medicaid Eligibility in Institutions

Rule or Allowance	Source
Entry into a public institution does not make a Medicaid-enrolled person ineligible for Medicaid if he or she would otherwise be eligible.	CMS, 1997; Stanton, 2004
Medicaid rules permit states to suspend rather than terminate Medicaid benefits during an individual's stay in a public institution.	Stanton, 2004
States must ensure that administrative systems do not improperly terminate individuals.	42 CFR §§435.911**
Immediate resumption of Medicaid coverage is required upon return to the community if an individual remains eligible.	HHS, 2001
States may not actively terminate someone's Medicaid coverage without determining that the person is no longer eligible under any of its eligibility categories (known as an ex-parte review).*	42 CFR §§435.916, 435.930**

* These rules require states to ensure they do not disenroll someone improperly and permit states to delay the redetermination of eligibility until just prior to a person's return to the community.

** See also the letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State, dated September 14, 2000, and letter from the Secretary of HHS to Congressman Charles Rangel, October 1, 2001.

enrollees who enter state prisons or public IMDs because they are concerned that (1) suspending Medicaid eligibility may conflict with Federal rules regarding eligibility redeterminations (RPC, 2005c), and (2) implementing data systems to track suspensions could be costly.⁶ States have claimed that CMS has not been sufficiently explicit regarding “whether or not an administrative match is available for costs associated with suspending eligibility for this population” (Atkins & Friedman, 2004). However, Federal regulations are clear in allowing states to claim FFP for administrative expenses associated with determining an applicant's Medicaid eligibility (42 CFR § 435.1001), and no rule

prohibits states from claiming administrative expenses for individuals filing new applications or seeking reinstatement during their stays in public institutions. In 2005, CMS noted that:

Federal administrative match would be available for costs associated with suspending Medicaid benefits for this population [Medicaid-eligible inmates]. FFP is available at the administrative rate for administrative processes or at the enhanced rate for systems-related expenses for the purposes of suspending inmates from the Medicaid rolls to avoid erroneous claims payment (CMS, 2005).

Rather than or in addition to developing strategies for suspending Medicaid eligibility, states can facilitate the application process for individuals residing in state institutions who are potentially eligible for Medicaid (because they either had Medicaid at entry or appear to meet Medicaid eligibility criteria as their discharge date approaches). No Federal rule prohibits an incarcerated individual or public IMD resident from filing a Medicaid application prior to returning to the community. In fact, states must allow anyone to apply for Medicaid at any time (§ 1902(a)

⁶ A letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State, dated September 14, 2000, notes, “[R]equiring states to suspend benefits for inmates could be administratively complex to implement.... This policy could require expensive changes to state systems and significant amounts of staff time could be spent tracking the status of inmates.”

(8), Social Security Act); once an application is filed, states must determine eligibility on a timely basis and ensure that their administrative systems do not improperly deny coverage (42 CFR § 435.911).

Compared with developing policies to suspend Medicaid eligibility, developing methods to facilitate applications may be more attractive to some states because doing so avoids the risk of inappropriate billing for FFP, may require fewer changes to existing data systems, and potentially allows states to claim administrative expenses for helping individuals reapply or file new Medicaid applications even while they are residing in public institutions. Furthermore, states may wish to develop procedures for facilitating Medicaid applications for potentially eligible individuals with no history of Medicaid enrollment as well as those already enrolled at the time of institutionalization.

2.2 Impact of Length of Stay on Medicaid Eligibility

Although they have policies that allow them to disenroll from Medicaid adults who enter state institutions already eligible for Medicaid, most states in fact do not actively terminate eligibility for these individuals. Rather, eligibility terminations typically depend on the length of institutionalization. Individuals with Medicaid who enter state facilities for a short period of time (less than a month in a jail or an IMD, for example) typically do not lose their Medicaid eligibility (see Exhibit 2). However, if they remain in state facilities for a year or longer, they are almost certain to lose Medicaid coverage because (1) they do not complete the necessary paperwork for redetermination; or (2) they lose disability benefits, which eliminates the administrative basis for their

Medicaid eligibility. Direct action on the part of a Medicaid agency to terminate eligibility at entrance to an institution happens infrequently because most state institutions do not have a formal mechanism to inform the Medicaid agency that a recipient has entered.

For individuals who do not have Medicaid coverage at entry into a state institution but who may be eligible at discharge, the institutional stay provides an opportunity for providers to help people with mental illness complete and submit an application for Medicaid. Although a decision regarding Medicaid eligibility can be made within 30 days after an application is submitted, the overall application process can take far longer if a disability determination is required first (that is, if the applicant has to qualify for Medicaid on the basis of disability). Stays in state prisons are typically sufficiently long to enable this application process to be completed. However, a short stay in an IMD (less than a month, for example) may provide an opportunity to begin the application process but will not allow its completion. Hence, the outpatient clinic to which an individual is referred will need to provide the followup monitoring of and assistance with the applications for both Medicaid and disability benefits as needed.

2.3 Rules and Practices Influencing the Maintenance of Medicaid Eligibility

In theory, individuals with Medicaid coverage at entry into public institutions may lose coverage as a result of one of three processes. First, they can lose Medicaid coverage because they do not complete the periodic redetermination process that is

Exhibit 2. Implications of Entry into State Institutions for Individuals' Medicaid Eligibility, by Medicaid Status at Entry and Length of Institutionalization

Type of Institution	Length of Institutionalization		
	For Less Than 1 Month	For 1–12 Months	For 1 Year or More
Eligible Individuals Enrolled in Medicaid at Entry			
An IMD	Will probably not lose Medicaid eligibility	May or may not lose eligibility	Not applicable*
A jail	Will probably not lose Medicaid eligibility	May or may not lose eligibility	Not applicable*
A state prison	Not applicable**	Not applicable**	Will lose eligibility
Potentially Eligible Individuals Not Enrolled in Medicaid at Entry			
An IMD	May have time to begin an application but probably not enough time to complete it	May or may not have enough time to complete an application	Not applicable*
A jail	May have time to begin an application but probably not enough time to complete it	May or may not have enough time to complete an application	Not applicable*
A state prison	Not applicable**	Not applicable**	Will have enough time to complete an application

* Few adults stay in IMDs or jails longer than 12 months.

** Most adults entering state prisons have sentences of 12 months or longer.

required to remain enrolled in the Medicaid program.⁷ Depending on when their redeterminations are due, individuals entering public institutions may remain on Medicaid rolls for up to 11 months following entry into a public institution and are disenrolled only when the state Medicaid agency does not receive the appropriate redetermination paperwork by the due date.

Virtually all individuals who enter state prisons with Medicaid coverage will lose coverage prior to discharge because they are usually committed for 12 months or longer.⁸ Lengths of stays in jails and prisons vary widely from a few weeks in jails to more than a year in prisons. Lengths of stays in IMDs vary from several days to many months; stays longer than a year are rare in most states. Consequently, individuals with Medicaid who enter jails, prisons, or IMDs for a short stay (several days to several

months, for example) probably will not lose their Medicaid coverage because they will not be subject to redetermination during this period.

The second way of losing Medicaid coverage applies to individuals who qualify for Medicaid on the basis of disability and whose entrance into an institution is reported to SSA. Jails, prisons, and certain mental

⁷ Federal law requires states to recertify Medicaid eligibility at least once every 12 months, and states have the option of recertifying eligibility more frequently. In most states, adults are recertified every 6 months (42 CFR § 435.916(a)). Recertification for enrollment in the Food Stamp Program typically triggers recertification for Medicaid. The certification period for the Food Stamp Program is determined by the state, but certification periods can be anywhere from 1 to 24 months, depending on characteristics of the household (7 CFR § 273.10(f)).

⁸ Personal communication, Charles Brodt, Director for Federal/State Health Policy, Oklahoma Health Care Authority, June 21, 2006.

health institutions can receive payment from SSA for reporting the incarceration or confinement of an SSI recipient or a Social Security retirement, survivor, or disability beneficiary.⁹ When SSA learns that a recipient has entered a correctional facility or an IMD, it suspends SSI cash benefits. If the individual remains in an institution for fewer than 12 months, cash benefits can be reinstated promptly upon discharge, assuming that the individual remains financially eligible as determined by a prerelease review. If he or she remains for a year or longer, a full reapplication is required. Federal rules do not require states to terminate Medicaid eligibility for individuals who lose SSI cash payments. However, in many states, Medicaid eligibility depends on SSI eligibility; hence, if SSI eligibility is suspended or terminated, Medicaid eligibility is lost.

The third way of losing Medicaid benefits involves procedures whereby the Medicaid agency is directly informed of an individual's entry into a state institution and actively terminates his or her eligibility. Interviews with several Medicaid directors indicate that active termination occurs far less frequently than the other means of losing Medicaid coverage, in part because of Federal rules stipulating that "states cannot terminate individuals from Medicaid until a

redetermination has been conducted, including an ex-parte review."¹⁰

For individuals who enter state institutions with Medicaid coverage, critical issues include (1) whether and how to suspend Medicaid coverage during an institutional stay and reinstate it at discharge, (2) how to conduct redeterminations to assess whether an individual still qualifies under the same category as he or she did at entry, or (3) whether to allow Medicaid coverage to lapse (see Exhibit 3). For those who were Medicaid-eligible on the basis of disability at entry, the process of determining Medicaid eligibility at discharge involves determining whether the individual's condition still meets the Federal definition of disability. If the individual does not qualify under the same Medicaid category, states must determine whether he or she may be eligible under other categories. Furthermore, specific policies and procedures for suspension, redetermination, and reinstatement may need to vary somewhat according to the category of eligibility at entry.

2.4 Rules and Practices Influencing the Establishment of Medicaid Eligibility

Many individuals with mental illness who enter public institutions do not have Medicaid coverage even though they would be eligible if they applied. Furthermore, in

⁹ Facilities are paid \$400 when the person's social security number, name, date of birth, and other identifying information are provided within 30 days of incarceration or confinement. The payment is \$200 when information is provided within 90 days. These incentive payments were established because SSA's timely receipt of this information ensures timely suspension of benefits and therefore minimizes inappropriate Federal expenditures (<http://ssa.gov/pubs/10088.htm>, accessed September 30, 2005).

¹⁰ See letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State, dated September 14, 2000, and confirmed in a letter from HHS Secretary to Congressman Charles Rangel, October 1, 2001.

Exhibit 3. Key Issues for Maintaining Medicaid Eligibility of Individuals with Mental Illness
Entering State Institutions with Medicaid Coverage

**For Individuals Enrolled in Medicaid at Entry,
States Could Consider the Following:**

- Establishing policies and procedures to keep beneficiaries enrolled in Medicaid during institutional stays while at the same time (1) suspending their access to Medicaid benefits; (2) ensuring periodic redeterminations, as required by category of eligibility; and (3) for those found ineligible at redetermination, determining whether these individuals may be eligible under other eligibility categories
- Designing policies and procedures for reinstating Medicaid coverage at discharge for individuals who remain Medicaid-eligible
- Varying policies and procedures according to the category of Medicaid eligibility at intake (for example, different procedures may be needed for those enrolled on the basis of disability, pregnancy, custodial parenthood, or other categories)
- Allowing Medicaid enrollment to lapse and then, as discharge date approaches, integrating assistance with Medicaid applications into the discharge planning processes

actual practice, Medicaid coverage lapses for many individuals who are enrolled in Medicaid at entry, especially if they remain institutionalized for longer than 12 months. To ensure that both groups of individuals have the opportunity to apply for Medicaid, several issues need to be addressed (see Exhibit 4).

First, information is required to assess whether an individual is potentially eligible for Medicaid. Eligibility for Medicaid is predicated on the decision by state Medicaid agencies that an individual fits into one of the many categories or groups through which an individual enrolls in Medicaid (see Appendix B). For individuals who are preparing to leave a state institution, this means that specific insurance, demographic, financial, and clinical information may need to be gathered at admission, stored and updated appropriately, and then made available to the discharge planner as the discharge date approaches.

Second, policies and procedures are needed to assist individuals in actually submitting a Medicaid application at least several months prior to discharge. In many states, the agency that handles the application process for Medicaid may (1) be reluctant to accept applications from individuals who are in state institutions because these individuals are not eligible at the time they submit the application (even though Federal law allows anyone to submit an application for Medicaid regardless of residential status) or (2) require in-person interviews at a local office as part of the standard application procedure. These practices need to be reexamined to ensure that eligible individuals with mental illness who are leaving state institutions have Medicaid at discharge.

Furthermore, efficient decisionmaking depends on effective coordination between staff in the institution and key state agencies. In instances where final decisions are not

Exhibit 4. Key Issues for Establishing Medicaid Eligibility of Individuals with Mental Illness
Released from State Institutions

For Individuals Not Enrolled in Medicaid at Entry (or Whose Medicaid Enrollment Lapses), States Could Consider the Following:

- Ensuring that information related to Medicaid applications is gathered systematically at intake or as part of the discharge planning process
- Implementing procedures to (1) initiate and track applications for Medicaid and Federal disability benefits while individuals are institutionalized, (2) ensure that state agencies will accept Medicaid applications from institutionalized individuals at least 30 to 60 days prior to discharge, and (3) facilitate efficient decisionmaking related to these applications
- Determining whether in-person interviews with Medicaid or Social Security staff are needed to complete the application and, if so, how they can be arranged while the person remains institutionalized
- Ensuring coordination among outpatient mental health providers, as needed, to track applications and coordinate with Medicaid and SSA eligibility workers after the individual has been discharged
- Developing procedures and policies to pursue retroactive eligibility for those who gain Medicaid eligibility postdischarge

made before discharge, coordination will be needed between institutional staff and the community providers to whom the individual is referred. Once the application is filed, it will be necessary to ensure that supplemental information, if needed, can be provided prior to discharge so that the individual will not have to refile an application if a decision is not made prior to discharge.

Finally, procedures and policies may be needed to pursue retroactive eligibility back to the date of discharge for those who gain Medicaid eligibility after discharge. Important provisions in the law allow individuals returning to the community to have access to prescription drugs and medical care through Medicaid while applying for coverage. Retroactive coverage for up to 3 months is available for those found eligible. The law specifies that Medicaid eligibility is effective retroactively 3 months before the application if the individual is determined to

have been eligible up to 3 months before applying (42 CFR § 435.914). Medical services provided during the retroactive period are eligible for FFP as long as the individual was not in a public institution at the time. Further, the agency may make Medicaid eligibility available from the first day of the month of application if the individual would have been eligible at any time during that month (42 CFR § 435.914).

States commonly require Medicaid applicants to apply in person (with the exception of pregnant women and children), although no Federal rule compels states to have this requirement. In-person application requirements help states obtain the information they need to assess income and resources and fulfill Federal requirements that applications must be signed by the applicant or the applicant's authorized representative (42 CFR § 435.907). However, such requirements can present a barrier to

coverage for individuals residing in public institutions. As a result, states have developed certain exceptions to requiring in-person visits. For example, states can allow individuals to apply through outstationed eligibility workers located at hospitals and community health centers, and Federal law specifies that states must provide such workers at locations other than social service offices for low-income pregnant women and children (42 CFR § 435.904).

2.5 Disability Benefits Policies

Individuals with disabling conditions may be eligible for cash assistance through one of two Federal disability benefit programs administered by SSA: (1) the SSI program for low-income individuals and (2) the SSDI program for workers who become disabled.

The SSI program was authorized by Title XVI of the Social Security Act for low-income elderly people, the blind, and people with severe disabilities. Designed to help those with little or no income, this program provides cash benefits to help individuals meet basic needs for food, clothing, and shelter. Essentially, the SSI program provides a uniform national floor on income eligibility for cash benefits for Americans 65 years of age and older and for people with disabilities. In most states, SSI recipients are automatically enrolled in Medicaid. In seven states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah) known as SSI criteria states, SSI recipients are eligible for Medicaid but must make a separate application for coverage. Eleven states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia), known as 209(b) states, exercise

the option of using income and resource requirements or disability definitions that are slightly more restrictive than those used by the SSI program. In these states, small proportions of SSI recipients may not be eligible for Medicaid, although these states are required to allow SSI recipients to “spend down” or deduct medical expenses from income when determining Medicaid eligibility (42 CFR § 435.121). As in SSI criteria states, SSI recipients in Section 209(b) states must apply separately for the Medicaid program.

The SSDI program is an entitlement for working-age individuals who have paid Social Security taxes for at least 20 quarters within the 40 quarters prior to application (20 CFR § 404.130).¹¹ Workers who do not meet this criterion will have their applications reviewed for SSI eligibility. SSDI benefits can be paid to workers, their families, and their survivors (see 20 CFR §§ 404.330–404.374, 404.390–404.392). Beneficiaries of the program are eligible for Medicare coverage, but only after SSDI eligibility has been established for 2 years (§ 226(b)(2)(A), Social Security Act). If their incomes are low enough, they also may be eligible for Medicaid coverage either because they are SSI recipients or because they belong to one of the other Medicaid eligibility groups.

2.5.1 Eligibility for SSI and SSDI

The SSI program offers cash assistance to three types of low-income individuals: (1) the aged (those 65 years of age or older), (2) the blind, and (3) the disabled (20 CFR

¹¹ The law makes special provisions for individuals who become disabled before age 31 (20 CFR § 404.130).

§ 416.202).¹² To be considered low income, an applicant's monthly income, after certain deductions, must be below the Federal benefit rate, which was \$623 for individuals and \$934 for couples as of January 2007 (see §2113 of the Social Security Handbook).¹³ In addition, resources or assets cannot be more than \$2,000 for an individual or \$3,000 for a couple (see 20 CFR §§ 416.1201–416.1266). SSDI benefits are an entitlement for individuals with an appropriate work history. The SSDI program does not have income and resource requirements, although applicants must demonstrate an inability to earn above the substantial gainful activity level because of a disabling condition.

Eligibility decisions for Federal disability benefit payments are typically more complex than for the Medicaid program because of the need to establish someone as disabled and as unable to earn sufficient income as a result. Applicants to the SSI and SSDI program must demonstrate that their disability results in their inability to engage in any substantial gainful activity (which was \$900 a month in 2007) and that their

condition will either result in death or last at least 12 months (see 20 CFR §§ 416.971–416.976, 416.905).¹⁴ Both programs define a disabling condition as one that is severe, is a “medically determinable physical or mental impairment,” and meets or equals a listing in the SSA listing of impairments (20 CFR § 416.905). Individuals must have a severe impairment that makes them unable to perform their past work (see 20 CFR § 416.960(b)) or any other substantial gainful work that exists. If the impairment is not in the listing of impairments (see Appendix 1 of 20 CFR § 416.404), the individual must be found to be unable to make an adjustment to any other type of work (20 CFR §§ 416.920, 416.945). For mental disorders, the SSA guidelines (SSA, 2008) state:

The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months.

Overall, determining disability requires 3 to 5 months (SSA, 2009a), but delays can be lengthy because of insufficient documentation. States also vary widely in the average time for a disability determination and the nature of delays. For example, in one state, only half of the SSI/SSDI applications for mentally ill persons are granted within 90 days (RPC, 2005d). In another, caseworkers

¹² The definition of “blind” includes having 20/200 vision or less with the use of a correcting lens in the better eye or tunnel vision of 20 degrees or less.

¹³ Deductions include the first \$20 of income; the first \$65 of earnings and half of remaining earnings; tax refunds; the value of food and home energy assistance; state or local assistance based on need; income set aside under a Plan to Achieve Self-Support (PASS); grants, scholarships, and fellowships; the value of loans; money someone else spends to pay expenses for food and shelter; and the value of impairment-related work expenses for items or services a person with disabilities needs to work (www.ssa.gov/notices/supplemental-security-income/text-income-ussi.htm, accessed September 30, 2005).

¹⁴ Throughout this discussion, there are several policies that are the same for SSI and SSDI applicants and recipients. In these instances, only law that pertains to the SSI program is cited for ease of presentation.

reported that many SSI/SSDI applications based on a mental illness are initially denied but then approved after a complicated appeals process; in this state, disability determinations for former inmates can take up to a year (RPC, 2005c).

Individuals usually begin the application process for Federal disability benefits at a local SSA office.¹⁵ Typically, the local SSA office manages the application process and determines whether individuals meet the financial requirements of the programs. If the individual meets the financial requirements, the local SSA office begins to work with the state's disability determination unit or office, which has responsibility for gathering the information needed to determine disability. Applicants must provide these state units the acceptable documentary evidence of the disabling condition, which typically includes all relevant medical records (20 CFR §§ 416.912, 416.913). If the medical staff at the state's disability determination unit determine that the medical records submitted by the applicant or the applicant's providers are insufficient, they order a consultative examination with a contracted provider (20 CFR §§ 416.917, 416.919). In some cases, the results of the consultative exam may provide all the documentary evidence available for the determination of disability.

Federal law allows for further functional assessments of applicants with mental impairments (20 CFR § 416.920a) in addition to the consultative examination. Applicants with mental impairments are rated on the degree to which an impairment interferes with their ability to function

“independently, appropriately, effectively, and on a sustained basis.” This includes assessing any episodic limitations, the amount of supervision or assistance required, and the settings in which applicants can function.¹⁶

Once the evidence of the disabling condition has been collected, the examiner and a medical consultant determine disability status. If the medical information collected does not adequately indicate severity or duration of illness, the application will be denied. Applicants can appeal denials (20 CFR § 416.1407).

One of the key factors contributing to delays in SSA's decisionmaking and to many denials involves insufficient documentation of functional impairment in an individual's medical record. In most instances, institutional medical records (as well as summaries of institutional stays that are developed at discharge and placed in the medical record) are written by clinical providers who (1) are communicating important treatment-related needs for clinical providers in the outpatient setting to which the individual is referred and (2) have little awareness of the information needed by SSA staff to make disability determinations, such as the level of the individual's impairment or the impact of the individual's diagnosis on his or her ability to work. Training caseworkers and other clinicians in the importance and methods for documenting SSA-related information is an essential component of efforts to improve the process

¹⁵ Beginning in 2005, a Web-based application process was initiated.

¹⁶ Applicants are rated on their activities of daily living (ADL), social functioning, concentration, persistence, and pace. Typically, applicants with no or mild limitations in ADL, social function, concentration, and persistence are not considered disabled for the purpose of Federal disability benefits.

of applying for Federal disability benefits (see Dennis, Perret, Seaman, & Wells, 2007).

2.5.2 Policies Governing Federal Disability Benefits for Adults Residing in State Institutions

Federal disability policy excludes individuals who become wards of the state from receiving Federal disability benefits when residing in a correctional facility or public IMD. However, key policies vary somewhat depending on whether a person is eligible for disability benefits at entry.

Adults Receiving Federal Disability Benefits at Entry. For individuals who are receiving Federal disability benefits when they enter a public institution, several Federal rules are designed to help them maintain eligibility for these benefits for at least the first 12 months after entry. The rules specify that an individual who is in a public institution for more than 1 month cannot receive SSI or SSDI benefits (20 CFR § 416.211(a)).¹⁷ He or she is placed on suspended eligibility status, and benefits may be reinstated upon release if the person continues to meet program requirements (20 CFR § 416.1321(b)). Evidence showing that he or she continues to have income and resources below the program's financial requirements for SSI must be submitted upon release. However, SSI eligibility ends when the stay reaches 12 months, and upon release the individual must file a new application, including evidence of disability and financial need (20 CFR § 416.1335). Because SSDI is an entitlement, these benefits are suspended

if the stay extends beyond 12 months and will be reinstated at discharge.

There are some exceptions to these regulations, in particular for IMD residents. SSA may continue providing SSI benefits for up to 3 months to IMD residents who have been admitted temporarily for psychiatric treatment if a physician writes that a stay is not expected to last more than 90 days. The individual must also show that the SSI payment is needed to maintain a home or living arrangement during the stay (§1611(e)(1)(G), Social Security Act).

Adults Eligible for but Not Receiving Disability Benefits at Entry. Similar to the Medicaid program, no Federal policy prohibits inmates of correctional facilities or residents of public IMDs from filing an application for Federal disability benefits. Moreover, at least two Federal policies may help individuals who reside in public institutions to establish or reestablish SSI benefits quickly upon returning to the community. These policies include (1) prerelease agreements that expedite the processing of applications prior to a person's return to the community and (2) presumptive eligibility.

Although an individual may file an application for Federal disability benefits as soon as discharge from a public institution is anticipated, the processing of these applications can be expedited if a prerelease agreement is in place. A prerelease agreement is described in the SSA's procedures manual as "a written or verbal agreement between an institution and SSA to cooperate in the processing of SSI applications under the pre-release procedure" (SSA, 2009b). A prerelease agreement can be developed between a local SSA office and an institution or the state. SSA local offices participating in

¹⁷ Benefit payments are terminated after a full calendar month of incarceration or residency. Furthermore, as noted previously, SSA has an incentive program to encourage public institutions and states to report the admission of SSI and SSDI beneficiaries (see footnote 7).

the agreement will process prerelease applications if the individual is applying while in a public institution, is likely to meet SSI or SSDI criteria upon release, and is expected to be released within 30 days after notification of potential eligibility for Federal disability benefits.¹⁸

Prerelease agreements are executed as a memorandum of agreement between SSA and the state agency or other entity charged with administration of the institution. If there is an agreement between SSA and the institution, SSA will provide training for institutional and social services staff to learn the prerelease procedure and will provide a contact to assist with the applications. For its part, the institution agrees to refer only those individuals who appear to be eligible for Federal disability benefits, to provide additional medical and nonmedical information needed to process the claims, to provide the anticipated release date, and to notify SSA upon an individual's release. SSA in turn agrees to process the new claim or reinstatement as quickly as possible and to notify the institution promptly of the individual's eligibility.

SSA law permits the determination of presumptive eligibility, which allows the receipt of disability benefits before eligibility is determined conclusively. If the information available at the time of application indicates a high probability that the individual will be found eligible for benefits, benefits can begin up to 6 months before eligibility is formally established (20 CFR § 416.931). All other eligibility requirements must be met at the time of the application, including income and resource criteria if the applicant is applying

for SSI benefits. Staff at a local SSA office may make determinations of presumptive eligibility only for specified impairment categories (for instance, total blindness or deafness, severe mental retardation, or being wheelchair-bound for at least 12 months).

2.6 Summary

Complex Federal rules regarding eligibility for Medicaid and Federal disability benefits, varied lengths of stay in institutionalization, and lengthy application procedures combine to create serious barriers to ensuring that individuals with mental illness residing in state institutions have Medicaid coverage at discharge. These barriers:

- Are somewhat different for individuals who enter these institutions with Medicaid coverage compared with those who are potentially eligible but are not enrolled at entry
- Vary in their practical implications depending on the individual's length of stay in an institution
- Involve the challenges of a complex application process, the lack of assistance in submitting complete applications in a timely manner, and long delays in application processing
- Can be especially difficult to overcome when disability has to be determined (or redetermined) before completing a Medicaid application

To address these barriers, states could pursue either or both of two options. One strategy involves suspending Medicaid eligibility for those who enter state institutions already enrolled in Medicaid and then reinstating eligibility at discharge. Federal regulations and transmittals provide

¹⁸ www.ssa.gov/notices/supplemental-security-income/spotlights/spot-prerelease.htm; accessed July 8, 2004.

a reasonably clear policy foundation for states to develop strategies to suspend Medicaid eligibility for Medicaid-enrolled individuals entering public institutions. However, most states have not developed such strategies for several reasons, including the desire to avoid the risk of billing the Federal Medicaid program for FFP and the lack of funds needed to establish the new data systems and administrative procedures required to institute a suspension-of-eligibility process.

The second strategy involves developing procedures to assist individuals to complete applications for both Federal disability benefits and Medicaid before they are discharged from state institutions. (As illustrated in Chapter III, Oklahoma elected to pursue this second strategy.) An array of Federal laws and regulations determines these application procedures, most of which were developed for adults in general and did not take into account the presence of a specific mental illness or medical condition.

Application procedures for Medicaid also vary somewhat depending on the category through which eligibility may be obtained. For example, for individuals who qualify for

Medicaid on the basis of disability, a disability determination must occur first. However, the criteria for determining disability for the purposes of Federal disability benefits are complex and require applicants to demonstrate that the disabling condition prevents them from engaging in work that can provide significant income support. Some states have developed options, such as prerelease agreements, designed to expedite access to Federal disability benefits—and Medicaid as a result—for individuals residing in correctional facilities or IMDs. The next chapter describes how Oklahoma has used this and other state options allowed under Federal law to design new efforts to facilitate Medicaid and disability benefit applications so that eligible individuals with mental illness obtain Medicaid coverage at discharge from a state prison or as soon as possible thereafter.



Increasing Medicaid Coverage at Release from Correctional Facilities: Results of a Model Program in Oklahoma

Like many states, Oklahoma witnessed a surge during the last decade in the number of inmates with serious mental illnesses. By 2002, approximately 26 percent (about 5,000 male inmates and 1,000 female inmates) of the 23,000 incarcerated individuals under the jurisdiction of the DOC had a history of mental illness or had exhibited some form of mental illness (Powitzky, 2003). By 2006, the number of inmates with a history or current symptoms of mental illnesses grew to 11,900, and the number with current symptoms of severe mental illness reached 6,000 (Powitzky, 2007).

Although the state lacked quantitative data on the number of mentally ill inmates who were released without Medicaid coverage, indirect evidence convinced program directors in the DOC that a large percentage of inmates potentially eligible for Medicaid were being released without such coverage. Furthermore, staff from both DOC and ODMHSAS noted that many inmates released without health insurance were unable to obtain the mental health services they needed as they reentered their communities.

In 2004, under a contract with SAMHSA, MPR began working with the state of Oklahoma to design, implement, and evaluate a program to ensure that eligible adults with mental illness were enrolled in Medicaid on the day of their release from DOC facilities or soon thereafter. This project—a collaboration of several Oklahoma state agencies, MPR, and SAMHSA—aimed to develop a model program and evaluation that could inform other states about best practices for, and

challenges to, enrolling inmates with mental illness in Medicaid after their release from correctional facilities.

This chapter describes the design and operation of Oklahoma’s model program for three DOC facilities and the program’s effects on Medicaid enrollment and other key outcomes. Specifically, this chapter summarizes:

- Interagency collaborations that resulted in the development of the model program to enroll eligible adults with mental illness in Medicaid on the day of their release from prison
- Program design characteristics and their objectives
- Oklahoma’s success in obtaining new resources, selecting and training program staff, collecting data, and developing new interagency procedures and agreements to implement the program
- Effects of the program on Medicaid enrollment and on three additional outcomes the intervention was expected to influence: postrelease mental health service use, rearrest, and employment

3.1 Overview of Program Development and Implementation

The initial meeting of the project’s interagency steering committee, held in January 2005, was essential for raising awareness about the growing number of people with mental illness in correctional facilities, ensuring that participants understood existing Medicaid eligibility

regulations, and gathering support for a new program that was likely to increase Medicaid enrollment. Three elements were critical for obtaining appropriate support from each agency: (1) a common and easily understood goal (ensuring Medicaid coverage for all eligible released inmates), (2) specification of the potential financial and nonfinancial implications of the program for each agency, and (3) participation of senior agency staff. The initial meeting also helped to build interagency relationships. As the project developed, monthly telephone meetings and yearly in-person meetings helped to manage this collaborative effort.

One early decision made by the steering committee involved the question of whether the state should consider developing methods for (1) suspending Medicaid eligibility for inmates who entered state prisons already enrolled in Medicaid and then reinstating it at discharge, (2) facilitating Medicaid and disability benefit applications for potentially eligible inmates several months prior to release, or (3) both approaches. Early in its deliberations, the steering committee decided that the second approach—developing strategies for assisting residents of state institutions to complete applications for Medicaid and Federal disability benefits—was preferable to developing methods for suspending eligibility for Medicaid-enrolled individuals entering state institutions. Three factors influenced this decision.

First, developing methods for suspending eligibility would require developing an interagency data system accessible by both DOC and DHS (which assesses eligibility for

Medicaid) to track inmate Medicaid enrollment and institutional status.¹⁹ The committee believed that developing such a data system was not feasible within a reasonable period of time, especially because the technical resources within DOC were devoted to other pressing problems with their information management system.

Second, most inmates with mental illness remain in state correctional facilities for longer than a year, meaning that they pass the date when they would be required to submit annual recertification forms to continue their enrollment in Medicaid. Suspending Medicaid eligibility for these inmates and automatically reinstating it at discharge would have required exempting them from the annual redetermination process. This exemption was seen as unwise because important factors influencing their Medicaid eligibility may have changed.

Third, many inmates without Medicaid coverage at entry are potentially eligible at discharge and would benefit from application assistance. The steering committee recognized that developing systematic

strategies for assisting inmates with the application process could cover both those without Medicaid at entry and those who lose Medicaid eligibility while incarcerated. Consequently, only one set of new procedures would need to be developed.

In addition to providing overall policy direction for the program development process, the steering committee was directly involved in:

- Developing the operational specifications for the new program
- Ensuring that program specifications were translated into feasible activities in the field
- Identifying existing or additional resources to help support the new program, including new appropriations for staff at DOC facilities and capitalizing on a relevant, federally sponsored training program
- Devising data systems to track the process of helping inmates apply for disability benefits and Medicaid
- Developing prerelease agreements between local facilities and SSA offices
- Advising MPR on the design of the evaluation of the program

The remainder of this chapter describes the program design, implementation, and evaluation that resulted from the collaborations among the agencies represented on the steering committee and between the steering committee and MPR.

3.2 Program Design

A subgroup of the project's steering committee developed the specifications for a

¹⁹ Suspension of eligibility would require an interagency data system that could (1) identify Medicaid-enrolled inmates when they entered prisons; (2) reliably inform DHS when a Medicaid enrollee became incarcerated; (3) ensure that DHS and OHCA worked together to move these individuals into a newly designated status that would need to be created and added to existing computer fields; (4) develop a new form or procedure for triggering reinstatement that would assess whether the individual was still eligible for Medicaid (especially important if the person was incarcerated for more than 12 months, which is true of most inmates in state prisons); (5) ensure that DOC sent the appropriate information to DHS regarding the inmate's date of discharge and community living arrangements; and (6) include fail-safe mechanisms for ensuring that no FFP was requested for medical care rendered before the inmate was discharged.

new program to be implemented at three DOC facilities: the Joseph Harp Correctional Center (a 1,400-bed, medium-security facility for men, with designated units for inmates with mental illness); the Mabel Bassett Correctional Center (a 200-bed, maximum-security facility for women with units for inmates with mental illness); and the Oklahoma State Penitentiary (a 2,000-bed, maximum-security prison with a mental health unit). The three facilities represent almost a quarter (23 percent) of all inmates in Oklahoma correctional facilities and about 36 percent of inmates with serious mental illness in the state.

In January 2007, as a result of special appropriations from the state legislature, three discharge managers (one in each facility) were hired by ODMHSAS to improve discharge planning for inmates with serious mental illness. As part of their responsibilities, the discharge managers worked with other members of the treatment teams to ensure that eligible inmates with mental illness had Medicaid by the time of their release.

3.2.1 Target Population

The project's target population included adults aged 18 or older who met specific diagnostic criteria based on the DOC Mental Health Classification System. Inmates who met these criteria had been diagnosed as having major depression, bipolar disorder, or psychoses. Many had a history of repeated stays in prison or inpatient treatment settings or were at high risk of rearrest and reincarceration. Inmates meeting these criteria who were released from one of the three project facilities between July 1, 2007, and March 31, 2008, were eligible for the

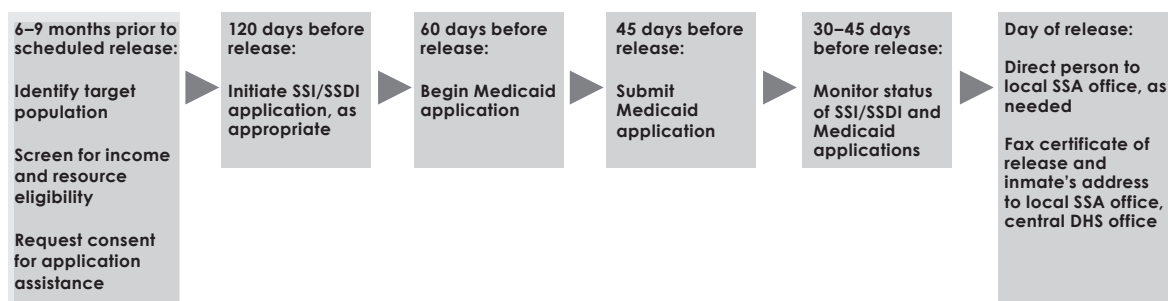
Federal disability and Medicaid application assistance provided by the new program.

3.2.2 Specific Program Objectives

Exhibit 5 provides an overview of the program and Appendix C includes detailed program specifications. In brief, the discharge manager was responsible for performing or ensuring that other staff on the clinical treatment team carried out the following activities:

- Identify individuals in the target population who are within 6 to 9 months of their release date, conduct eligibility screens for SSI/SSDI and Medicaid, and obtain the required signed consent form.
- At about 4 months prior to the anticipated release date, mail signed consent forms to the appropriate SSA office, submit a disability report form, and participate, with the inmate, in a teleapplication according to procedures detailed in the relevant prerelease agreement.
- After the teleapplication is submitted, fax documentation of medical reports and the inmate's discharge planning summary (if available) to SSA, mail documentation of income and resources (if any) to the local SSA office, and maintain contact with the assigned disability examiner.
- About 60 days prior to the anticipated release date, help the inmate fill out the appropriate Medicaid application.
- About 30 to 45 days prior to the anticipated release date, contact the designated person in the central office

Exhibit 5. Overview of New Intervention at DOC Facilities



of DHS and then, on behalf of the inmate, electronically submit the notification of the SSA disability determination and the Medicaid application (which DHS flags as a prerelease application).²⁰

- After the Medicaid application has been submitted, monitor the status of the Medicaid application by maintaining contact with the designated person in the central DHS office and addressing any requests for additional information.
- If the inmate is found eligible for Medicaid pending release, ensure that the central DHS office is ready to certify the inmate's Medicaid Recipient

Identification (RID) number upon receiving a faxed copy of the certificate of release and the individual's community address on the day of release.

- On the day of release, for inmates who have been approved for SSI/SSDI or have pending applications, ensure that the former inmate brings the discharge certificate and other information to the local SSA office.

3.2.3 Necessary Procedural Changes

Oklahoma implemented certain procedural changes to help discharge managers and treatment teams complete Federal disability and Medicaid applications for eligible inmates. In addition to designing the new application procedure protocol, steering committee members arranged for staff training and developed formal and informal interagency agreements between DOC, DDD, local SSA offices, and DHS to facilitate the prerelease application process. Compared with the system in place prior to the project, these actions—and the associated training programs, data collection tools, and interagency agreements to support them—reflect a substantial change in policies and procedures (see Exhibit 6).

²⁰ Oklahoma is one of 11 Section 209(b) states that have more restrictive Medicaid eligibility requirements than those of the SSI program and as a result require SSI recipients to apply separately for Medicaid. Specifically, Oklahoma uses an asset test that is slightly more restrictive than the asset test used by the SSI program. The 10 other Section 209(b) states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, and Virginia. Seven additional states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah) use the same eligibility criteria but require SSI recipients to file a separate application for Medicaid. Ensuring that eligible inmates enroll in Medicaid in all these states may require somewhat different procedures than in other states, where enrollment in the SSI program brings automatic enrollment in Medicaid.

Exhibit 6. Changes in Oklahoma’s Policies and Procedures Affecting Inmates with Mental Illness in Three Prisons

Before Program Implementation	After Program Implementation
Limited resources for assisting inmates with mental illness to reenter communities	Additional staff whose primary purpose is to assist discharge planning for inmates with mental illness
Treatment teams with limited access to information on community-based mental health services	ODMHSAS staff within DOC facilities providing critical link to community-based mental health services
No organized step-by-step procedure for helping inmates complete applications for disability benefits or Medicaid	Development of specific protocol guiding the process of completing disability and Medicaid applications for inmates with mental illness
No organized training for staff with regard to applications for Federal disability benefits or Medicaid	Staff trained in application procedures for Federal disability benefits and Medicaid
Little-used or nonexistent prerelease agreements between prisons and local SSA offices	Prerelease agreements in place between all participating prisons and local SSA offices
Mandatory in-person interview at DHS office postdischarge	In-person interview waived by DHS if appropriate information is received from prison staff
No mechanisms within DHS or SSA to identify prerelease cases	Special flags established within DHS, DDD, and local SSA offices to identify applications needing facilitated reviews

3.3 Evaluation of Program Implementation

The study used quantitative data provided by Oklahoma and qualitative data gathered through key informant interviews conducted in mid-2008 to address the following questions about the implementation of the new program:

- What new financial, staff, and training resources were used to implement the program?
- What new interagency collaborations supported the program’s implementation?
- To what extent did the program accomplish its objective of enrolling inmates with mental illness into Medicaid on the day of discharge?

In this section, we address each of these questions.

3.3.1 What New Resources Were Needed for Program Implementation?

To be implemented effectively, new programs frequently require new resources. Three resources were particularly important for the new program in Oklahoma: (1) legislative funds to support new staff in the DOC facilities, (2) the availability of a relevant national training program that had been implemented in Oklahoma prior to the development of the DOC program, and (3) the capacity to track electronically an inmate’s progress through the application process.

Financial Resources for New Staff. The development of the DOC program benefited substantially from the Oklahoma legislature’s approval of \$1 million in new appropriations for discharge planning for inmates with mental illness. Specifically, during the 2006 legislative session, the Oklahoma legislature

provided funding for ODMHSAS to hire a discharge manager for each of three DOC facilities, beginning in January 2007. (The appropriations were also used by ODMHSAS to fund co-occurring treatment specialists and an expanded Reentry Intensive Care Coordination Team [RICCT] program.) All three discharge managers had prior experience working in corrections: One had worked inside an Oklahoma correctional facility, one had worked in the community for DOC, and one had worked in a correctional facility in another state. The hourly salary for the new staff was more than \$22, in line with average earnings of therapists and clinical counselors in the state.²¹

As a member of the prison treatment team, discharge managers are responsible for helping inmates with mental illness reenter their communities successfully. They directly assist (or help social service staff to assist) inmates with applications for Federal disability and Medicaid benefits. In addition, discharge managers (1) help inmates and their families prepare emotionally for the discharge; (2) assist as needed in linking inmates to treatment resources in the community; and (3) support inmates in meeting other needs, such as obtaining food stamps or housing. The discharge managers are especially well suited to bridge the gap between prison treatment teams and community-based services because they are

ODMHSAS employees (and therefore have credibility with community-based providers) and have offices in the DOC facilities (and therefore are part of the prison-based mental health teams). Because the new appropriations for discharge planning became part of Oklahoma's standard operating budget, the program activities implemented by the discharge managers are expected to continue for the foreseeable future.

Access to a National Training Program on Improving Applications for Federal Disability Benefits. Although the discharge managers were broadly aware of application requirements for Federal disability benefits and Medicaid, they required specific training in the procedures that would help the state SSA and Medicaid offices to process applications in a timely and efficient manner. Coincidentally, Oklahoma received support in 2005 to implement the SSI-SSDI Outreach, Access, and Recovery (SOAR) program (see Dennis et al., 2007).²² This national program trains caseworkers to assist homeless adults in the process of applying for SSI and SSDI and includes suggestions for improving documentation of a client's functional status in medical records and discharge summaries. The person responsible for implementing SOAR in Oklahoma participated on the project's steering committee and was able to

²¹ Average earnings and cost of living are lower in Oklahoma than in other states within the region and nationally. For example, average hourly income for mental health counselors in 2007 was \$16.18 in Oklahoma compared with \$17.24 in the region and \$17.89 nationally (D. Wright, personal communication, based on data collected from Economic Modeling Specialists, Inc.).

²² As part of SOAR, SAMHSA developed the Stepping Stones to Recovery curriculum in an effort to help case managers assist homeless adults with serious mental illnesses and co-occurring disorders with the application process for Social Security disability benefits. The curriculum provides an indepth, step-by-step explanation of the application and disability determination process for case managers who assist persons who are homeless to apply for SSI/SSDI. See www.prainc.com/SOAR for additional information.

ensure that the discharge managers participated in these trainings. Furthermore, because the SOAR training focuses only on SSI and SSDI applications, state staff from DOC, ODMHSAS, and DHS developed an additional 2-hour component that specifically covered the state's Medicaid application process.

By the time of the official start date of the new program (July 2007), all three discharge managers in the DOC facilities had completed SOAR training and the additional Medicaid application training.²³ During a group interview, each of the three discharge managers mentioned that this training had substantially helped them understand the SSI, SSDI, and Medicaid application processes and assisted them in facilitating the application process for inmates in their facilities. The social service specialists and facility-based psychologists involved in the discharge planning process also received SOAR and Medicaid application training. Several of these individuals reported that they found these trainings particularly helpful for understanding how to write case notes that would assist SSA and DDD staff with disability determinations.

Enhanced Capacity to Track Electronically an Individual's Progress Through the Application Procedures. For the project to be successful, existing data systems needed modifications to enable discharge managers to track client progress and assess the impact of new efforts to enhance Medicaid coverage of individuals leaving state institutions. When this project began, the DOC was in the process of planning

major changes to its existing information management systems. However, the final design and implementation of the changes to the DOC data system were substantially delayed and, as a result, ODMHSAS developed a Web-based reporting system solely for the discharge managers to use for tracking progress in assisting inmates with their Medicaid and Federal disability benefit applications. The Web-based system used by the discharge managers at the correctional facilities will be integrated into emerging information management systems for these facilities at a future date.

The Web-based data system supplements data maintained by the DOC on all inmates by adding information on the mental health status and the status of entitlement applications of program participants. The discharge managers described the Web-based tracking tool as a work in progress and alterations to the system are ongoing to make it more flexible. For example, discharge managers would like to have a reporting feature that enables them to sort their client list by anticipated date of discharge.

3.3.2 What New Interagency Collaborations Supported the Program's Implementation?

Although the DOC discharge managers directly assisted inmates with mental illness to complete applications for Medicaid and Federal disability benefits, staff from several Oklahoma agencies—including DOC, ODMHSAS, DHS, DDD, and state SSA offices—were involved in ensuring that inmates actually enrolled in these programs. These agencies have different missions, procedures, and “cultures.” To ensure that applications for disability benefits and

²³ Two discharge managers also received training on managing and treating clients with conduct disorders.

Medicaid were submitted and adjudicated in a timely manner, members of the interagency steering committee worked to (1) revise existing interagency agreements and develop new ones and (2) foster informal working relationships among staff members in different agencies.

Formal and Informal Interagency Agreements. Certain procedural changes were made to support collaboration among staff members from different agencies. Specifically, DHS (1) agreed to accept Medicaid applications from an inmate 30 days before discharge (which generally had not been the case previously); (2) waived requirements for an in-person interview from these individuals, provided all other application requirements were met; and (3) designated a person in the state office to handle all applications from inmates at the three participating prisons to ensure the applications were processed in a timely manner. In addition, formal prerelease agreements were negotiated (or in some instances renegotiated) between the three state prisons and the local SSA offices. Finally, a memorandum of understanding (MOU) between ODMHSAS and DOC allowed data sharing between key staff involved in the project.²⁴

Informal Interagency Collaboration. In addition to developing formal documents, the staff from DOC held a series of meetings between the discharge managers, staff

members at DDD, staff members in the local SSA offices, and personnel from the central DHS office to ensure that all the individuals who were actually implementing the program had the opportunity to get to know one another in at least one face-to-face meeting. Interviews with key informants at the end of the study period underscored the importance of these meetings because they gave staff from the different agencies an opportunity to meet one another, understand one another's role in achieving a common goal, and commit to maintaining good communication (for example, by exchanging telephone numbers).

Three key changes were made in application procedures as a result of these informal meetings. First, discharge managers agreed to flag inmate applications so that DDD, SSA, and DHS offices could easily identify files for individuals residing in correctional facilities. Second, treatment teams (including discharge managers, psychiatrists, and social workers) followed recommendations made by DDD staff members regarding the type of information to submit in disability applications to improve the disability determination rate. Third, staff increased the frequency with which information was transferred between DHS, SSA, and the discharge managers about inmates' application status and discharge dates. To eliminate delays in processing Medicaid applications, the discharge managers agreed to fax copies of inmates' certificates of discharge to DHS. In return, DHS offered to provide more frequent updates about the Medicaid application status. The leadership at DOC viewed this local collaboration as essential

²⁴ Copies of the prelease agreements between correctional facilities and local SSA offices and the MOU between ODMHSAS and DOC are available upon request by contacting Audra Wenzlow (at awenzlow@mathematica-mpr.com) or Judith Teich (at judith.teich@samhsa.hhs.gov).

for successful implementation of the program.

3.3.3 *Did the Program Accomplish its Objectives?*

The program's primary objective was to ensure that eligible inmates with mental illness were enrolled in Medicaid on the day of release. Information collected from Medicaid records, DOC administrative records, key informant interviews, and the new Web-based reporting system for the discharge managers provides insight into the program's success and initial obstacles in achieving this objective.

Enrolling Eligible Inmates in Medicaid. Of all inmates discharged from one of the three project facilities during the 9-month study period (July 2007–March 2008), DOC records indicate that 77 were in the population targeted for the program (that is, they met clinical criteria and were released during the study period). In theory, data on all these inmates should have been entered into the Web-based tracking tool that was designed to monitor an inmate's progress through the application process. In practice, discharge managers did not formally screen 24 of these 77 inmates, and as a result, data were not entered into the tracking tool for these individuals. These inmates were not screened for at least one of the following reasons:

- *Some inmates were released sooner than expected.* Eligible inmates were due to be screened for the project about 6 to 9 months prior to release. However, release dates are somewhat unpredictable in state prisons. For example, prison officials can release an inmate months earlier than originally expected due to good behavior or for

other reasons. Discharge managers and other members of the treatment teams may have begun working with an inmate on Medicaid or disability benefit applications but may not have reached the milestones that would have triggered data entry before the inmate's release.

- *Application assistance was provided to some inmates by members of the treatment team other than the discharge manager.* Although the discharge manager was technically responsible for tracking the application process for designated inmates, in practice, other members of the treatment team staff (for example, a social service specialist) took on these responsibilities for some inmates. However, these staff members did not have access to the Web-based tracking system, and consequently, information for some of these cases was not entered into the data system.
- *Early in the study period, there was some misunderstanding about what should be entered into the system.* As is often the case when new data systems are implemented, there was some misunderstanding about what data should be entered for particular inmates. For example, one discharge manager reported that all data on inmates who declined to have their disability status evaluated were excluded from the Web-based reporting system, when in fact certain information should have been entered.
- *Workload demands became heavy over time.* The discharge managers began working in January 2007, participated

in orientation and SOAR training activities through May, and slowly began having inmates assigned to them. By the fall of 2007, workloads had increased substantially, and as a result, the discharge managers may not have had as much time as they needed to ensure that all necessary data were entered into the Web-based system, especially for those inmates who were working with other treatment team members.

To ensure that estimates of the program's effects are as accurate as possible, the report includes data (including Medicaid enrollment information) on all 77 inmates who met program criteria, rather than just the 53 who were screened by the discharge managers and

for whom information was entered into the Web-based tracking system.²⁵ Overall, a quarter of the target population and 32 percent of screened inmates were enrolled in Medicaid by the day of release (Exhibit 7). Almost 38 percent of targeted inmates and 47 percent of screened inmates were enrolled in Medicaid within 90 days of release.

In recognition of the fact that the discharge managers and the clinical teams

²⁵ Discharge managers assisted an additional 15 inmates who were expected to remain institutionalized in other settings after release and therefore were not targeted for the program. Discharge managers also assisted another nine inmates with less severe mental health conditions and high levels of need. These inmates were later determined not to fit the study's clinical eligibility criteria because their conditions were not sufficiently severe.

Exhibit 7. Medicaid Enrollment Among Inmates Targeted for the Intervention and Released from Project Correctional Facilities Between July 1, 2007, and March 31, 2008

Measure	Target Population	Screened Inmates
Number of inmates with severe mental illness released between July 2007 and March 2008	77	53
Percentage enrolled in Medicaid		
On day of release	24.7	32.1
Within 30 days of release	28.6	37.7
Within 60 days of release	33.7	43.4
Within 90 days of release	37.7	47.2
Number of inmates with severe mental illness released in last 3 months of intervention (between January 2008 and March 2008)	30	20
Percentage enrolled in Medicaid		
On day of release	33.3	50.0
Within 30 days of release	33.3	50.0
Within 60 days of release	40.0	60.0
Within 90 days of release	43.3	65.0

Source: MPR analysis of project database compiled from ODMHSAS, DOC, and OHCA administrative records

overall became more efficient over time in providing application assistance to inmates, the study examined data from the last 3 months of the study period, at which time the discharge managers would have been in their jobs for about a year. Of the inmates released during this period (January 2008–March 2008), the project’s goal—Medicaid enrollment on day of discharge—was attained for a third of targeted inmates and half of those screened to receive application assistance. Within 90 days of release, 43 percent of targeted inmates and 65 percent of screened inmates discharged were enrolled in Medicaid.

During interviews held at the end of the study period (March 2008), discharge managers identified two key challenges in helping inmates complete applications for public assistance. First, collecting information from inmates with severe mental illness sometimes required considerable clinical skill and multiple meetings with both the inmate and other staff. Discharge managers cited the importance of training in both mental health and criminal behavior for being able to assist inmates with application procedures. Second, as previously noted, inmates were sometimes released unexpectedly from prison before the application process was complete. Because discharge managers ended contact with inmates upon release, the application process was curtailed for these inmates.

Successful implementation of the program, as measured by Medicaid enrollment after release, varied across facilities. In two of the facilities, about 30 percent of all targeted inmates and almost 40 percent of screened inmates were enrolled in Medicaid on the

day of release. In the third facility, only 1 of 16 inmates targeted for the program had enrolled in Medicaid within 90 days of release. Key informants indicated that the unique characteristics of the eligible prisoners in the low-enrollment facility, rather than facility difference, could explain this variation. Of the 16 eligible inmates in this facility, 2 entered an IMD after discharge, 5 were uncooperative and either were not screened or refused assistance, and 2 were reincarcerated within 30 days.

Completing Federal Disability Applications. Most inmates with mental illness are eligible for Medicaid on the basis of disability, and Medicaid eligibility typically depends on successful completion of SSI or SSDI applications. For 53 screened inmates whose information was recorded in the Web-based tracking system, 93 percent had income and assets below the Medicaid eligibility threshold, and all except 2 of these inmates consented to assistance with either Federal disability or Medicaid applications (Exhibit 8). Discharge managers recorded that almost 70 percent were likely eligible for SSI or SSDI (more than half were likely eligible for SSI, and an additional 13 percent were likely eligible for only SSDI). SSA teleapplications were initiated for 26 enrollees, or 49 percent of all inmates with mental illness screened for the program (70 percent of those likely eligible for SSI or SSDI).

Although teleapplications were not completed for about 30 percent of likely eligibles, the data indicate that about half these were already enrolled in SSI or SSDI at entry (data not shown). Therefore, 85 percent of inmates identified by discharge managers as likely eligible for SSI or SSDI received

Exhibit 8. Intervention Services Provided to Screened Inmates with Severe Mental Illness Before Release as Recorded in the Project’s Web-Based Tracking System

Measure	Target Population	Percentage of Screened Inmates
Inmates with severe mental illness screened for assistance with SSI, SSDI, and Medicaid applications	53	100.0
Income and asset detail recorded in Web-based tracking system	49	92.5
Below income and asset threshold for Medicaid eligibility	43	81.3
Refused assistance with Federal disability benefits or Medicaid	2	3.8
Likely eligible for SSI or SSDI	37	69.8
SSI	30	56.6
SSDI (of those not likely eligible for SSI)	7	13.2
Began application for SSI or SSDI	26	49.1

Source: MPR analysis of project database compiled from ODMHSAS Web-based tracking system
SSDI = Social Security Disability Insurance; SSI = Supplemental Security Income

appropriate Federal disability application program services.

Data on Disability Determination Outcomes. In addition to examining data from the Web-based system developed for the discharge managers, the study was able to obtain information on outcomes of disability determinations for inmates in Oklahoma’s correctional facilities during and prior to the study period. Oklahoma’s DDD reported that the percent of inmates in Oklahoma correctional facilities with approved disability determinations increased substantially during the project period—from 52 percent of submitted applications in Federal fiscal year 2007 (the year in which the project began) to 89.9 percent in Federal fiscal year 2008 (when the intervention was fully implemented). Although the data do not allow the report to isolate the rate of positive disability determinations in the three intervention facilities, interviews with discharge managers and DDD staff members

suggest that the formal and informal collaboration between staff at the three facilities and DDD improved the overall efficiency with which disability applications were submitted and processed.

3.4 Evaluation of Program Effects

To serve as a model program, the changes implemented in Oklahoma must significantly increase Medicaid enrollment among inmates with mental illness who leave correctional facilities relative to what would have occurred had the program not been implemented. Increases in Medicaid enrollment should subsequently improve access to health services and reduce the likelihood of several negative outcomes, including rearrest and entry into an IMD.

This section documents the effects of the new program in Oklahoma on Medicaid enrollment, health service use, rearrest, and employment of inmates with severe mental

illness after release from prison. Specifically, relative to others who did not receive the program services, the report addresses the following questions:

- Does the intervention increase the percentage of adults with mental illness who have Medicaid coverage after release from a correctional facility?
- Does the intervention result in better access to health care services as measured by increased use of mental health services compared with similar adults released from a correctional facility that did not have program services?
- Does the intervention reduce the likelihood that adults with mental illness are arrested or enter an IMD after release, or increase the likelihood of employment?

To address these questions, the study used a multivariate model that compared outcomes of program participants with outcomes of inmates with mental illness of similar severity released from (a) the same project facilities during the previous 3 years (2004 to 2006), (b) other Oklahoma correctional facilities during the project period, and (c) other Oklahoma correctional facilities during the previous 3 years. This strategy enabled MPR to use difference-of-differences estimation to identify program effects based on comparisons across facilities and over time. This approach to assessing program effects assumes that without the program, changes in Medicaid enrollment and other outcomes would have been similar among inmates in the project facilities and those in the comparison group facilities.

Analyses also took into account any differences in age, race, gender, education level, Medicaid status at entry, and length of incarceration between the treatment and comparison groups.

In the following sections, the report presents the average predicted effects of the program on the likelihood that inmates enroll in Medicaid, use mental health services, are arrested, or are employed within 90 days of release.²⁶ Standard errors are computed using the Delta method (Stata `inteff` command) (Norton, Wang, & Ai, 2004). Because sample sizes were small, the study could identify only large effects.²⁷

3.4.1 Characteristics of Inmates in the Intervention and Three Comparison Groups

Exhibit 9 presents the number and characteristics of inmates in the target population and in each of the three comparison groups. As noted previously, 77 inmates were in the target population and were released from project facilities between July 2007 and March 2008 (the project

²⁶ MPR would have preferred to measure rearrest, entry into an IMD, and employment outcomes within 6 months or a year after release, rather than within 90 days of release but were unable to do so. Oklahoma staff members intend to further investigate the long-term effects of the program, including effects on recidivism, at a later time.

²⁷ The study tested the robustness of the findings by (1) applying the same model to preintervention data and (2) applying the same model to a RICCT program that was expanded during the same time period but had different program goals. In both cases, the estimated effects should be zero. Additionally, the study estimated the model excluding inmates who were known to have transferred between facilities in the year prior to release to ensure that the findings were not affected by allocation of inmates to specific facilities.

Exhibit 9. Characteristics of Inmates with Severe Mental Illness Released from Oklahoma Correctional Facilities

Measure	Inmates Released from Project Facilities		Inmates Released from Comparison Group Facilities	
	Baseline (2004–2006)	Project Period (July 2007–March 2008)	Baseline	Project Period (July 2007–March 2008)
Number of inmates	195	77	284	130
Demographic Characteristics				
Age (percentage)				
18–24 years old	13.3	10.4	15.1	7.7
25–34 years old	35.4	33.8	37.3	30.8
35–44 years old	31.3	27.3	27.8	37.7
45–54 years old	16.4	18.2	16.2	19.2
55–64 years old	2.6	7.8	3.5	4.6
65 and older	1.0	2.6	0.0	0.0
Race (percentage)				
White (non-Hispanic)	59.0	50.6	60.9	59.2
Black (non-Hispanic)	29.7	33.8	29.9	29.2
Hispanic	1.5	1.3	1.1	3.8
Native American	8.2	13.0	7.7	6.9
Other	1.0	1.3	0.0	0.8
Missing	0.5	0.0	0.4	0.0
Percentage female	29.2	39.0	6.3	22.3
Education: Test of Adult Basic Education (TABE) Score (among those with nonmissing TABE scores)				
Score = 0	19.2	23.8	11.7	6.6
Basic literacy (0–5.9)	47.8	42.9	44.2	40.5
Adult basic education (6.0–8.9)	17.6	20.6	17.4	32.2
Pre-GED (9.0–10.5)	7.1	3.2	12.8	10.7
High school equivalency (10.6–12.9)	8.2	9.5	14.0	9.9
Percent with missing TABE score	6.7	18.2	6.7	6.9
Criminal History				
Percentage with prior felony conviction	69.7	71.4	79.9	79.2
Percentage with prior violent felony conviction	27.7	26.0	25.4	31.5
Length of incarceration (percentage)				
<1 year	12.3	9.1	18.7	16.9
1–2 years	34.4	40.3	41.2	46.9
3–5 years	31.8	27.3	25.4	20.0
6–9 years	11.3	14.3	10.2	11.5
10+ years	10.3	9.1	4.6	4.6
Average length of incarceration (years)	4.5	4.5	3.3	3.3
Program Participation				
Percentage enrolled in Medicaid at entry	3.6	9.1	3.2	6.2
Percentage with disability as basis of eligibility (among those enrolled at entry)	71.4	85.7	77.8	62.5
Met with RICCT	.0	27.3	.0	11.5

Source: MPR analysis of project database compiled from ODMHSAS, DOC, and OHCA administrative records

period). The number of inmates in each of the comparison groups is larger: 195 were released from the same project facilities between 2004 and 2006 (the baseline period), 284 were released from other facilities during the baseline period, and 130 were released from other facilities during the project period.

More than 60 percent of inmates in each of the four groups were between ages 25 and 44 at release, a majority were White, and most were male.²⁸ Inmates with a severe mental illness typically scored in the 0.0 to 5.9 range on the Test of Adult Basic Education (TABE), indicating they had only basic literacy skills. Most had prior felony convictions and more than a quarter had prior violent felony convictions. Average length of incarceration varied from 1 to 5 years.

Compared with inmates released from the comparison group facilities, inmates from the three project facilities tended to have lower TABE scores and fewer had prior felony convictions. They also had longer incarcerations, averaging more than 4.5 years compared with 3.3 years for inmates released from nonproject facilities during the baseline and project periods. Furthermore, 9 percent of inmates in the targeted population during the project period were enrolled in Medicaid at entry, compared with only 3 to 6 percent in the three comparison groups. Some differences between these groups are expected because of the small sample sizes.

Nevertheless, because education level, length of incarceration, and Medicaid

enrollment before incarceration are associated with the study outcomes, these differences highlight the importance of using multivariate models to control for differences between the treatment and comparison groups in our estimate of program effects. In the remainder of this chapter, we present both unadjusted outcomes (rates of Medicaid enrollment for each subgroup) and adjusted estimates of program effects that control for these differences.

3.4.2 Program Effects on Medicaid Enrollment After Release from Prison

The program had significant positive effects on Medicaid enrollment of inmates with severe mental illness released from Oklahoma prisons. As Exhibit 10 shows, on the day of release, 24.7 percent of inmates at the participating facilities were enrolled in Medicaid, compared with 8.2 percent of inmates at the same facilities in the 2 years prior to the implementation of the new program and 3.5 percent at baseline and 3.1 percent during the project period for inmates in comparison facilities. In addition:

- After adjusting for Medicaid enrollment at entry and other variables, the analyses indicate that the program increased Medicaid enrollment on the day of discharge by 14.5 percentage points.
- The measured effect within 90 days of discharge was slightly higher, at 16.3 percentage points, suggesting that the

²⁸ Data for one prison were not available during the baseline period.

Exhibit 10. Medicaid Enrollment Among Inmates with Severe Mental Illness upon Release from Oklahoma Correctional Facilities

Measure	Inmates Released from Project Facilities			Inmates Released from Comparison Group Facilities			Difference of Differences Estimate		
	Baseline (2004-2006)	Project Period (July 2007-March 2008)	Difference	Baseline (2004-2006)	Project Period (July 2007-March 2008)	Difference	Unadjusted	Adjusted ^a (Effect Estimate)	p Value ^a
Total number of inmates	195	77	NA	284	130	NA	NA	NA	NA
Percentage enrolled in Medicaid									
On day of release	8.2	24.7	16.5	3.5	3.1	-0.4	21.6	14.5*	0.012
Within 30 days of release	14.4	28.6	14.2	6.0	6.2	0.2	22.4	10.6*	0.041
Within 60 days of release	16.4	33.8	17.4	8.1	6.9	-1.2	26.8	14.7*	0.013
Within 90 days of release	16.9	37.7	20.7	9.2	9.2	0.1	28.4	16.3**	0.008

Source: MPR analyses of project database compiled from ODMHSAS, DOC, and OHCA administrative records.

^a Adjusted difference-of-differences estimates are the average of predicted effects based on a model that adjusts for age, race, gender, TABE score, length of incarceration, and Medicaid status at entry. Separate econometric analyses were conducted for each outcome presented in the table.

*Significantly different from zero at the .05 level, one-tailed test

**Significantly different from zero at the .01 level, one-tailed test

NA = not applicable

effects of the program extended for at least 3 months after release from prison.²⁹

Although the study's estimated effects are large and significant, subgroup analyses suggest that the effects of the program on Medicaid enrollment were even larger once the program became better established. The report estimates that among the small group of inmates discharged during the last 3 months of the intervention, enrollment in Medicaid increased by 27.7 percentage points as a result of the program (p-value 0.028), almost double the effect estimated for the full project period (data not shown).

Exploratory analyses suggest that the program was particularly effective for certain inmate subgroups. As mentioned previously in this chapter, inmates were successfully enrolled in Medicaid in only two of the three project facilities. In these two facilities, the program increased enrollment in Medicaid on day of release by 17.4 percentage points (p-value 0.010; data not shown). Further

examination of the subgroups for which the program is particularly effective would be useful in helping target future programs but would require larger sample sizes.

3.4.3 Program Effects on Secondary Outcomes: Service Use, Rearrest, and Employment

As would be expected, the increase in Medicaid enrollment associated with the program was paired with an increase in use of Medicaid mental health services. The report estimates that the program was associated with a 15.7 percentage point increase in use of any Medicaid-financed service—including a 14.2 percentage point increase in outpatient service use and a 9.9 percentage point increase in Medicaid prescription drug use within 90 days of release (Exhibit 11). That is, a larger percentage of inmates with mental illness discharged from correctional facilities obtained Medicaid-covered services as a result of participating in the program.

Additional analyses of data on the use of mental health services funded by either Medicaid or ODMHSAS found no differences between the groups.³⁰ The study also found no significant effect of the program on arrest and employment outcomes during the short 90-day followup period. These results are not surprising because any effects of the program and resulting increase in Medicaid enrollment on long-term outcomes are expected to appear at least 6 months or more after inmates are released from a correctional facility.

²⁹ The study's sensitivity analyses suggest that these results are consistent with the model assumptions. Using 2006 data as the "program period," the report estimates no effect (0.02 percentage points) on Medicaid enrollment on the day of discharge, as would be expected before the program was implemented. The study also used the model to estimate the effect of the RICCT program, which was designed to assist inmates' transition to the community in both project and nonproject facilities and was expanded during the project period. Because this program did not focus on Federal disability or Medicaid applications, it should have no effect on Medicaid enrollment outcomes. The study could not reject this hypothesis (point estimate of 17.4 percentage points, standard error 14.2). The study also tested the robustness of the results to selective transitioning of inmates to project facilities during the project period. After excluding 138 inmates from the sample that transitioned between facilities during the year before their release, the estimate effect of the program remained significant at 16.8 percentage points (p-value 0.017).

³⁰ It should be noted that because the sample size of the study population is relatively small, the analyses presented here may not be able to detect effects if they exist.

Exhibit 11. Mental Health Service Use, Arrest, and Employment Among Inmates with Severe Mental Illness within 90 Days of Release from Oklahoma Correctional Facilities

Measure	Inmates Released from Project Facilities			Inmates Released from Comparison Group Facilities			Difference of Differences Estimate		
	Baseline (2004-2006)	Project Period (July 2007-March 2008)	Difference	Baseline (2004-2006)	Project Period (July 2007-March 2008)	Difference	Unadjusted	Adjusted ^a (Effect Estimate)	p Value ^a
Total number of inmates	195	77	NA	284	130	NA	NA	NA	NA
Percentage of inmates:									
Using mental health services within 90 days of release									
Medicaid-financed service									
Any service	6.7	23.4	16.7	3.9	2.3	-1.6	18.3	15.7**	0.009
Outpatient	4.6	19.5	14.9	3.5	2.3	-1.2	16.1	14.2*	0.015
Prescription drug	3.1	14.3	11.2	1.8	1.5	-0.2	11.4	9.9*	0.041
ODMHSAS-financed service									
Outpatient (any service)	44.1	57.1	13.0	26.4	34.6	8.2	4.8	3.7	0.329
Prescription drug	25.1	28.6	3.4	13.0	20.0	7.0	-3.5	-4.4	0.274
Inpatient (IMD)	2.1	2.6	0.5	2.1	0.8	-1.3	1.9	2.0	0.263
Medicaid or ODMHSAS-financed service	46.7	62.3	15.7	27.1	35.4	8.3	7.4	6.1	0.236
Arrested within 90 days of release	10.3	9.1	-1.2	9.5	6.9	-2.6	1.4	2.2	0.331
Employed within 90 days of release	7.2	6.5	-0.7	14.4	17.7	3.3	-3.9	-2.9	0.280

Source: MPR analyses of project database compiled from ODMHSAS, DOC, and OHCA administrative records

^a Adjusted difference-of-differences estimates are the average of predicted effects based on a model that adjusts for age, race, gender, TABE score, length of incarceration, and Medicaid status at entry. Separate econometric analyses were conducted for each outcome presented in the table.

*Significantly different from zero at the .05 level, one-tailed test

**Significantly different from zero at the .01 level, one-tailed test

NA = not applicable

3.5 Summary

The program implemented in Oklahoma offers a useful model and case study for developing new programs to ensure that residents of correctional facilities have Medicaid at release or as soon as possible thereafter. Three components of the project were critical to its success: (1) the collaboration of key staff from many Oklahoma agencies at the state and local levels, (2) state financing that enabled Oklahoma to hire new discharge managers to implement the program, and (3) funding from SAMHSA that enabled MPR to support the program design and conduct a comprehensive evaluation.

Specifically, the combined efforts of Oklahoma and MPR staff resulted in a collaborative project that:

- Established a steering committee that included key stakeholders whose purpose was to resolve issues and provide overall policy direction for the program development process
- Developed operational specifications for the new program (see Appendix C)
- Identified existing or additional resources that helped support the new program, including the new appropriations for staff at DOC facilities, capitalizing on a relevant federally sponsored training program, and identifying staffing resources to develop a new data tracking system

- Developed interagency agreements to support the project's goal
- Evaluated the implementation and effects of the program on Medicaid enrollment, mental health service use, and other outcomes

This collaboration resulted in an ongoing program that is significantly improving access to Medicaid coverage for adults with mental illness who are leaving Oklahoma correctional facilities. Based on a comparison of outcomes for inmates targeted for the program between July 1, 2007, and March 31, 2008, and for inmates in three comparison groups, the report estimates that the program increased Medicaid enrollment on the day of release by 14.5 percentage points, a statistically significant increase.

Oklahoma staff faced several major challenges in implementing the program, including difficulties identifying the target population and inefficiencies in sharing information between agencies. By the end of the intervention period, discharge managers had addressed many barriers to program implementation and the program appeared to be increasing its effectiveness. During the last 3 months of the intervention, the program (relative to baseline and comparison group facilities) was associated with a 27.7 percentage point increase in the likelihood that inmates with severe mental illness were enrolled in Medicaid on the day of release.

IV.

Medicaid Eligibility of Clients in an Institution for Mental Diseases: A Case Study from Oklahoma

During the past several decades, state and Federal policies have aimed to enhance community-based services for adults with serious mental illness. As a result, lengths of stay in residential settings such as IMDs have decreased dramatically (Bao & Sturm, 2001). This trend has also affected Oklahoma's psychiatric facilities. For example, at Griffin Memorial Hospital (GMH), Oklahoma's largest IMD, the average length of stay among discharged clients was 20 days in fiscal year 2008; in comparison, lengths of stay at GMH averaged longer than a month in the mid-1990s (D. Wright, personal communication, 2008).

In theory, short stays in IMDs have two implications for efforts to ensure that eligible clients are enrolled in Medicaid at discharge:

- Because the majority of clients stay for less than 1 month, those who enter an IMD with Medicaid coverage are almost certain to exit with enrollment intact; disenrollment from Medicaid typically requires more time than the usual IMD stay allows. As a result, there is little need to suspend Medicaid enrollment or facilitate the reenrollment of these clients.
- For clients who are not enrolled but may be eligible for Medicaid at entry to an IMD, short stays give IMD staff little time to initiate the required applications. The first few days of an IMD stay are usually focused on stabilizing the client. Once a client is stabilized, staff members begin working with the client's family, linking the client to community-based treatment, and securing appropriate housing before discharge. Staff may alert the client to the importance of working

with a community-based provider to seek Medicaid coverage (and explain the corresponding need to first initiate an application for disability benefits) but are unlikely to have the time to initiate and follow through on such applications.

Although these implications suggest that increasing Medicaid enrollment among clients leaving IMDs would be challenging, few studies have examined the extent to which individuals with mental illness have Medicaid or are potentially eligible for Medicaid at entry to and discharge from an IMD and the feasibility of assisting them with Medicaid applications. This chapter presents results of the analysis of quantitative data on the characteristics and Medicaid status of individuals entering and leaving GMH.

The chapter first describes the Medicaid status at entry and exit for clients admitted to GMH and discharged to one of three nearby counties between July 2007 and March 2008.³¹ Then, the demographic and other characteristics of three groups are compared: (1) clients who were enrolled in Medicaid at entry, (2) clients we identified as potentially eligible for Medicaid at entry based on their demographic and socioeconomic characteristics and public program participation (including enrollment in SSI), and (3) clients whose Medicaid eligibility status remained unknown. Finally,

for each of these groups, this chapter examines several postdischarge outcomes, including Medicaid enrollment, employment, arrest, and reentry to an IMD.

4.1 Medicaid Status at Entry and Discharge

Of the 753 clients in the study sample, 221 (29.3 percent) had Medicaid at entry to GMH; of these, all but 4 were still enrolled in Medicaid at discharge (Exhibit 12). Most (88.7 percent) were eligible on the basis of disability; the others were not disabled but eligible adults (10.9 percent) or children (.05 percent) (data not shown; percentages do not sum to 100 due to rounding). The remaining clients (532 individuals) did not have Medicaid at entry; of these, only 7 obtained Medicaid by day of discharge.

To identify clients who could potentially be targeted for Medicaid application assistance at GMH, the study separated those not enrolled in Medicaid at entry into two groups: (1) those potentially eligible and (2) those whose potential for Medicaid eligibility was unknown at entry.

The first group, referred to as those potentially eligible for Medicaid, included clients who were enrolled in SSI, enrolled in SSDI and had income at or below 100 percent of the Federal poverty level (FPL), or who were pregnant and had income at or below 100 percent FPL. Using these criteria, 32 of the 532 clients who did not have Medicaid at entry (4.2 percent of all clients) were identified as potentially eligible for Medicaid (see Exhibit 12). Of these, 20 were SSI recipients at entry, 11 were SSDI recipients with low income, and one was pregnant with low income. Two (6.3 percent) of these 32 clients were enrolled in Medicaid at discharge.

³¹ These three counties (Cleveland, McClain, and Oklahoma) were chosen because the majority of GMH clients are discharged to them and the original efforts to develop and evaluate a new program were focused on these counties. Because the sample is limited to people who entered and left GMH during the 9-month observation period, the data do not represent the small number of clients who are long-term (more than 9 months) residents.

Exhibit 12. Medicaid Enrollment Among Clients Discharged from Griffin Memorial Hospital, with and without Medicaid at Entry

Measure	Total (Percentage)	With Medicaid at Discharge	Without Medicaid at Discharge
Total number of clients admitted and discharged from GMH between July 2007 and March 2008	753 (100.0)	224	529
With Medicaid at entry	221 (29.3)	217	4
Without Medicaid at entry	532 (70.7)	7	525
Potentially eligible for Medicaid	32 (4.2)	2	30
SSI enrollee	20 (2.7)	2	18
SSDI only enrollee and at or below 100 percent of FPL	11 (1.5)	0	11
Pregnant at entry and at or below 100 percent of FPL	1 (0.1)	0	1
Medicaid eligibility potential unknown	500 (66.4)	5	495

Source: MPR analysis of project database compiled from ODMHSAS Web-based tracking system
SSDI = Social Security Disability Insurance; SSI = Supplemental Security Income

On the basis of SSI enrollment, these criteria may overestimate eligibility for Medicaid because SSI enrollment does not automatically ensure Medicaid coverage in Oklahoma.³² These criteria may also underestimate eligibility for Medicaid if SSI, SSDI, pregnancy, or income data are incomplete.

The second group consisted of clients whose potential for Medicaid eligibility was unknown at entry. These clients were not enrolled in Medicaid or SSI; however, more than 85 percent of those with available income data had income at or below 100 percent of FPL.³³ Of people entering and

discharged from GMH during the study period, 500 clients (66.4 percent) were in this group. Five of these clients (1.0 percent) were enrolled in Medicaid at discharge. Provided they also met Medicaid asset requirements and were determined disabled, many of the other 495 clients may have been eligible for Medicaid. However, to be enrolled, the majority of this group would first have needed to undergo the SSI or SSDI application process and receive a disability determination.

4.2 Client Characteristics

To characterize the differences between the three groups of interest (clients who were enrolled in Medicaid at entry, who were potentially eligible for Medicaid at entry, and whose potential for Medicaid was unknown at entry), the study examined their demographic characteristics and lengths of stay (Exhibit 13).

³² Oklahoma is one of 11 Section 209(b) states that elected to use more restrictive Medicaid eligibility requirements than those of the SSI program, and as a result, SSI beneficiaries in Oklahoma must file separate applications for Medicaid (see footnote 18 for details).
³³ Income data are available for only 312 (41 percent) of the 753 clients in our sample because the original evaluation design only called for tracking income of clients discharged to two of the three counties.

Exhibit 13. Demographic Characteristics of Clients Discharged from Griffin Memorial Hospital Between July 2007 and March 2008

Measure	Overall	Clients Enrolled in Medicaid at Entry	Clients Not Enrolled in Medicaid at Entry but Potentially Eligible	Clients Not Enrolled in Medicaid and Whose Potential Eligibility Is Unknown
Number of clients	753	221	32	500
Age (percentage)				
21–24 years old	11.0	10.0	9.4	11.6
25–34 years old	26.7	21.3	15.6	29.8
35–44 years old	27.2	28.1	25.0	27.0
45–54 years old	24.7	28.1	37.5	22.4
55–64 years old	10.4	12.7	12.5	9.2
Race (percentage)				
White (non-Hispanic)	70.8	66.1	56.3	73.8
Black (non-Hispanic)	18.6	23.1	31.3	15.8
Hispanic	3.1	3.6	6.3	2.6
Native American	6.4	5.9	6.3	6.6
Other	1.2	1.4	0.0	1.2
Highest grade completed (percentage)				
0–8	5.3	7.2	0.0	4.8
9–11	24.2	30.8	31.3	20.8
12	48.2	47.5	43.8	48.8
13–15	15.1	11.3	12.5	17.0
16+	7.2	3.2	12.5	8.6
Percentage female	40.5	52.0	37.5	35.6
Percentage pregnant (among females)	1.0	1.7	8.3	0.0
Income ≤ 100 percent FPL	35.9	38.9	53.1	33.4
Income > 100 percent FPL	5.6	0.9	0.0	8.0
Income information missing	58.6	60.2	46.9	58.6

Source: MPR analysis of project database compiled from ODMHSAS and GMH administrative records

Demographics. Generally, the characteristics of clients with unknown potential for Medicaid eligibility were different from those enrolled in or potentially eligible for Medicaid. A larger percentage of those with unknown potential for Medicaid were young (41.4 percent were under age 35 compared with 31.3 and 25.0 percent, respectively, among those enrolled or

potentially eligible for Medicaid); White (73.8 percent, compared with 66.1 and 56.3 percent, respectively, among those enrolled or potentially eligible for Medicaid); and had less than a high school education (25.6 percent compared with 38.0 and 31.3 percent, respectively, among those enrolled or potentially eligible for Medicaid). Those already enrolled in Medicaid were more

likely to be female than those not enrolled. Clients potentially eligible for Medicaid, by virtue of the criteria used to determine membership in each of the groups, were more likely to be pregnant, have reported income information, and have income below the FPL.

Client Stays. Clients with unknown potential for Medicaid eligibility at entry also differed in their patterns of prior admissions and length of stay from those who were enrolled in or potentially eligible for Medicaid (Exhibit 14). Specifically, a smaller percentage had a previous stay or stays in GMH during the study period (14.6 percent, compared with 20.4 and 28.1 percent, respectively, among those enrolled or potentially eligible for Medicaid) or had been

admitted to an IMD at some point previously (48.4 percent, compared with 66.1 and 59.4 percent, respectively, among those enrolled or potentially eligible for Medicaid). Almost 43 percent of clients whose eligibility potential was unknown stayed in GMH for less than a week, compared with 29.9 and 31.3 percent, respectively, among clients enrolled or potentially eligible for Medicaid.

The young age and short stays of people with unknown potential for Medicaid eligibility suggest that these individuals had less contact with the social service system and may not have had the opportunity to enroll in Medicaid or apply for Federal disability benefits. Their short stays also suggest that these individuals may have had less severe mental health conditions.

Exhibit 14. Characteristics of Stays for Clients Discharged from Griffin Memorial Hospital Between July 2007 and March 2008

Measure	Overall	Clients Enrolled in Medicaid at Entry	Clients Not Enrolled in Medicaid at Entry but Potentially Eligible	Clients Not Enrolled in Medicaid and Whose Potential Eligibility Is Unknown
Number of clients	753	221	32	500
Clients with previous stays in GMH during study period (percentage)	16.9	20.4	28.1	14.6
Percentage with prior IMD stay	54.1	66.1	59.4	48.4
Length of stay (percentage)				
< 7 days	38.5	29.9	31.3	42.8
1–2 weeks	32.8	34.8	43.8	31.2
3–4 weeks	17.3	20.4	12.5	16.2
1–2 months	7.8	10.9	6.3	6.6
3–5 months	3.2	3.6	6.3	2.8
6–11 months	0.4	0.5	0.0	0.4
Median length of stay (days)	8	10	8	8
Type of admission (percentage)				
Voluntary	16.7	12.2	12.5	19.0
Court commitment	83.3	87.8	87.5	81.0

Source: MPR analysis of project database compiled from ODMHSAS and GMH administrative records

Consistent with this hypothesis, a larger percentage of these clients entered GMH voluntarily (19 percent, compared with 12.2 and 12.5 percent among those enrolled and those potentially eligible for Medicaid, respectively).

4.3 Postdischarge Outcomes

The study examined several key postdischarge outcomes for the three groups of clients, including Medicaid enrollment on the day of discharge and within 30, 60, 90, and 180 days of discharge as well as ODMHSAS-financed service use, arrest, and employment within 90 days of discharge.³⁴

³⁴ Data were collected about 90 days after the project end date. To ensure an adequate followup period, analyses of Medicaid outcomes measured at 180 days after discharge excluded clients discharged during the last 3 months of the study period (January–March 2008).

Medicaid Enrollment. As noted previously, virtually all clients who were enrolled in Medicaid at entry to GMH were enrolled upon discharge; the four that lost their coverage during their stay at GMH regained it within 6 months (Exhibit 15). In comparison, only 6.3 percent of potentially eligible clients and 1 percent of clients with unknown potential for eligibility were enrolled in Medicaid on the day of discharge. The percentages enrolled within 6 months of discharge for these two groups were 31.8 and 7.7, respectively.

Although the number of clients potentially eligible for Medicaid is small and represents only 4.2 percent of all clients leaving GMH (32 individuals), a program to help clients with Medicaid applications could be particularly effective for these individuals. Because almost all are already enrolled in SSI

Exhibit 15. Medicaid Enrollment Status of Clients Discharged from Griffin Memorial Hospital Between July 2007 and March 2008

Measure	Total	Clients Enrolled in Medicaid at Entry	Clients Not Enrolled in Medicaid at Entry but Potentially Eligible	Clients Not Enrolled in Medicaid and Whose Potential Eligibility Is Unknown
Total number of clients	753	221	32	500
Percentage of clients enrolled in Medicaid upon discharge				
On day of discharge	29.7	98.2	6.3	1.0
Within 30 days of discharge	30.4	99.1	9.4	1.4
Within 60 days of discharge	31.7	99.5	15.6	2.8
Within 90 days of discharge	32.7	99.5	18.8	4.0
Number of clients discharged within first 6 months of study period*	462	141	22	299
Percentage of clients enrolled in Medicaid upon discharge				
Within 180 days of discharge	37.0	100.0	31.8	7.7

Source: MPR analysis of project database compiled from ODMHSAS, GMH, and OHCA administrative records

* See footnote 32

or SSDI and need to complete only a Medicaid application, enrollment for many of these clients could be at least initiated in the IMD. Among clients with unknown potential for Medicaid eligibility, stays at the IMD are far too short to complete the process of assisting clients with applications for disability benefits. Although Federal disability applications could begin in the IMD, application progress would need to be monitored and Medicaid applications would need to be completed for these individuals in the community after discharge.

ODMHSAS-Financed Service Use, Arrest, and Employment. Although the data cannot be used to identify causal effects, descriptive analyses of the association between Medicaid status at entry and post-discharge outcomes suggest several interesting avenues for further research.

First, individuals who were potentially eligible for Medicaid were the most likely of

the three groups to be arrested at some point after discharge (15.6 percent compared with 5.9 percent among clients enrolled in Medicaid and 7.8 percent among those with unknown potential for Medicaid eligibility; Exhibit 16). These clients were also least likely to be employed within 90 days of release (9.4 percent, compared with 15.4 percent among enrolled clients and 34.4 percent among clients with unknown potential for Medicaid eligibility). These results suggest that further studies are warranted to determine whether helping these individuals enroll in Medicaid could mitigate negative postdischarge arrest and employment outcomes for this group.

Second, while clients with unknown potential for Medicaid eligibility were younger and had less contact with the social service system before entry into GMH, their contact with the ODMHSAS-financed mental health system after discharge was at

Exhibit 16. Postdischarge Arrest, Employment, and Mental Health Service Use Among Clients Discharged from Griffin Memorial Hospital, by Medicaid Eligibility Status at Entry

Measure	Total	Clients Enrolled in Medicaid at Entry	Clients Not Enrolled in Medicaid at Entry but Potentially Eligible	Clients Not Enrolled in Medicaid and Whose Potential Eligibility Is Unknown
Total number of clients	753	221	32	500
Percentage of clients				
Arrested within 90 days of release	7.6	5.9	15.6	7.8
Employed within 90 days of release*	27.8	15.4	9.4	34.4
Using ODMHSAS-financed mental health services within 90 days of release				
Outpatient (any service)	55.0	56.1	56.3	64.0
Inpatient (IMD)	7.4	8.1	3.1	7.4

Source: MPR analysis of project database compiled from ODMHSAS, GMH, OSBI, and OESC administrative records

* Employment represents only those individuals whose employers contribute to the state unemployment compensation fund.

the same level as that of the other groups. In fact, 64 percent used outpatient mental health services and 7.4 percent reentered an IMD within 90 days of discharge. In comparison, only 56 percent of the other client groups used ODMHSAS-financed outpatient services and 8.1 percent of those enrolled and 3.1 percent of those potentially eligible reentered an IMD within 90 days of discharge. This suggests that many clients in the group where potential Medicaid eligibility is unknown will have continued contact with the mental health service system. Although helping them enroll in Federal disability and Medicaid programs may require significant community outreach, enrolling them in Medicaid may have important implications for the financing of their care in the community and the frequency of their readmission into an IMD.

4.4 Summary

Since the early 1990s, the efforts of state and Federal policies to enhance community-based services to treat the mentally ill have decreased the amount of time clients reside within IMDs. The analyses of data from GMH, Oklahoma's largest IMD, show that the median length of stay was 8 days for clients entering and leaving GMH between July 2007 and March 2008, and 89 percent of these clients stayed for less than a month. Fewer than 4 percent stayed for longer than 2 months. It is not surprising then that most clients who entered GMH with Medicaid did not lose this coverage. Moreover, among those who did lose Medicaid coverage by discharge, all regained it within 6 months.

Thirty-two clients who entered GMH during the study period (4 percent of all entering clients, or about three clients per month) were potentially eligible but not

enrolled in Medicaid. Of the 32 clients, only 6 were enrolled in Medicaid within 3 months after leaving GMH. Analyses also indicated that these 32 clients were less likely than other clients to be employed and more likely to be arrested after discharge. The small size of and limited information known about this group means that these conclusions should be viewed with caution. Nonetheless, these findings raise the question of whether more timely access to Medicaid would have improved outcomes for these clients by enhancing employment and decreasing arrest rates. Even though the target population is numerically small, an intervention designed to ensure that such clients have Medicaid as soon as possible after discharge may have substantial benefits.

For the remaining 66 percent of admitted clients, accessing Medicaid may require a disability determination, and assisting such clients would require substantial resources for tracking them across mental health facilities, including residential, outpatient, and inpatient settings. Such collaboration would be a formidable task, although the reentry of clients to an IMD or community-based setting would provide the opportunity to continue intervention efforts. While these individuals are less likely than clients already enrolled or potentially eligible for Medicaid to have a prior IMD stay, once discharged, they are more likely to receive outpatient care in an ODMHSAS-financed, community-based facility. Should resources be made available for such an initiative, the study's results underscore the importance of fostering collaboration between residential settings (such as IMDs) and community-based settings to help motivated clients complete their Medicaid and disability benefit applications.

V. Synthesis of Study Findings

Between late 2004 and early 2009, staff from a wide range of state agencies in Oklahoma worked together, with technical assistance from MPR, to develop strategies for ensuring that eligible individuals with mental illness who were in state institutions had Medicaid coverage at discharge. The project involved implementing and evaluating new programs in two different types of institutions: state prisons and an IMD. To evaluate these efforts, the MPR team gathered quantitative and qualitative data on the implementation of both programs and the impact of one of them.

This chapter synthesizes the lessons learned from the evaluation. The chapter first compares the different experiences in implementing the programs in the two systems. Then, the chapter summarizes findings from the impact evaluation of the new discharge planning program in the state prisons. Finally, key results are highlighted from the analyses of data on the Medicaid status of clients entering Oklahoma's largest IMD and consider the implications for future interventions.

5.1 Lessons Learned About Program Implementation

By any measure, the implementation of the new program in the state prisons was successful. One important building block for the program's success was set in place during a meeting in the first months of the project. At that meeting, directors of relevant agencies agreed that (1) the problem of not having access to Medicaid at discharge

affected a large number of inmates with mental illness; (2) that this was an important social and policy issue; and that (3) perhaps most important, the problem could be solved through interagency collaboration. Many other factors also contributed to the success of the program:

- Additional state legislative appropriations enabled ODMHSAS to hire new discharge managers.
- Existing and new training programs helped these discharge managers to assume their responsibilities effectively.
- New data systems were established to support and document the work.
- Program "champions" within both DOC and ODMHSAS provided strong leadership and internal advocacy.
- Staff from multiple agencies at the state and local levels collaborated effectively

to address implementation challenges as they emerged.

- Most inmates who were potential beneficiaries of the program were available for meetings with the discharge managers and other members of the clinical team over a long period of time.

Although the program in the DOC facilities was successfully implemented, the staff faced several major challenges, including difficulties identifying the target population and inefficiencies in sharing client information among agencies at the local and state levels. For example, at first, the state DHS office was not receiving information from the state SSA office regarding the outcome of the disability determination process, and hence could not complete a Medicaid determination. This and most other implementation problems were usually identified during regular steering committee meetings. Solutions were developed either during these meetings or through subsequent calls between key staff.

In the IMD, the intervention initially developed for this project aimed to more systematically identify clients who were not Medicaid-enrolled and to document the extent to which existing staff were assisting clients with Medicaid application. Although documentation procedures and an application tracking form were developed for the project, they were not implemented as planned. An important factor contributing to this outcome was related to one of the most striking differences between implementing a program in prisons and the IMD: the target population's length of stay. In the IMD, most clients who might have benefited from the new program stay for less than 30 days—an extremely short period of time for staff to

determine whether application assistance is needed and then to actually complete the application process.

At an operational level, accurately determining whether a client is already enrolled in or is potentially eligible for Medicaid, SSI, or SSDI requires communication with multiple agencies, the client, or family members (or some combination of all three). Many clients are discharged from an IMD even before this information has been gathered, much less examined by the social services staff. Short lengths of stay make it (1) difficult to identify whether clients are potentially Medicaid-eligible, and if so, to help them complete a Medicaid application; and (2) impossible to complete an application for Federal disability benefits.

In addition to the challenges associated with short lengths of stay, there was considerable uncertainty regarding the proportion of clients who (1) entered the IMD with Medicaid coverage and (2) entered the IMD without Medicaid coverage but were potentially Medicaid-eligible. In part because information about the scope of the problem was lacking, no new resources (that is, neither new staff nor new dollars) were allocated to implementing the new efforts at the IMD. Furthermore, the burden of documenting the steps taken to help clients work on Medicaid applications fell to existing staff who were already quite busy with issues related to stabilizing the client, working with the client's family, and finding community postdischarge services such as housing, food, and ongoing treatment.

Comparing the experiences in the two settings reinforces conclusions from other evaluations of social programs that critical factors in a program's successful

implementation include a widely shared goal, effective leadership, and new resources.

5.2 Quantitative Findings from the Evaluation of the Program in Correctional Facilities

Based on a comparison between outcomes for inmates targeted for the program between July 1, 2007, and March 31, 2008, and those of three comparison groups, the study finds that the program implemented in the state correctional facilities was successful in increasing the rate of Medicaid enrollment among discharged inmates. On the day of release, 24.7 percent of inmates at the participating facilities were enrolled in Medicaid, compared with 8.2 percent of inmates at the same facilities in the 3 years prior to the implementation of the new program and 3.5 percent of inmates at baseline and 3.1 percent of inmates during the project period in comparison facilities.

Adjusting for the rate of Medicaid enrollment at entry to the facility and other characteristics, we estimate that the program increased Medicaid enrollment on the day of release by 14.5 percentage points, a statistically significant increase. The evidence also suggests that the program became more effective over time: During the last 3 months of the intervention, the program (relative to baseline and comparison group facilities) was associated with a 27.7 percentage point increase in the likelihood that inmates with severe mental illness were enrolled in Medicaid on the day of release. The study found no significant effects of the program on postdischarge ODMHSAS-financed service use, arrest, or employment within 3 months of discharge. Further analyses of the long-term effects of the program are warranted.

5.3 Potential for Implementing Similar Programs in IMDs and Other Institutions

Analyses of data from GMH, Oklahoma's largest IMD, illustrate the impact of policies that have emphasized decreasing lengths of stay at state IMDs. The study found that the median length of stay was 8 days for clients discharged between July 2007 and March 2008 and 88.6 percent of these clients stayed for less than a month. Fewer than 4 percent of clients stayed for longer than 2 months. It is not surprising then that most clients who entered GMH with Medicaid did not lose this coverage. Moreover, for those who did lose Medicaid coverage by discharge, all regained it within 6 months.

Nevertheless, analyses suggest that the core rationale for implementing a program to foster Medicaid enrollment in IMDs remains sound. Most GMH clients (70.7 percent) did not have Medicaid at entry, and few of those were enrolled within 3 months of discharge. However, short lengths of stays in IMDs imply that institution-based programs could be effective in helping only a small portion of clients. New models of application assistance are needed for most people who are discharged from IMDs.

Specifically, an institution-based program like the one implemented in Oklahoma prisons could benefit a small number of IMD clients (about 4 percent at GMH) with no Medicaid coverage who receive Federal disability benefits and thus require minimal Medicaid application assistance. In states like Oklahoma, where SSI recipients are not automatically eligible for Medicaid benefits and must apply separately for the program, even a short stay in an IMD would enable

staff to help those receiving disability benefits to enroll in Medicaid on the day of discharge or soon thereafter. For these IMD clients, and for inmates with serious mental illness discharged from correctional facilities, programs like the one implemented in Oklahoma prisons could be effective in increasing Medicaid coverage. The programs also have the potential to decrease the likelihood of recidivism by improving long-term health outcomes. As illustrated by Oklahoma's model program, new resources, staff training, and changes to policies and procedures that simplify application processes are critical to the success of such programs.

Many of the remaining IMD clients (about 66 percent of admissions at GMH) might be eligible for Medicaid but would need to first receive a disability determination to be considered for Medicaid eligibility. The

challenge to enrolling such clients in Medicaid involves supporting their applications for both disability benefits and Medicaid. For these clients, applications for benefits could be started in the IMD setting but because of the short length of IMD stays, would need to be monitored and completed in the community. This involves tracking clients across multiple service providers (the IMD, community mental health centers, and other clinics or private practitioners across multiple counties)—a task that would require substantial levels of collaboration, data sharing, and staffing resources. For such individuals with mental illness who are institutionalized for short periods of time, a new, community-based model would need to be developed to support Medicaid application assistance.

Project Authors, Members of the Steering Committee, and Other Contributors

The authors of this report are Audra Wenzlow, Henry T. Ireys, Carol Irvin, and Matthew Hodges of Mathematica Policy Research.

Judith Teich and Jeff Buck of the Survey, Analysis and Financing Branch, Division of State and Community Systems Development, Center for Mental Health Services, SAMHSA provided the initial impetus for this project.

Members of the Oklahoma steering committee—which provided direction to the project’s design, implementation, and evaluation during the 4-year project period (2005 to 2008)—included:

- Phyllis Abbott, Dan Alcorn, Ray Bottger, Jin-Song Chen, Steve Davis, Amanda Dyer, J. B. Fancher, Larry Gross, John Hudgens, Carol Kellison, Tracy Leeper, Randy May, Jackie Millspaugh, Kathy Otis-Davis, Carrie Slatton-Hodges, Lyn Walker, Terri White, and David Wright at the Oklahoma Department of Mental Health and Substance Abuse Services
- Judith Atkinson, Shawn Franks, Karen Hylton, and Mary Stalnaker at the

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- Charles Brodt and Debbie Spaeth at the Oklahoma Health Care Authority
- Courtney Charish, Mike Connelly, Bob Mann, and Robert Powitzky at the Oklahoma Department of Corrections
- Karen Jackson, Noel Tyler, and Bruce Smith at the Disability Determination Division of the Oklahoma Department of Rehabilitation Services
- Dennis Purifoy and Nancy Shaw at the Social Security Administration

All these individuals participated in multiple meetings, giving generously of their time and wisdom. Many of them helped collect administrative and program implementation data for the project. The evaluation of the program would not have been possible without their assistance. Special appreciation is due Terri White for moving the project forward at critical moments, Bob Mann for his leadership in advancing the project at the Department of Corrections, and Steve Davis for his good counsel and enduring support of the evaluation.

Numerous other state officials and agency staff answered questions and helped with the background information that was essential for writing this report. In January 2005, the authors of the report met with several commissioners of key agencies, including Terry Cline (Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services); Rand Baker (Deputy Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services); Howard Hendrick (Executive Director, Oklahoma Department of Human Services); Mike Fogarty (Chief Executive Officer, Oklahoma Health Care Authority); and Ron Ward (Executive Director, Department of Corrections).

The following individuals also contributed their time and experience at critical stages of the project: James Keithley and Laura Pitman (clinical coordinators at Joseph Harp and Mabel Bassett Correctional Centers, respectively, during the study period); Donna Bond, Scott Martinson, and April Summers (discharge managers for Oklahoma Department of Mental Health and Substance Abuse Services); Buffy Heater, Debra Johnson, and Shelly Patterson (Oklahoma Health Care Authority); and Sue Fereday and Mike Griffin (Social Security Administration).

Several staff from the Centers for Medicare & Medicaid Services also provided critical

information and participated in several telephone conference calls. Staff members include Mary Jean Duckett (Deputy Director, Disabled and Elderly Health Program Group, Center for Medicaid and State Operations); Roy Trudel (Technical Director, Division of Eligibility, Enrollment and Outreach, Center for Medicaid and State Operations); Tom Shenk (Health Insurance Specialist, Division of Benefits and Coverage, Center for Medicaid and State Operations); Joe Reeder (Health Insurance Specialist, Division of Medicaid and Children's Health, Financial and Program Operations Branch, Dallas Regional Office); and Gary Martin (Division of Medicaid and Children's Health, Financial and Program Operations Branch, Dallas Regional Office).

Additional staff at Mathematica Policy Research contributed to this report. Jennifer Dowd, Meredith Lee, and Melissa Neuman participated in site visits and interviews with agency staff in Oklahoma. Marilyn Ellwood helped explain Oklahoma's Medicaid eligibility rules. Susan Williams conducted an indepth literature review. Kerianne Hourihan provided excellent programming assistance. Margo Rosenbach carefully reviewed and provided insightful comments on earlier drafts of the report. Daryl Hall, Amanda Bernhardt, Leah Hackleman, and John Kennedy skillfully edited the report, and Sharon Clark and Susan Moore provided invaluable secretarial support.

Appendix A

Oklahoma Steering Committee

By participating in numerous telephone conference calls over a period of 4 years, the individuals below served as a steering committee to help design the program, develop the data-gathering procedures for the evaluation, and ensure that both the program and evaluation were implemented as planned:

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In addition to the regular participants on the
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Appendix B

Medicaid Eligibility Groups

Mandatory Medicaid Eligibility Groups

SSI Recipients. States are required to provide Medicaid coverage to low-income individuals who are aged, blind, or disabled (CFR 42§§435.120 and 435.121). In most states, this requirement means that all SSI recipients are eligible for Medicaid. Nevertheless, 11 states exercise their right to use eligibility requirements that are slightly more restrictive than the SSI program, which means that a small number of SSI recipients may not qualify for coverage.^a In these states, SSI recipients who do not qualify for Medicaid coverage must be allowed to “deduct from income incurred medical and remedial expenses (that is, spend down) to become eligible” (CFR 42§435.121). Spend-down provisions like this one require the individual to have recurring medical expenses, such as long-term need for prescription medication, sufficiently large to lower income to the SSI income standard.

Qualified individuals with disabilities. States must provide Medicaid coverage to two groups of individuals with disabilities who do not qualify for SSI benefits: (1) SSI

recipients who lose their SSI benefits because their earnings push them over the income limits of the SSI program (Section 1905(q) of the Social Security Act and CFR 42§435.120) and (2) individuals who qualify for Medicare Part A (hospital) benefits on the basis of disability.^b Individuals whose SSI benefits end because of increased earnings are entitled to continue to receive Medicaid coverage. Coverage continues until they are able to purchase reasonably equivalent insurance. Individuals who qualify for Medicare Part A benefits on the basis of disability must have income less than 200 percent of poverty and their resources (or assets) must not exceed \$4,000 for individuals and \$6,000 for a couple (Section 1902(a)(10) of the Social Security Act). This category essentially provides Medicaid coverage to SSDI beneficiaries who have limited income and resources.

Pregnant women. States must cover pregnant women who have income less than

^a Known as 209(b) states for the section of the 1972 amendments to the Social Security Act. This section allows states, within certain guidelines, to use a more restrictive definition of disability and more restrictive income and resource requirements than the SSI program.

^b Additional provisions are made for elderly SSI recipients. SSI recipients who also receive Social Security retirement benefits may lose their SSI benefits when cost-of-living adjustments to their Federal retirement benefits increase their income above SSI standards. Under the “Pickle Amendment,” states must disregard this increase and maintain Medicaid coverage for these individuals (CFR 42§435.135). Similar provisions are made for disabled widows and widowers (CFR 42§435.137 and 435.138).

133 percent of poverty (CFR 42§435.116). Coverage must be provided through 60 days postpartum (CFR 42 435.170). At their option, states can cover all pregnant women who have income less than 185 percent of poverty (CFR 42§435.201). For this group of adults, states must provide outstationed eligibility workers who can determine eligibility at community locations, such as hospitals and community health centers, and make available simplified application forms (CFR 42§435.904). In most states, financial requirements for this group are unusually generous and frequently do not include limitations on family resources.

Low-income parents with dependent children. Low-income adults seeking Medicaid through provisions established for parents must (1) live with a minor child (a child who is less than 18 years of age) and (2) be related to the child either by blood or by legal guardianship. Most parents qualify through the Section 1931 group created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193), which established Section 1931 of the Social Security Act. A state must cover parents who meet the Aid to Families of Dependent Children (AFDC) eligibility criteria that were in effect as of July 16, 1996. States may elect to establish more generous eligibility criteria. Parents are eligible under this provision, regardless of their participation in the state’s Transitional Assistance for Needy Families (TANF) program, the program that replaced AFDC. The parent must either be single or part of a two-parent family in which the principal earner works no more than 100 hours each month.^c

Low-income Medicare beneficiaries. States are required to offer assistance for Medicare premium and cost-sharing requirements to certain categories of Medicare beneficiaries who have low incomes and limited assets (no more than \$4,000 for individuals and \$6,000 for couples). Medicare beneficiaries who have incomes at or below 100 percent of poverty are eligible for Medicaid coverage (Section 1902(a)(10)(E)(i) of the Social Security Act). With regard to those known as Qualified Medicare Beneficiaries (QMBs), states must meet all Medicare cost-sharing requirements, including Part A premiums (if necessary), Part B premiums, copayments, and deductibles. States must also assist Specified Low-Income Medicare Beneficiaries (SLMBs) who have incomes between 100 and 120 percent of poverty (Section 1902(a)(10)(E)(iii) of the Social Security Act). The Medicaid program is required to pay their Medicare Part B monthly premiums only. The Balanced Budget Act (BBA) of 1997 (requires states to cover Medicaid Part B monthly premiums for Medicare beneficiaries whose income is between 120 and 135 percent of poverty). This last group does not have an entitlement to Medicaid coverage and Federal funding for this group is capped each year. States must limit the number of enrollees in this group so as not to exceed the capped amount

^c Federal rules also specify that states must continue to cover low-income parents who lose Medicaid eligibility due to an increase in earnings (CFR 42§435.112). Under this provision, working parents enrolled in Medicaid are entitled to have their eligibility extended for at least 6 months and as many as 12 months, if their income does not exceed 185 percent of poverty. Parents must have been on Medicaid for 3 of the 6 preceding months to qualify through this provision.

and must select individuals for this category of coverage on a “first come, first served” basis.

Optional Medicaid Eligibility Groups

Medically needy. Currently, 36 states have exercised the option of extending Medicaid coverage to children, pregnant women, low-income parents, the disabled, and the elderly who have incomes or resources that exceed the standards for other eligibility groups (CFR 42§§435.300 through 435.350). Individuals either can qualify because their incomes are below the standard for the group, or because the state allows individuals to “spend down” their income by deducting incurred medical expenses from income so as to reduce net income to the standard established for this group (CFR 42§435.811). For those with disabilities who do not qualify for SSI benefits because of excessive income or resources, this option is an important path for accessing Medicaid benefits, particularly if they have recurring drug and medical expenses.

Poverty-related coverage. States may elect to cover all persons who are aged, blind, and disabled if their income is less than poverty (Section 1902(r)(2) of the Social Security Act). People with disabilities must meet the SSI definition of disability. This is an important option for people not eligible for SSI benefits because of excessive income.

State supplementation payments-only recipients. Under SSI law, states have the option of providing cash payments to supplement Federal SSI payments, known as state supplementation payments (SSP) (CFR 20§416.2001). They can provide these payments to individuals who meet the SSI definition of disability but earn too much to qualify for SSI; these individuals are known

as SSP-only recipients. States have the option of extending Medicaid coverage to SSP-only recipients (CFR 42§§435.232 and 435.234).

Working disabled. In recent years, the Federal government has taken steps to create incentives for individuals with disabilities to return to work. The “1997 BBA” and the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170) allow states to expand coverage to individuals who meet the SSI definition of disability but have income or resources above those for mandatory groups (Section 1902(a)(10)(A)(ii) (xiii) of the Social Security Act). The Ticket to Work legislation allows states to set income and resource requirements at any level they choose for working-age adults who meet SSI requirements for disability.^d

Home and community-based waiver services. States can use section 1915(c) of the Social Security Act to establish new Medicaid-financed home and community-based services that are designed to substitute for the long-term care individuals would receive in hospitals, nursing facilities, or intermediate-care facilities for persons with mental retardation (ICFs/MR). These programs can be designed to target individuals in specific age groups and with specific conditions, and the services can be restricted to certain areas of the state.^e

^d States may elect to continue Medicaid coverage for individuals eligible for coverage through the Ticket to Work provisions when they lose Federal disability benefits due to improvement in their medical condition.

^e As of 2005, states had implemented 272 waiver programs (University of California at San Francisco estimates based on CMS Form 372 for the Kaiser Commission on Medicaid and the Uninsured, December 2008. “Medicaid Home and Community-Based Service Programs: Data Update” available at http://www.kff.org/medicaid/upload/7720_02.pdf).

Appendix C

Specifications for a Model Intervention to Establish or Maintain Medicaid Eligibility for Individuals Leaving State Prisons

May 2007

Since September 2004, researchers at Mathematica Policy Research have worked with a steering committee in Oklahoma to develop a new intervention to ensure that eligible inmates with mental illness who leave state prisons are enrolled in Medicaid on the day of discharge or as soon as possible after discharge.

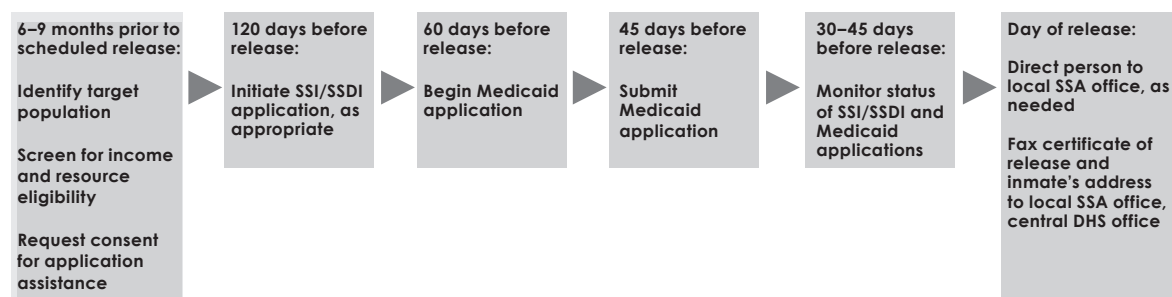
Inmates cannot become eligible for Medicaid enrollment while they are in prison, and individuals entering prisons as Medicaid recipients typically lose eligibility during their incarceration. Most inmates who are potentially eligible for Medicaid at discharge qualify on the basis of disability, although some will qualify because they are pregnant or custodial parents. Consequently, most inmates will need to apply for SSI or SSDI and be determined disabled as defined by the SSA before their Medicaid applications can be completed.

Prisons operated by the Oklahoma DOC have had limited capacity to conduct comprehensive discharge planning for inmates with mental illness and have been unable to consistently assist inmates with applications to SSI, SSDI, or Medicaid. In the fall of 2006, however, ODMHSAS appropriated funds for three new positions devoted to discharge planning for inmates with serious mental illness and began to establish a corresponding Web-based reporting and tracking system. Referred to as “discharge managers,” these individuals were hired in January 2007 and are now working with existing treatment teams in three facilities (the Joseph Harp Correctional Center, the Mabel Bassett Correctional Center, and the Oklahoma State Penitentiary) to assist inmates with mental illness to reenter their communities successfully. This document describes the components of their work related to the new intervention. As Figure 1 illustrates, these components involve initiating and monitoring applications for SSI or SSDI and for Medicaid.

The Oklahoma-Mathematica project also entails evaluating the new intervention. Hence, for purposes of evaluating the intervention, the project focuses on inmates with serious mental illness who are discharged from the three facilities noted above between July 1, 2007, and March 31, 2008. Plans for evaluating the new intervention are described elsewhere.

Figure 1. Overview of Intervention at Department of Correction Facilities

Duration of Intervention: 9 Months



Specific Steps and Actions Needed to Implement the Intervention

Activities conducted 6–9 months prior to anticipated release date

This section expands the description of the intervention activities illustrated in Figure 1.

1. Treatment team or discharge manager at each facility—Joseph Harp Correctional Center, Mabel Bassett Correctional Center, or the Oklahoma State Penitentiary (OSP)— identifies target population, defined as inmates 18 years of age and older at the time of anticipated release who have
 - A mental health service classification of “C”^f or
 - A mental health service classification of “B” and high levels of need because of serious functional limitations or anticipated problems living in the community
2. For these individuals, the treatment team or discharge manager:
 - Obtains information about their receipt of
 - ▶ Disability benefits prior to incarceration from a designated person in the local SSA office and
 - ▶ Medicaid benefits prior to incarceration from a designated office in the Oklahoma DHS, the state agency that determines and monitors Medicaid eligibility
 - Conducts eligibility screens for SSI/SSDI and Medicaid by reviewing all available information on inmate’s income and resources, and past eligibility for Federal disability benefits or Medicaid
 - Meets with inmates to discuss
 - ▶ General issues related to SSI/SSDI and Medicaid applications
 - ▶ Importance of these programs to the inmate, and need to participate in the application process by providing accurate information

^f The Oklahoma DOC uses a classification system that assigns inmates to a level (A through D) that reflects current need for treatment services.

-
3. For each inmate likely to be eligible for SSI/SSDI and/or Medicaid benefits (based on the eligibility screen), the discharge manager^g:
 - Records this determination in the data system
 - Obtains signed consent required for assistance with SSI/SSDI and Medicaid applications (SSA 3288 will be used for SSI/SSDI applicants)
 - Records date of consent or refusal in the data system
 - Begins to collect application-related information for inmates likely to be eligible for SSI/SSDI and/or Medicaid benefits (and who provide consent) by meeting with the inmate to discuss
 - ▶ Information needed for SSI/SSDI and Medicaid applications (for example, Social Security Number and citizenship status)
 - ▶ How to obtain the necessary documentation for income, assets, and medical history
 4. For inmates likely to be ineligible for SSI/SSDI and/or Medicaid benefits, the discharge manager records this determination in the data system

Activities conducted 4 months (about 120 days) prior to anticipated release date

5. The treatment team or discharge manager:
 - Mails signed consent form (SSA 827) to the local SSA office, which allows SSA to gather medical records, provider names, and contact information
 - Completes the disability report form (SSA 3368) online and submits it to the local SSA office, thereby providing SSA with information about the client's medical condition, health care providers, medications, education, and job skills
 - Ensures that a medical summary report is completed and, if needed, obtains sign-off from a physician or psychologist before sending to the local SSA office
6. The treatment team or discharge manager contacts the designated SSA liaison in the local SSA office and schedules a teleapplication^h
 - On the day of the teleapplication, the treatment team or discharge manager meets with the inmate and participates in the call
 - The local SSA office flags the record as a Joseph Harp, Mabel Bassett, or OSP prerelease case
 - If the teleapplication cannot be completed during the initial call, the treatment team or discharge manager arranges for all needed followup (including scheduling and

^g For inmates with parole hearings at which they are granted an early release date, application support will start prior to or soon after the hearing. For inmates who had SSI coverage at time of intake and may be incarcerated for fewer than 12 months, the reinstatement process will be initiated (rather than the reapplication process). For those inmates enrolled in SSDI at time of intake, the reinstatement process will be initiated, assuming the inmate is still disabled as determined by a continuing disability review (CDR).

^h Each DOC facility has negotiated a prerelease agreement with its local SSA office that allows SSI/SSDI applications to be submitted 120 days prior to anticipated release.

attending any additional calls) and ensures the application is completed within 5 working days of the initial teleapplication

7. After the teleapplication:
 - On the basis of information received from the local SSA office, the state's Disability Determination Division (DDD) sets up a secure electronic file for the inmate that will house the documentation needed for the disability determination
 - The treatment team or discharge manager
 - ▶ Faxes documentation of medical reports and the inmate's discharge planning summary (if available) to the secure electronic file and
 - ▶ Mails documentation of income and resources (if any) to local SSA office
8. The discharge manager records the date that the initial application was completed (that is, the date on which SSA has sufficient information to determine financial eligibility for SSI/SSDI benefits) in the data system
9. The treatment team or discharge manager follows up periodically with SSA to learn the result of the financial eligibility determination, and the discharge manager records the decision and date of decision in the data system
 - If an inmate is not financially eligible for SSI/SSDI benefits or if other nonmedical factors (e.g., citizenship issues, disability acquired during the commission of a crime) prohibit receipt of these benefits, the treatment team or discharge manager begins the Medicaid application process (see below)ⁱ
10. If an inmate is financially eligible for SSI/SSDI benefits, the disability determination process starts, which includes the following:
 - The local SSA office sends the case to DDD immediately after financial eligibility is determined
 - DDD assigns the case immediately to a disability examiner and notifies the treatment team or discharge manager
 - The local SSA office and DDD disability examiner contacts the treatment team or discharge manager when a question about the application arises or additional information is required^j
11. The treatment team or discharge manager maintains ongoing contact with the inmate and once every 2 weeks contacts the disability examiner at DDD to assess the progress of the application

ⁱ In Oklahoma, individuals who are not eligible for SSI may be eligible for Medicaid. For example, SSA may determine that an applicant is not financially eligible for SSI benefits, and hence will not move forward to assess disability status. However, if DHS determines that the individual is financially eligible for Medicaid, then the level-of-care evaluation unit within OHCA (the state's Medicaid agency) can make a disability determination (using SSA criteria). If this unit determines that the person is disabled, he or she qualifies for Medicaid.

^j Consultative examinations (CEs) are generally not scheduled for inmates because of the extent of resources needed to bring an inmate to a doctor's office outside the prison.

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12. When notified, the discharge manager records the results of the disability determination and the date of the decision in the database

Activities conducted 60–30 days prior to anticipated release date

13. At 60 days prior to anticipated release date, the treatment team or discharge manager meets with the inmate to begin collecting documentation for a Medicaid application
14. The treatment team or discharge manager helps the inmate fill out the appropriate Medicaid application:
 - The Family Support Services (FSS-1) application for most inmates or
 - The SoonerCare application, for inmates who are pregnant or custodians of minor children (which can be obtained from the OHCA website)
15. About 30–45 days prior to anticipated release date, the treatment team or discharge manager contacts the designated person in the central office of DHS and then electronically submits, on behalf of the inmate, the Medicaid application and the notification of the SSA disability determination
16. DHS flags the application as a Joseph Harp, Mabel Bassett, or OSP prerelease case
17. In the presumably rare instances when the SSA disability determination is not available 30 days before anticipated discharge,^k the treatment team or discharge manager sends the medical information that was submitted to the SSA office to both the designated person in the DHS central office and to the level-of-care unit in OHCA, the state's Medicaid agency
 - The DHS office and the OHCA level of care unit flags the application as a Joseph Harp, Mabel Bassett, or OSP prerelease case, conducts the disability determination immediately, and notifies the discharge manager of the decision
 - The discharge manager records the date the application was submitted to the DHS central office and OHCA level-of-care unit in the data system
18. After the Medicaid application has been submitted, the treatment team or discharge manager monitors the status of the Medicaid application by maintaining contact with the designated person in central DHS office and addressing any requests for additional information
19. If the inmate is found eligible for Medicaid pending release, the treatment team or discharge manager
 - Ensures that the central DHS office is ready to certify the inmate's Medicaid Recipient Identification (RID) number upon receiving a faxed copy of the certificate of release and the individual's community address on the day of release

^k For example, an inmate's discharge may be moved unexpectedly to a date before SSA has had time to complete the disability determination.

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- Informs the inmate that after receipt of the certificate of release, and assuming the DHS office has a community address for the inmate, OHCA will mail the inmate his/her Medicaid card
20. When a Medicaid decision is made, the discharge manager records the decision and the date of the decision in the data system
 21. If the inmate is found ineligible for Medicaid, the treatment team or discharge manager begins to assist the inmate to access appropriate community resources that will be needed upon release
 22. At discharge, the treatment team or discharge manager provides information about the inmate's SSI/SSDI and Medicaid status to the inmate's
 - Re-entry Intensive Care Coordination Team (RICCT)
 - Parole or probation officer or
 - Staff at the community mental health center where the inmate was referred

Activities conducted on the day of release

23. For inmates who have been approved for SSI/SSDI or have pending applications, the treatment team or discharge manager makes every effort to ensure that the inmate goes to the local SSA office on the day of release (or within 24 hours) with:
 - Certificate of release and personal identification
 - Confirmation of community residence
 - Payment information (e.g., account information for direct deposit, whether the inmate will be own payee or will designate a payee)
 - The designated payee, if the inmate designates a payee, so that the designated payee can complete the appropriate forms
24. The treatment team or discharge manager faxes a copy of the certificate of release with the individual's community address to the central DHS office and local SSA office
 - The central DHS office certifies the inmate's Medicaid RID number and informs OHCA
 - OHCA sends the inmate his or her Medicaid card

Abbreviations and Acronyms

ADL	Activities of Daily Living
AFDC	Aid to Families of Dependent Children
BBA	Balanced Budget Act (1997)
CDR	Continuing Disability Review
CE	Consultative Examination
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
DDD	Disability Determination Division
DHS	Oklahoma Department of Human Services
DOC	Oklahoma Department of Corrections
DOJ	U.S. Department of Justice
FFP	Federal Financial Participation
FPL	Federal Poverty Level
FSS	Family Support Services
GED	General Education Diploma
GMH	Griffin Memorial Hospital
HHS	U.S. Department of Health and Human Services
ICF	Intermediate-Care Facility
ICIS	Integrated Client Information System
IMD	Institution for Mental Diseases
MGP	Medication Grant Program
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MPR	Mathematica Policy Research, Inc.
MR	Mental Retardation
ODMHSAS	Oklahoma Department of Mental Health and Substance Abuse Services
OESC	Oklahoma Employment Security Commission
OHCA	Oklahoma Health Care Authority
OMH	New York Office of Mental Health
OSBI	Oklahoma State Bureau of Investigation
OSP	Oklahoma State Penitentiary
PASS	Plan to Achieve Self-Support
POMS	Programs Operations Manual System
QMB	Qualified Medicare Beneficiary

RICCT	Re-Entry Intensive Care Coordination Team
RID	Recipient Identification Number
RPC	Reentry Policy Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SGA	Substantial Gainful Activity
SLMB	Specified Low-Income Medicare Beneficiary
SOAR	SSI-SSDI Outreach, Access, and Recovery
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSP	State Supplemental Payment
TABE	Test of Adult Basic Education
TANF	Transitional Assistance for Needy Families
UI	Unemployment Insurance

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