A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth

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ModelsforChange
Systems Reform in Juvenile Justice

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Executive Summary

Juvenile justice, mental health, and Medicaid agencies have a common interest in meeting the health needs of youth in the juvenile justice system. There is evidence that youth involved in the juvenile justice system have both unmet, and more extensive than average, needs. Better meeting those needs could result in more efficient and effective use of the resources available to the three agencies – and in decreased recidivism, as well as improvements in children's well-being and their ability to remain in the community.[1] However, these three agencies have different, yet overlapping, program objectives, funding sources, target populations, and partners at the federal, state, and county levels. This situation creates both barriers and opportunities in using these agencies' resources to meet the health and behavioral health needs of children involved with the juvenile justice system.

In mid-2008, the National Academy for State Health Policy (NASHP) began work to: (1) identify the barriers to the effective use of the resources available to juvenile justice, mental health, and Medicaid agencies to meet the health and mental health needs of children involved with the juvenile justice system, and (2) surface potential policies and strategies that states could implement to address those barriers. Specifically, with the support of the John D. and Catherine T. MacArthur Foundation, NASHP staff conducted a literature review and interviewed agency and community stakeholders in five states. Analysis of the interviews found that the barriers cited by informants fell into two categories:

Knowledge: Staff from one agency reported that they did not always know the relevant policies of the other agency, staff in local agencies did not know relevant state policies (and vice versa), and there was little data about the health needs of the children served by more than one agency.

Policy: Interviewees report that some state policies presented barriers for those seeking to access the coverage or services for which children qualified.

Finally, this study identified opportunities for improvement and 'promising practices' within four strategic areas:

- Improving knowledge of how the relevant systems do (or should) work among state agencies and local/state levels,
- Improving eligibility policies and processes to ensure that Medicaid eligible children participate in the program,
- Improving service coverage policies to ensure that Medicaid beneficiaries in the juvenile justice system receive the Medicaid covered services they need, and
- Collaborating among agencies to use their combined resources to meet the needs of these children.

Introduction

Improving coordination among state agencies overseeing the juvenile justice, mental health, and Medicaid systems is crucial to improving access to quality health services for juvenile justice-involved youth.[2]

In 2003, 2.2 million youth under the age of 18 were arrested in the United States.[3] While the juvenile crime rate has de-

creased since the mid-1990s,[4] on average there are 100,000 youth held in juvenile residential facilities each day.[5] Juvenile justice-involved youth have a variety of physical and mental health needs, and unfortunately, the juvenile justice system has become a system of last resort for many marginalized children. This is especially the case for those in poverty with experiences of trauma or mental disorders.[6] It is estimated that over 60 percent of juvenile justice-involved youth meet criteria for three or more mental health disorders, with girls at significantly higher risk than boys.[7] Physical health issues among juvenile justice-involved youth include high rates of asthma, sexually transmitted diseases, unmet dental needs, and pregnancy.[8] Contributing to these youths' health problems are often the absence of health insurance, a regular source of medical care, and/or the family support needed to ensure adequate medical follow-up post-discharge.[9]

Medicaid is a building block for state efforts to improve access to care. This makes Medicaid a critical partner in the juvenile justice system's efforts to meet the health needs of the children it serves.

Medicaid is important not just as a financing mechanism, but also because it creates a structure for outreach and enrollment, access to medical and behavioral health providers, and quality improvement. It is difficult to quantify Medicaid's importance to this population because there is little national data regarding the number of children involved in the juvenile justice system who are eligible for Medicaid, what services they use, or how much Medicaid spends for their care. But, as will be discussed later, it is likely that many of these children are eligible for Medicaid and there is evidence that they have a greater than average need for services. Data from one state reinforces this idea. In Jefferson Parish, Louisiana, state officials estimate 79 percent of arrested youth receive services through Medicaid and/or the State Children's Health Insurance Program.[10]

Some states are developing mechanisms to plan and implement more coordinated and integrated health services for juvenile justice-involved youth. However, barriers to eligibility and service delivery may keep many youth in the juvenile justice system from accessing the needed services for which they qualify. The National Academy for State Health Policy (NASHP), with the support of the John D. and Catherine T. MacArthur Foundation, is working with the *Models for Change* grantee organizations and state policy makers to address the health needs of youth in the juvenile justice system. This paper:

- Describes the core concepts of the three state-administered programs with major responsibilities for serving these children – juvenile justice, mental health, and Medicaid, and
- Highlights both the barriers and opportunities for working across agencies to use Medicaid to meet these children's health needs, as identified in interviews with stakeholders in the *Models for Change* states.

About the *Models for Change* Initiative

Models for Change: Systems Reform in Juvenile Justice has grown out of the juvenile justice-focused grantmaking of the John D. and Catherine T. MacArthur Foundation. Beginning in 1996, MacArthur's efforts at the national level included considerable investment in research to expand the knowledge base with regard to adolescent development and delinquent behavior, and they laid the groundwork for significant changes in law, policy, and practice. In 2004, the Foundation launched the *Models for Change* initiative to bring about systemic reform at the state and local levels. The initiative seeks to develop replicable, system-wide changes in states that can serve as models for reform in other jurisdictions. The core *Models for Change* states –Pennsylvania, Illinois, Louisiana, and Washington – were chosen based on a variety of criteria, including their political and fiscal commitment to reform, support for reform both in and outside the juvenile justice system, and the likelihood that other states would follow their lead. The initiative's goal is to accelerate progress towards more rational, fair, effective, and developmentally sound juvenile justice systems and thus develop models for replication. *Models for Change* has awarded grants to support juvenile justice reform in twelve more states through action networks focusing on key issues. For example, one of the *Models for Change* action networks is working to improve the way the juvenile justice system addresses the needs of youth with mental health problems.[11] While *Models for Change* encompasses more than health care, both the MacArthur Foundation and its partner states recognize that addressing the health needs of system-involved youth is an important part of improving the overall juvenile justice system.

NASHP has been a member of the *Models for Change* initiative since September 2007. We provide guidance and information about Medicaid policy to help *Models for Change* states improve access to health coverage and health care for juvenile justice-involved youth.[12] To that end, this report focuses upon the opportunities and barriers in the relationship between juvenile justice, mental health and Medicaid agencies in the *Models for Change* states as well as additionally selected states.

Through a formal work plan development process with MacArthur, *Models for Change* states identified specific areas

in which to concentrate their juvenile justice system reform efforts.[13]

- Priorities in *Illinois* include: promoting community-based alternatives to secure confinement; ensuring that young people accused of crimes are treated as individuals, in a developmentally appropriate manner; and assuring that the juvenile justice system treats all alleged offenders fairly regardless of their race or ethnicity (or reducing disproportionate minority contact).
- Reform efforts in *Louisiana* are focusing on bringing about change in three areas: expanding alternatives to formal processing and secure confinement, increasing access to evidence-based services, and reducing disproportionate minority contact with the juvenile justice system.
- *Pennsylvania* is working to improve its system of aftercare services and supports as well as coordination between the mental health and juvenile justice systems. The state also seeks to reduce disproportionate minority contact with the juvenile justice system.
- *Washington* is accelerating change in three areas: expanding alternatives to formal processing and secure confinement, reducing disproportionate minority contact with the juvenile justice system, and improving access to mental health services.

NASHP used *Models for Change* states and others selected from a literature review to focus our work, begin to identify barriers and solutions, and confirm findings highlighted in previous work and research. NASHP conducted phone interviews with stakeholders in the *Models for Change* states to obtain information and opinions about the working relationships between state Medicaid agencies and juvenile justice authorities in each state.

Based on knowledge gathered from previous NASHP projects, NASHP staff conducted interviews with officials from additional states identified as having 'promising practices' for improving health coverage and health care for juvenile justice-involved youth that may be replicable in other states. Specifically, this report highlights findings from New Mexico in addition to findings from the four *Models for Change* states. Interview questions are available in the appendix.

Overview of Relevant Programs

Juvenile justice, mental health, and Medicaid programs all touch the lives of juvenile justice-involved youth. State-administered juvenile justice and mental health programs govern the provision of servicesscreening, treatment, and care coordination of services for this population. Medicaid provides comprehensive health coverage to more than half of all poor and low-income children – including youth involved with the juvenile justice system. However, all the programs have different objectives, target different but often overlapping populations, and share responsibilities to varying degrees with federal, state, and county agencies.

Juvenile Justice

Each state operates its own juvenile justice program. The federal Office of Juvenile Justice Delinquency Prevention (OJJDP) oversees compliance with Federal juvenile justice-related regulations and provides funding to the states. Provisions of the Juvenile Justice and Delinquency Prevention Act pertain to children who commit crimes or are delinquent, as well as children with mental illness at risk for delinquency.[14] The Act provides classifications used by states to identify children with mental health needs. OJJDP supports states and local communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. It also works with states to help improve the juvenile justice system's ability to protect public safety, hold offenders accountable, and provide mental health treatment and rehabilitative services.

Prior to trial, the vast majority of youth awaiting trial are released rather than detained in a juvenile justice facility.[15] (Detained and committed youth are usually housed in different facilities). Less than a quarter of youth who are adjudicated delinquent (found guilty) are committed to a facility or institution to serve a sentence; most are ordered to probation in a community setting.[16] Community settings (which include group homes and wilderness programs) vary in size and can be privately or publicly operated. Federal law stipulates that state juvenile justice systems provide timely and appropriate physical and mental health services to youth in the system, specifically those held in commitment facilities.[17]

States administer and organize basic services in a variety of ways for juveniles who have been arrested for a delinquent offense and referred to court.[18] These basic services include: detention (or temporary custody while awaiting a court's decision), probation ("conditional freedom"), placement in a secure

facility after adjudication, and aftercare (or conditional release with supervision).[19]

Every state has an executive branch agency with responsibility for administering these services. Depending on the state, the agency with this authority may be a social/human services agency, a separate juvenile corrections agency, or, infrequently, an adult corrections agency. Additionally, states differ in the degree to which local authorities control services. In general, "centralized" states have a state agency in charge of services across the state, while "decentralized" states put local authorities in charge of probation services and (in some cases) detention centers. In other states, there is a mix of both state and locally run delinquency services.[20]

Mental Health

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides funds to states and local entities to help them administer, support, and/or establish children's mental health programs. SAMHSA also provides block grant funding for states to maintain and enhance mental health services, including services for juvenile justice-involved youth. SAMHSA sponsors the Systems of Care Initiative to help children and adolescents with severe mental illnesses and their families receive a variety of services from schools, community mental health centers, and social services organizations, as well as to facilitate coordination among these service providers.

The Public Health Service Act allows states to provide mental health services to children up to age 18, including juvenile justice-involved youth, who have a diagnosed mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that results in impairment that substantially interferes with or limits the child's functioning in family, school, or community activities.[21]

Children and youth receive mental health services in an array of settings. The President's New Freedom Commission on Mental Health formally recognizes that individuals with mental disorders are seen by multiple systems, including the juvenile justice system.[22] A national survey conducted by SAMHSA indicates that from 2005 to 2006, an average of 13 percent of youth aged 12-17 received services for emotional or behavioral problems in specialty mental health settings; about 3 million youth (12 percent) received these services in a school-based setting, and a smaller number (about 750,000 or 3 percent) of youth received services for emotional or behavioral problems from a physician.[23] About 12 percent of youth received outpatient mental health services, and 3 percent received inpatient mental health services.[24]

State mental health agencies administer a variety of programs that promote mental health among children and adults. These agencies mainly serve individuals who have been diagnosed with a mental disorder and often focus on those with severe emotional disabilities. Some states have a separate mental health agency for children within the broader mental health agency.

Medicaid

Title XIX of the Social Security Act establishes Medicaid as an entitlement program that is administered by states within federal guidelines. Medicaid pays for medical assistance for certain individuals and families with low incomes.[25] Medicaid provides health coverage to about half of the nation's low-income children.[26]

Two dimensions to Medicaid coverage determine what services an individual beneficiary receives. The first is whether the service is covered by the program (covered services). The second is whether an individual beneficiary qualifies to receive a covered service (medical necessity).

For children under age 21, federal Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements establish a consistent set of covered services and definition of medical necessity across states. EPSDT ensures that each child's health and developmental needs are assessed through initial and periodic examinations and evaluations, and that health and developmental problems are identified and treated early.[27] EPSDT regulations require states to cover, for children, all Medicaid benefits that can be covered under federal Medicaid law even if the state chooses not to cover the service for adults. For example, a Medicaid agency can choose not to provide dental services to adults – but it must provide them to children. Also, EPSDT regulations require Medicaid agencies to make available all covered services needed "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the [EPSDT] screening services."[28]

The federal government shares the cost of qualified Medicaid services with states at a set rate that varies by state (the Federal Medical Assistance Percentage or FMAP).[29] Longstanding federal law prohibits federal Medicaid funds from providing "care or services for any individual who is an inmate of a public institution."[30] This law is often understood to mean that Med-

icaid is not available to pay for services for youth in the juvenile justice system. However, states can receive federal Medicaid funding for youth in many juvenile justice settings:[31]

- States can receive federal Medicaid funds to pay for medical services for eligible youth in private institutions. A public institution is a place that is "the responsibility of a governmental unit or over which a governmental unit exercises administrative control."[32] And, "a public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that services no more than 16 residents, or a children care institution with respect to children receiving foster care or foster care payments."[33] In 1997, the federal government clarified that Medicaid funds are available for eligible youth placed in a non-secure setting regardless of whether they have been found guilty of a crime.[34]
- Youth ordered to large public institutions may remain enrolled in Medicaid. Youth can be kept on the Medicaid rolls while in a public institution as long as federal Medicaid funds are not used to pay for their care. A 2003 letter confirmed that "states need not *terminate* Medicaid eligibility during an individual's period of incarceration."[35]
- Federal Medicaid funds may be available to pay for services for youth during detention. Federal Medicaid regulations leave room for Medicaid to continue to pay for services until the final disposition of a case.[36] Some states have interpreted these regulations to mean that federal Medicaid funds are available for services while in detention. While a recent interpretation from the federal Medicaid agency suggests that the agency would not approve states that want to pursue this policy, this policy may be revisited in the future.[37]

Service Delivery[38]

As of June 30, 2006, approximately 45.6 million people participated in Medicaid.[39] Children comprise a substantial proportion of Medicaid beneficiaries, with 28 million children enrolled during 2005.[40] Sixty-five percent of all Medicaid beneficiaries (or 29.8 million people), representing 48 states, were enrolled in managed care in 2006.[41]

States determine how services will be delivered to Medicaid beneficiaries. The two types of Medicaid service delivery are fee-for-service and managed care. Under fee-for-service, participating providers bill Medicaid directly; the payment amount varies by service and Medicaid manages the services through processes such as prior authorization. Most youth receive a few services under fee-for-service.

Under managed care, there are two major Medicaid service delivery models: primary care case management (PCCM) and managed care organizations (MCOs). In the former, a subset of Medicaid providers agrees to serve as PCCM providers for enrollees. PCCM providers agree to directly provide primary care services and coordinate most specialty services. PCCM providers receive additional funding (a set amount per member per month, or PMPM) for coordinating care. In this model, Medicaid will not pay for services delivered by a provider other than the PCCM provider without the authorization of the PCCM provider. Under MCO managed care delivery, organizations contract with the state Medicaid agency to deliver a set package of benefits to a defined group of enrollees. The benefits package may or may not be comprehensive. The MCO pays for services, and it may require enrollees to use a limited list of providers. MCOs are paid a set dollar amount (PMPM) payment for all services and administrative activities.

States manage their Medicaid programs by establishing medical necessity definitions and utilization controls to ensure that individuals receive services only when medically necessary. States are able to 'split' the benefit package so that a package of services similar to a commercial package is delivered through one system (e.g., MCOs), while other services are delivered through another system.[42] But, for children federal law requires that Medicaid agencies continue to meet the EPSDT requirements as a wrap-around to services covered in the benefit package if that coverage is less than what is required under EPSDT. Thus, EPSDT is a platform for improving access to health coverage and health care for juvenile justice-involved youth.

Barriers to the Effective and Appropriate Use of Medicaid in Delivering Care to Juvenile Justice-Involved Youth

Conversations with policy makers in the *Models for Change* states confirmed differences in regulations, operating missions, organizational structures, processes, and languages among the agencies responsible for delivering services to juvenile justice-involved youth.

"It is a tense relationship at best—goals aren't perfectly aligned. One has uncapped entitlement and the other has capped entitlement."

--Juvenile justice official

However, juvenile justice and Medicaid agencies have a common interest in meeting the health needs of this population. Unmet health needs may present juvenile justice agencies with increased recidivism rates and unanticipated increases in mental health service utilization and medical costs. Poor health care may lead to unanticipated increases in expenditures and case management services for Medicaid agencies.[43] This 'shared mission' makes it paramount to better understand each other's policies. The barriers identified through our interviews with case study states can be categorized into two groups: knowledge and policy.

Knowledge Barriers

Understanding Medicaid and juvenile justice systems can be a daunting task. These systems differ not only by state, but also often by county or region within a state. It is no surprise that officials from these systems often cited lack of knowledge about the other's policies as a challenge in meeting the needs of children in the juvenile justice system. Specific challenges cited include: (1) lack of information about services offered by sister agencies at the state level; (2) lack of knowledge at the local level regarding state policies, and conversely, state-level understanding of local practices, even within the same agency; and (3) a lack of information about the number, needs, and utilization of children served by two or more of the three agencies critical to delivery of services (Medicaid, mental health and juvenile justice).

Lack of Knowledge about Services Offered by Sister Agencies at the State Level

Juvenile justice and Medicaid agencies each serve broad populations, yet they often work in silos. Medicaid officials from case study states reported not always understanding the services available and delivered within juvenile justice and/or mental health. Likewise, juvenile justice interviewees were unsure what services Medicaid provides, or could potentially provide, to juvenile justice-involved youth.

Knowledge of reimbursement policies for evidence-based practices was a commonly cited barrier.[44] For example, Medicaid can play a meaningful role in supporting evidence-based practices, even covering as much as half of operating costs for service delivery. However, it is often assumed (inaccurately) by juvenile justice and mental health officials that "Medicaid does not pay for evidence-based practices."

Lack of Information of State Policies at Local Level (or at State Level of Local Practices)

Implementation of policy at the local level, by juvenile justice court judges, staff in community settings, and/or mental health professionals, often occurs without a broader knowledge of state policies that could lead to improved access to, and quality of, health care services. For example, in one state, interviewees reported that some juvenile courts were unaware that Medicaid should only pay for services found to be medically necessary. Some courts also assumed that a juvenile court order placing a youth in a Medicaid-funded facility ensured Medicaid reimbursement for the facility.

In addition, officials were often aware of policies that had been initiated to facilitate access to Medicaid for juvenile justice-involved youth, but were unsure of the status of the processes and the extent to which they had been implemented or successful. Finally, state officials with county-based juvenile justice and mental health systems, such as Illinois and Washington, reported particular difficulties in understanding how, and by whom, changes to an individual beneficiary's Medicaid eligibility were completed as the child moved through the system and how the health and mental health services were delivered.

Lack of Information on the Intersection of Medicaid and Juvenile Justice

State officials reported that they had little information about the children served by both the Medicaid and juvenile justice systems. Policy makers interviewed for this project did not definitively know what percentage of juvenile justice-involved youth in their states are Medicaid-eligible. Neither Medicaid nor juvenile justice agencies reported collecting or tracking this information. As a result, both systems remain uncertain of the physical and mental health needs of Medicaid-eligible children who become involved with the juvenile justice system, the utilization and cost experience of this group, and the extent to which the systems are meeting their needs.

Policy Barriers

Stakeholders reported that those seeking to provide coverage

and services to juvenile justice-involved children and their families found it difficult to navigate the complex Medicaid system. The multiple transition points within the juvenile justice system and their effect on Medicaid coverage add to the difficulty. The challenges they reported can be grouped into eligibility and service categories.

Eligibility

As mentioned earlier, states do not receive FMAP for services provided to Medicaid beneficiaries who are "inmates of a public institution." This federal exclusion does not require states to terminate the eligibility of children entering the juvenile justice system, nor does it prevent them from providing Medicaid coverage to those children involved with the juvenile justice system but who are not inmates of a public institution. The exclusion does, however, increase the complexity of Medicaid eligibility policies for these children.

State Medicaid policies govern whether a child's eligibility will be suspended or terminated when entering secure confinement, under what circumstances a child is defined as "an inmate of a public institution," and how to ensure that transitions occur according to policy. The complexity of these polices and the often-changing circumstances of juvenile justice involved-children and their families may result in loss of eligibility, even when a child could have remained Medicaid eligible. Long delays in processing Medicaid applications during transitions and lack of assistance during the application process further complicate the effective and appropriate use of Medicaid in delivering care to juvenile justice-involved youth.

Service Coverage

It is essential that those seeking Medicaid-covered services for juvenile justice-involved youth understand and follow the appropriate service coverage requirements to ensure Medicaid reimbursement. Some interviewees cited a lack of clear policy guidance on who can (and how to) bill for services for the juvenile justice population. There are two major reasons why providers who serve youth involved in the juvenile justice system may not be paid for providing a medially necessary, Medicaid-covered service.

- *Providers may not be approved to provide the service.* Providers who wish to be reimbursed by Medicaid must be certified by Medicaid to provide the service. To qualify for certification providers must meet Medicaid criteria, which may include specific licensure, training, supervisory, or other criteria. Further, if the beneficiary is enrolled in a Medicaid-contracted MCO, the provider must almost always be a part of the MCO's provider network in order to receive payment. MCOs usually only contract with providers approved through a credentialing process – and may not contract with all providers who qualify through the process. Some interviewees reported that some providers who deliver services to juvenile justice-involved youth did not meet the criteria for Medicaid or MCO participation.
- *Providers may not obtain the proper authorization to deliver a service.* Medicaid fee-for-service, MCOs, and PCCM programs all have authorization requirements for many services. These requirements vary by delivery system. Sometimes the service cannot be provided without an authorization and sometimes the authorization is needed in order to provide more than a specific amount of the service. Interviewees reported that providers encountered several difficulties with authorization requirements: not knowing that an authorization was required, not knowing how to obtain an authorization, and not being able to obtain authorization quickly enough to provide services when needed. Interviewees also reported that juvenile justice-involved youth experienced delays in care and services due to discrepancies between what a court orders, what Medicaid covers, and what managed care contractors allow.

Finally, some interviewees identified workforce shortages as a challenge to delivery of services. For example, juvenile court judges sometimes order a youth to be placed in a residential/psychiatric setting rather than a community setting, because they do not believe the child will be able to obtain the services needed in the community. The juvenile justice system thus becomes the last resort for this population. Interviewees were especially concerned about the paucity of qualified mental health providers.

Strategies for Addressing the Barriers to The Effective and Appropriate Use of Medicaid in Delivering Care to Juvenile Justice-Involved Youth

The case study states recognize the barriers to the effective (and appropriate) use of Medicaid in delivering care to juvenile justice-involved children and have developed policies and strategies intended to address these barriers. These policies and strategies can be grouped into four categories:

(1) Improving knowledge of how Medicaid and juvenile justice systems do (or should) work;

(2) Improving eligibility policy and processes to ensure that Medicaid eligible children participate in the program;

(3) Improving service coverage policies and procedures to ensure that Medicaid beneficiaries in the juvenile justice system receive Medicaid-covered services; and

(4) Improving agency collaboration so that the agencies can work together to surface and address challenges that cut across programs.

> "It's a very good relationship; and it includes partners in mental health and substance abuse offices. The three offices work closely together to make improvements in system [to improve health services for juvenile justice-involved youth]."
>
> ---Medicaid policy maker

Opportunities for Improving Knowledge of How Systems Do (or Should) Work Among State Agencies and Local/State Levels

One of the first steps for coordinating and ensuring access to health services for juvenile justice-involved youth is improving inter-agency and intra-agency knowledge of how the Medicaid, juvenile justice, and mental health systems work at both state and local levels.

A 2005 study[45] suggests that communication between and within Medicaid and juvenile justice agencies is not standardized or coordinated. About one-third of state and local Medicaid agencies surveyed stated that the vast majority of state and local justice agencies do not submit claims to Medicaid.[46] The same survey found that state and local Medicaid agencies' responses about specific policies affecting juvenile justice-involved youth contradicted one another in 21 percent of the states, and state and local justice agencies' responses about these policies disagreed in 27 percent of the states. In other words, in at least one out of five states, local and state agencies within the same department were utilizing conflicting information or standards. Medicaid and juvenile justice agencies need to understand each other's policies, as well as their own state and local system policies, in order to identify policy barriers and develop solutions to ensuring that juvenile justice-involved youth and their families are connected to Medicaid when appropriate.

Through our interviews, we identified three important outcomes that can be achieved through policies and strategies designed to increase understanding of program policies:

- Staff in both Medicaid and juvenile justice systems are familiar with existing policies and procedures governing availability and delivery of health services for Medicaid eligible youth involved in the justice system.
- State and local officials understand how they can combine state funding streams and coordinate care to better serve juvenile justice-involved youth.
- Agencies have access to and routinely share relevant data and information with each other.

Several of the case study states are working to improve knowledge regarding how Medicaid, juvenile justice, and mental health systems work. Strategies implemented by Illinois, Louisiana, Washington, and New Mexico are particularly noteworthy.

Illinois

In 1999, Illinois created the Bureau of Interagency Coordination (BIC), which, among other things, provides a central point of contact within the Medicaid department for many state agencies that provide services to individuals covered by the Illinois Medical programs. The agencies include the Department of Human Services (DHS), an umbrella agency that provides programs and services for individuals with alcoholism and substance abuse, individuals with mental health needs, and

persons with disabilities, including developmental and physical disabilities, and HIV or AIDS. BIC also works with agencies outside of DHS, including the University of Illinois Division of Specialized Care for Children, the Department of Children and Family Services (the child welfare agency), and the County Courts Offices that participate in the state's Juvenile Rehabilitation Medicaid Matching Fund Program.[47]

The Illinois Department of Healthcare and Family Services administers the Medicaid Matching Fund program. Intergovernmental agreements with the County Courts Offices outline the specific responsibilities required of each in order to appropriately access the federal match for Medicaid mental health services provided at the county level. Through the BIC, Illinois has established a statewide infrastructure that facilitates communication and information sharing between Medicaid and the counties that participate in the Medicaid Matching Fund program.

Louisiana

Louisiana has established a unique system for connecting local and state policy makers and stakeholders across various agencies. In response to recommendations brought forward by the Juvenile Justice Implementation Commission and the Children's Cabinet, the Louisiana Legislature passed Act 555 in 2004, which created children and youth planning boards within each judicial district.[48] The planning boards coordinate and identify gaps in local services for children with (or at risk of developing) social, emotional, or developmental problems. Planning board members include district attorneys, judges, school system representatives, advocates, family members, and other stakeholders. Local planning boards bring their findings and suggestions up to the state level; planning board recommendations are then taken into consideration when putting together budgets and requests for proposals for mental health and juvenile justice facilities.

Washington[49]

A Medicaid administrative match agreement between King County Superior Court and the Health and Recovery Services Administration of the Washington State Department of Social and Health Services allows the County to receive, through the state, FMAP for educating juvenile probation counselors, at-risk youth program staff, dependency Court Appointed Special Advocate (CASA) staff, and specialty court staff about the Medicaid program, Medicaid providers, and Medicaid enrollment and services. Counselor training covers the administration of the state's risk assessment tool, which is used statewide to screen and triage youths into evidence-based practices, as appropriate.[50] The tool assesses mental health and drug use history as well as Medicaid eligibility. Interviewees believe that King County's education component has greatly improved probation counselors' understanding of the Medicaid program.[51]

New Mexico

Across New Mexico, Children, Youth, and Families Department (CYFD) employees who work directly with juvenile justice-involved youth receive training on the state's presumptive eligibility processes (described in detail in the next section). Presumptive eligibility is a process by which a state approves "qualified entities" to determine temporary Medicaid eligibility. Once presumptive eligibility is determined, youth can access care without awaiting final determination on their Medicaid application. Regardless of the final eligibility determination, providers are guaranteed payment for care they deliver, and states are guaranteed regular federal matching funds during the presumptive eligibility period, which is usually 30 to 60 days. Presumptive eligibility training is one strategy states can use to promote cross-agency understanding. Interviewees report that this training has improved knowledge of Medicaid eligibility among CYFD officials which has helped promote access for all Medicaid clients, especially juvenile justice-involved youth.

Also, since 1997 New Mexico has maintained a statewide database, the Family and Child Tracking System or FACTS, which provides staff (specifically state and local juvenile justice, mental health, and Medicaid staff) access to information on all juvenile justice and child welfare clients.[52] Each month CYFD staff members receive several standard reports from FACTS for analysis; staff also have complete access to a Human Services Department database with Medicaid eligibility information. By comparing FACTS data or reports with information in the Human Services Department database, staff are able to determine Medicaid eligibility status among the juvenile justice population. FACTS is refined continuously to improve inter- and intra-agency information sharing.

Improving Eligibility Policy and Processes to Ensure that Medicaid Eligible Children Participate in the Program

States have many options for improving policies and processes to ensure that eligible children participate in Medicaid during pre-adjudication, if detained in a non-secure setting and released, or exiting a secure facility. Short detainment periods make timely notification to Medicaid about a youth's involvement with the juvenile justice system difficult at best. As a result, a detained beneficiary's length of stay may determine his or her Medicaid eligibility status. One state, for example, reports that juvenile justice-involved youth may be in and out of detention before an eligibility worker would be aware of placement, as the average detention is 30 to 40 days. Juvenile justice and mental health staff can play a vital role by assessing youths' eligibility, helping youths submit Medicaid applications prior to their release, and ensuring that eligible youth have a Medicaid card in hand as they walk out of the facility doors.[53]

Interviewees in case study states identified the following as important outcomes related to Medicaid eligibility:

(1) Eligible juvenile justice-involved youth are reached and expeditiously enrolled in Medicaid, where appropriate.

(2) Youth are connected to, and continue to receive, coverage for necessary health and mental health services throughout their experience in the juvenile justice system.

(3) No federal match is claimed for youths who are inmates of public institutions (as defined earlier in this paper), but the match and coverage are reinstated and in place when youth are released.

(4) Involved agencies have clearly defined roles and responsibilities in the eligibility process.

Several of the case study states have put policies into place to ensure that children participate in Medicaid when eligible. Those implemented by New Mexico, Pennsylvania, and Washington are particularly extensive.

New Mexico[54]

New Mexico has put into place several strategies that interviewees reported have made a "big difference in improving access for all, specifically juvenile justice." New Mexico is one of 14 states with presumptive eligibility for children.[55]

In New Mexico, presumptive eligibility determiners may grant children under age 19 from families with income of less than 235 percent of the federal poverty level with up to 60 days of presumptive eligibility pending processing of a full Medicaid application. New Mexico has also established the Medicaid On-Site Application Assistance (MOSAA) program, which is designed to provide assistance to families with children under age 19 (among others) in completing the full Medicaid application. It also enables those families to apply for Medicaid without going to a state office.

While these policies apply to all children, New Mexico has created provisions to ensure that children leaving a juvenile justice placement benefit from them. The State Medicaid agency allows staff from the New Mexico Children, Youth and Families Department (CYFD) who participate in a two-day training program to make presumptive eligibility determinations and participate in the MOSAA program.[56] Training may be either in-person or by video and classes are offered quarterly. Topics covered include eligibility guidelines for children and pregnant women and instructions on how to collect the appropriate documentation.[57] Trainees receive a manual and informational memos with any policy updates.

In 2007, CYFD built on this capability by creating a network of regional transition coordinators who work with youth involved in the juvenile justice system from intake through release.[58] Regional coordinators help plan successful returns to the community by ensuring that needed supports, such as behavioral health services, housing, employment, and education are in place for youth. These coordinators make presumptive eligibility determinations and help families complete full Medicaid applications. The state aims to make it standard procedure for this paperwork to be completed ahead of time so that it can be submitted when a youth is released. CYFD prioritizes applications from children with significant behavioral health needs to ensure that they are assigned a transition coordinator. According to interviewees, the transition coordinator process provides a needed link between the facility and the community to support transition of services for youth.

Also, the New Mexico Department of Health (DOH) allows staff from CYFD to obtain birth certificates for children involved in the juvenile justice system from the DOH website. Interviewees estimate that almost half of the children in the juvenile justice system who are born in New Mexico do not have their birth certificates, which are a required part of a full Medicaid application. As a result, they reported that web access and the ability to print out birth certificates have helped simplify and expedite the application process during and after adjudication.

Finally, New Mexico has helped streamline the Medicaid application process for youth exiting facilities. New Mexico's Juvenile Parole Board (JPB) is a major part of the process for youth exiting facilities, as it makes parole decisions. JPB discusses all youth transitioning out of placement, and creates an opportunity for families and children to come together. JBP has its own governance structure and budget, although it is administratively attached to the CYFD.[59] JPB meets once a month in a single location; all youth undergoing paroling procedures are transported to that location. Each youth's family is contacted before the parole date so that they can bring key documents with them in order to fill out Medicaid applications and connect to other needed services. The state has an agreement with the Albuquerque office, which processes all applications submitted from throughout the state, even if an application is going to a different office. Once JPB paroles an individual, it faxes a document to the Albuquerque office for processing. State policy makers report that having families and children together in the same physical location facilitates the eligibility process because families can complete applications. (Youth cannot be enrolled in Medicaid until they are paroled.)

Pennsylvania

Pennsylvania has made a series of eligibility process improvements for juvenile justice-involved children by creating a system of cross-agency liaisons and tracking information about clients. Liaisons between probation offices, detention centers, and county assistance offices (where Medicaid eligibility is determined) work together to help connect transitioning youth to needed services, such as those administered by Medicaid and/or mental health agencies. Detention centers notify the county assistance office about where each youth will be transitioning. The liaisons consider continuing youths' Medicaid eligibility where appropriate (for example, if moving into a community-based setting).

This liaison system is buttressed by Medicaid eligibility and MCO enrollment information that the state tracks and maintains. Within the client information (eligibility) system, there is a specific code for facility placement, such as a juvenile detention center. If a child is Medicaid-eligible before being admitted to a detention center, the state maintains the child's eligibility, but adds a code to indicate that the child is in a juvenile justice facility. The system also tracks the number of days of placement within a juvenile detention center. (After 35 days, the youth moves from MCO to fee-for-service).[60] Additionally, the Medicaid agency requires each Medicaid-contracted plan to have a special needs unit and case managers to work directly with child welfare agencies, detention centers, and probation to resolve for the agency any problems related to Medicaid.

Washington

Washington has improved policies to ensure that eligible juvenile justice-involved youth participate in Medicaid. The state provides 12-month continuous eligibility to children, which assures them Medicaid coverage for that period regardless of any changes in family circumstances or income. Children who enter and exit a local detention facility (both pre- and post-adjudication) during the 12-month eligibility period remain Medicaid-eligible after release. Additionally, when eligible youth leave any Juvenile Rehabilitation Administration (JRA) facility (which includes both secure and non-secure facilities) in Washington, they are re-instated for the remainder of the continuous eligibility period.[61] Additionally, staff at JRA facilities complete Medicaid applications up to 45 days before a youth's anticipated release date and families are provided a contact within their community where the application can be sent. A designation team in the state's Medicaid office coordinates services with facilities, so that eligible children receive a card quickly.

Improving Service Coverage Policies to Ensure that Medicaid Beneficiaries in the Juvenile Justice System Receive Medicaid-Covered Services

Many of the children involved with the juvenile justice system either qualify for, or are currently receiving, Medicaid. Ensuring that eligible children receive the Medicaid-covered services for which they qualify is of value to the shared mission of juvenile justice, mental health and Medicaid agencies. Interviewees in case study states identified the following as important outcomes of service coverage:

(1) Components of clinical services, such as Multi-Systemic Therapy,[62] that have been shown to be effective for achieving juvenile justice system goals, can be covered by Medicaid when medically necessary.

(2) Services that promote early identification, such as behavioral health or substance abuse screening, are covered by Medicaid.

(3) Provider continuity is maintained as children move among systems and payers.

(4) Case managers and staff from the juvenile justice system are included in care planning for physical and behavioral health care services. Conversely, those responsible for providing physical and behavioral health care participate in care planning activities led by juvenile justice system staff.

Several of the case study states have put policies into place in an effort to ensure that children receive appropriate services and maintain continuity of care. For example, Louisiana's multi-state agency task force, the Juvenile Justice Implementation Commission, has successfully amended the state plan to include components of evidence-based practices as 'covered' services under Medicaid when appropriate. Extensive policies implemented by New Mexico, Pennsylvania, and Washington are highlighted here.

New Mexico

In 2005 New Mexico implemented a Behavioral Health Collaborative to improve the delivery of most publicly funded behavioral health services in the state. Seventeen state agencies – including CYFD (encompassing juvenile justice and protective services) and the Departments of Human Services (Medicaid), Health, Corrections, Public Education, Transportation, and Labor – participate and contribute to a common funding pool. The collaborative selected a single contractor to manage its behavioral health services. New Mexico believes that having a single contractor managing its behavioral health network and services will improve care by coordinating services as people transfer among systems. New Mexico developed this approach to ensure continuity of providers regardless of source of funding for the service (e.g., the same provider can, if qualified, provide services funded by Medicaid and services funded by juvenile justice), and to streamline provider credentialing, billing, and payment.

To make this transition, the collaborative worked with stakeholders to develop cross-agency service definitions. While not solely designed for children involved with juvenile justice, the system was designed with their needs in mind. Services include transportation and Multi-Systemic Therapy. The collaborative also developed a cross-walk of the services covered by CYFD funding to the service definitions and coding used under the new program.[63] In addition, the request for proposal for contracting services included requirements for improving delivery of services to children in the juvenile justice system, including:

- Early identification of children who are engaging in delinquent behavior or have high-risk factors for severe emotional disturbance, including screening for mental health and substance abuse needs.
- Participation in case planning and discharge planning by the juvenile justice system, including staff from that system in service planning for juvenile justice-involved youth.
- Coordination between juvenile detention facilities and behavioral health providers by establishing a process to "communicate the behavioral health needs of juveniles at intake and discharge and to establish continuity of care between the juvenile detention facility and the behavioral health contractor."[64]

Interviewees described a "natural overlap" between the Behavioral Health Collaborative and a transition coordinator process recently implemented by CYFD to support and coordinate community-based services for youth transitioning out of juvenile justice facilities.

Pennsylvania

In 2005, Pennsylvania's Department of Public Welfare (Medicaid) began the Integrated Children's Service Initiative.[65] The purpose of this initiative was to enhance child and family access to all behavioral health services funded by the department, including those delivered to Medicaid eligible children involved with the juvenile justice system; to serve and protect children through increased accountability; and to maximize the use of federal funding for services eligible for federal reimbursement.

Policy makers recognized that the responsibility of the Medicaid program is to pay for medically necessary services, while that of the juvenile justice system is much broader, including providing for the safety of both the child and the community, and enabling children to develop the competencies they need to function within their communities. The Integrated Children's Initiative differentiates between behavioral health services needed to treat a mental health condition (Medicaid role) and those services the same child may need to meet the broader goals of the juvenile justice system (juvenile justice and mental health system role). This allows for Medicaid reimbursement for services having a 'qualified treatment component,' such as Multi-Systemic Therapy. It also clarifies that Medicaid funding should be used to pay for medically necessary services, while juvenile justice funding should be used to pay for those that are not medically necessary. The Department of Public Welfare also worked to identify and add behavioral health providers

who served juvenile justice clients to the roster of Medicaid-certified providers.[66]

In addition, Pennsylvania's managed care contracts contain elements to facilitate coordination of care for children involved in the juvenile justice system, including requirements to:

- Enter into letters of agreement with county children and youth agencies and juvenile probation offices so as to define procedures for ensuring that care delivered to children who are clients of these agencies is coordinated and to identify points of contact in the agency and MCO.
- Establish a special needs unit to oversee and coordinate the delivery of covered services to members of populations with special needs, including those involved with the juvenile justice system. The contract specifies the qualifications and responsibilities of the special needs unit, which include coordination with specified government entities, including county children and youth agencies and juvenile probation offices.[67]

Washington

King County Superior Court in Washington receives Medicaid Administrative Matching Funds for staff outreach and linkage activities to encourage youth enrollment and outreach services for youth in its juvenile justice system. The matching funds are used to pay for Superior Court operations and non-reporting support staff.[68] King County Superior Court juvenile probation officers, social workers, and case managers help youth entering the juvenile justice system and their families complete a Medicaid eligibility application, access needed support through state and local Medicaid application workers, and make referrals for health, mental health, chemical dependency services to Medicaid providers in the community. These activities are compensated at the federal 50 percent matching rate.

In an effort to ensure that all juvenile justice-involved youth in the county have access to health insurance and other necessary and court-ordered services, the Juvenile Court Services Division of the King County Superior Court recently partnered with Seattle-King County Public Health to provide support services to youth. Through this partnership, an outreach worker assists youth and families involved in probation, truancy matters, and Family Treatment Court and/or Juvenile Drug Court by, for example, signing youth up for Medicaid and other important services. An additional health outreach worker visits youth in detention and provides similar resources to detained clients.

Agency Collaboration

Cross-agency collaboration is key to surfacing and addressing the barriers to physical and mental health coverage and care for juvenile justice-involved youth. A strong partnership between state Medicaid, mental health, and juvenile justice agencies is vital to meeting the health needs of juvenile justice-involved youth. Developing solutions for both knowledge and practice barriers that will work for all agencies requires a clear articulation by state health policy makers of goals for improving care for juvenile justice-involved youth. The prevalence of mental health disorders among juvenile justice-involved youth is demonstrated by recent research that shows juvenile justice is a system of last resort for families of children with mental health needs. A 2004 study issued by Congress concluded that juvenile detention centers are being used inappropriately to hold thousands of youth in need of mental health services: "the use of juvenile detention facilities to house youth waiting for community mental health services is widespread and a serious national problem."[69]

Due to the preponderance of physical and mental illness among juvenile-justice involved youth, the juvenile justice and mental health systems are increasingly working collaboratively to address the unmet mental health needs of this population. Policy makers in case study states identified three components for promoting cooperative relationships among agencies:

(1) Agencies have opportunities to convene and partner via formal or informal structures.

(2) Each agency understands its role in meeting the health needs of juvenile justice-involved youth.

(3) States have mechanisms to learn about system inefficiencies, fragmentation, and duplication, as well as opportunities for improving coordination.

Several of the case study states have put policies into place to address inter-agency collaboration. Both Louisiana and Washington have taken action to promote this collaboration to better meet the needs of juvenile justice-involved youth.

Louisiana

With passage of the Juvenile Justice Reform Act of 2003, the Louisiana legislature mandated improved coordination among agencies that serve youth and families involved in the juvenile justice system, including the Department of Health and Hospitals (which includes Medicaid and mental health) and the

Department of Corrections.[70] The legislation called for these departments to cooperate by creating interagency agreements to facilitate data sharing about juvenile justice-involved youth and families. It also created a Juvenile Justice Implementation Commission to execute and report on the elements of system reform, including developing a proposal for a single state entity for children by integrating components of existing departments. Additionally, the legislation re-established the Children's Cabinet to coordinate policies and programs for children across the state, with an added emphasis on juvenile justice. For example, the original legislation required the Cabinet to review and submit recommendations for the children's budget based on estimated service delivery costs and goals across the various departments serving children, youth, and families.[71] Interviewees cited this reform legislation as an impetus for change and believe it promotes shared responsibility among key agencies for improving the welfare of juvenile justice-involved youth.

Washington

Washington has undertaken collaboration in two ways. The Children's Mental Health Initiative – a collaboration between the Department of Social and Health Services, the Juvenile Rehabilitation Administration, and the Health and Recovery/ Mental Health Division – was established in 2004 to create a joint/shared mission around the delivery of children's mental health services. The Initiative introduced and expanded the use of evidence based practices; used blended and braided funding for high-intensity services for youth with complex needs; and involved families, stakeholders, minority communities, and native tribes to contribute to the decision making process.[72]

In 2007 the state followed up on the Children's Mental Health Initiative and enacted a law to implement a mental health system for children that prioritizes early identification, intervention, and prevention; family involvement; cultural sensitivity; community-based services; and coordination of existing programs and funding.[73] The law explicitly references Medicaid-eligible, juvenile justice-involved youth. It calls for the Department of Social and Health Services to expedite delivery for youth exiting the juvenile justice system by creating procedures to coordinate efforts between its field offices, Juvenile Rehabilitation Administration institutions, and county juvenile courts. Interviewees noted that this law drew attention to the importance of meeting the mental health needs of all children, including those involved with the juvenile justice system. In doing so it elevated the status of the working relationship between state agencies. As a result, interviewees believe daily operations and communication across agencies have improved.

Summary

Juvenile justice, mental health and Medicaid agencies have overlapping missions and often serve the same populations. These agencies also have a shared interest in meeting the health needs of youth in the juvenile justice system. Interviews with officials in five states and a review of relevant research uncovered several barriers to addressing the health needs of juvenile-justice involved youth:

- State officials are not always familiar with existing policies at different levels within their own departments or sister agencies that serve juvenile justice-involved youth.
- In some cases, existing policies and processes complicate or delay Medicaid eligibility for juvenile justice-involved youth (such as termination of Medicaid eligibility for youth upon entry into the juvenile justice system).
- Medicaid service delivery requirements – such as prior authorization and provider certification – are not always clear to, and therefore not followed by, those within the juvenile justice system.

This report uncovered strategies that states can use to address the aforementioned challenges.

(1) Improve inter- and intra-agency knowledge of how Medicaid and juvenile justice systems do (or should) work together. For example, states can:

- Create or use umbrella entities to maximize understanding of blended funding and care coordination approaches.
- Implement training programs or demonstration projects across agencies and court jurisdictions to broaden understanding of Medicaid eligibility and billing procedures.

(2) Improve eligibility policy and processes to ensure that Medicaid eligible children participate in the program. States can:

- Implement continuous and/or presumptive Medicaid eligibility for children and put in place policies to expedite Medicaid eligibility determination for youths exiting secure facilities.
- Create care coordinators and/or liaisons between secure facilities, community based placements, and Medicaid field offices.
- Establish interagency agreements and/or memoranda of understanding to clarify each agency's responsibility in the eligibility process.

(3) Improve service coverage policies to ensure that Medicaid beneficiaries in the juvenile justice system receive the services for which they qualify. States can:

- Cover clinical services, such as Multi-Systemic Therapy, that have been shown to be effective for achieving juvenile justice system goals under Medicaid when medically necessary.
- Cover under Medicaid those services that promote early identification of health needs, such as behavioral health or substance abuse screening.
- Maintain provider continuity as children move among systems.
- Include those responsible for providing physical and behavioral health care in care planning activities led by juvenile justice system staff, as well as juvenile justice case managers, in care planning for physical and behavioral health care services.

(4) Foster agency collaboration. States can:

- Create formal or informal structures for partnerships, such as legislatively mandated multi-agency collaborative bodies or interdepartmental task forces.
- Ensure each agency understands its role in meeting the health needs of juvenile justice-involved youth.

Notes

1 Throughout this paper, the terms "youth" and "children" are used interchangeably. It is important to note that typically the juvenile justice system uses "youth," whereas Medicaid uses the term "children." Please note: under Medicaid, children are individuals under the age of 21. The age at which youth come under the jurisdiction of the adult criminal justice system rather than the juvenile justice system varies by state and by circumstances. See Christopher Hartney. "Youth Under Age 18 in the Criminal Justice System." National Council on Crime and Delinquency (June 2006), 2. Retrieved 11 November 2008. http://www.nccd-crc.org/nccd/pubs/2006may_factsheet_youthadult.pdf.

2 Throughout this report, "juvenile justice-involved youth" refers to youth involved with any level of the juvenile justice system, from arrest and pre-adjudication to probation or commitment to facilities ranging from secure institutions to community group homes, and post-commitment or parole. For detailed discussion about the transition points in the juvenile justice system, see Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Portland, ME: National Academy for State Health Policy, July 2008), 12-15.

3 Howard Snyder and Melissa Sickmund, *Juvenile Offenders and Victims: 2006 National Report* (Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2006).

4 Office of Juvenile Justice and Delinquency Prevention. "OJJDP Statistical Briefing Book." (December 13, 2007) OJJDP. Retrieved 21 April 2008. http://ojjdp.ncjrs.org/ojstatbb/crime/JAR_Display.asp?ID=qa05200.

5 Karen Clark and Shelly Gehshan, *Meeting the Health Needs of Youth Involved in the Juvenile Justice System* (Washington, D.C.: Joint Center for Political and Economic Studies, 2007), 1.

6 See U.S. House of Representatives Committee on Government Reform—Minority Staff Special Investigation Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States*, July 2004. http://oversight.house.gov/documents/20040817121901-25170.pdf and Cornelia Ashby, *Child Welfare and Juvenile Justice: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services* (Washington, D.C.: U.S. General Accounting Office, 2003), GAO-03-865T.

7 Jennie Shufelt and Joseph Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study* (Delmar, NY: National Center for Mental Health and Juvenile Justice, 2006), 5.

8 See the following publications: Ravindra A. Gupta et al., "Delinquent Youth in Corrections: Medicaid and Reentry Into the Community" *Pediatrics* 115, no. 4 (April 2005): 1077-1083. Ronald Feinstein et al., "Medical Status of Adolescents at Time of Admission to a Juvenile Detention Center," *Journal of Adolescent Health* 22, no. 3 (1998): 190-196.; and Mana Golzari, Stephen Hunt, and Arash Anoshiravani, "The Health Status of Youth in Juvenile Detention Facilities." *Journal of Adolescent Health*. 38, no. 6 (June 2006):776-82.

9 Ronald Feinstein et al., "Medical Status of Adolescents at Time of Admission to a Juvenile Detention Center"

10 Personal communication with Stephen Phillippi of the Louisiana University Health Sciences Center.

11 To learn more about *Models for Change*, visit http://www.modelsforchange.net/.

12 Information about additional NASHP *Models for Change* publications are available online at www.nashp.org.

13 The *Models for Change* states' work also consists of "Strategic Opportunities for Technical Assistance"—these are additional priority areas focusing on Multi-System Coordination and Collaboration and Juvenile Indigent Representation.

14 42 USC § 5601. The Act has been reauthorized numerous times, including 2002. A reauthorization bill (S.3155) was introduced in June 2008; after approval by the Senate Judiciary Committee, the bill was placed on the Senate Legislative Calendar in September 2008. See Thomas.loc.gov for additional information.

15 Howard Snyder and Melissa Sickmund, *Juvenile Offenders and Victims: 2006 National Report*.

16 Ibid.

17 42 USC § 14141(a) and U.S. Department of Justice, Civil Rights Division, *Investigation of the Scioto Juvenile Correctional Facility*, Delaware, Ohio, May 9, 2007. This letter finds "the constitution requires that youth in juvenile justice institutions receive adequate mental health care," as cited by Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth*.

18 Unless otherwise noted, all information in this section is from Melanie King, "Guide to the State Juvenile Justice Profiles" *Technical Assistance to the Juvenile Court: Special Project Bulletin* (Pittsburgh, PA: National Center for Juvenile Justice, April 2006). Retrieved 17 October 2008. http://ncjj.servehttp.com/NCJJWebsite/pdf/taspecialbulletinstateprofiles.pdf.

19 National Center for Juvenile Justice. "Glossary." *State Juvenile Justice Profiles*. 2006. Retrieved 17 October 2008. http://www.ncjj.org/stateprofiles/asp/glossary.asp.

20 To learn how a particular state's juvenile justice system is organized, visit the National Center for Juvenile Justice's State Juvenile Justice Profiles at http://www.ncjj.org/stateprofiles.

21 42 U.S.C. 201. See United States Department of Health and Human Services. "Public Health Service." Retrieved 28 October 2008. http://www.os.dhhs.gov/about/opdivs/phs.html.

22 For more information visit http://www.mentalhealthcommission.gov.

23 Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Mental Health Service Use among Youths Aged 12 to 17: 2005 and 2006*. (Rockville, MD: SAMHSA, September 2008). Retrieved 28 October 2008. http://www.oas.samhsa.gov/2k8/MHyouthTX/MHyouthTX.htm.

24 Ibid.

25 For more information, see Centers for Medicare and Medicaid Services. "Medicaid Program – General Information: Technical Summary." Retrieved 28 October 2008. http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage.

26 Kaiser Commission on Medicaid and the Uninsured. *Health Coverage for Low-Income Children*. (Washington, DC: Kaiser Family Foundation, January 2007), 1. Retrieved 28 October 2008. http://www.kff.org/uninsured/upload/2144-05.pdf.

27 Neva Kaye, Jennifer May, and Andy Snyder, *New Opportunities and Continuing Challenges: A Report from the NASHP EPSDT Forum* (Portland, ME: National Academy for State Health Policy, 2008), 2.

28 Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2002), 60-61. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14260. Different rules apply to Medicaid for adults; states have more flexibility in terms of covered benefits and medical necessity definitions for adults. See pages 60-65 of The Medicaid Resource Book.

29 For FY 2009, the FMAP range is 50% to 75.84%. See April Grady, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*. CRS Report RL32950. (Washington, D.C.: Congressional Research Service, January 24, 2008). Retrieved 18 October 2008. lhttp://aging.senate.gov/crs/medicaid6.pdf.

30 Social Security Act § 1905(a)(28)(A). As amended and related enactments through January 1, 2007. An inmate is one "serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities." 42 C.F.R. 441.33(a)(1), 435.1008(a)(1).

31 For more information, see Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth*.

32 See 42 CFR § 435.1009 and 42 CFR § 435.1010.

33 Ibid.

34 Ibid.

35 Letter from Jane Perkins, National Health Law Program to the National Association of Protection and Advocacy Systems. August 31, 2003; referencing a letter from Mary Jean Duckett, Director, CMS Division of Benefits, Coverage and Payment, to Mr. Robert J. Raubach, Georgia Advocacy Office, September 29, 1999.

36 Under the regulations, a youth is in a "public institution for a temporary period pending other arrangements appropriate to his needs," he is not considered an inmate of a public institution, and federal Medicaid funds are available. 42 CFR § 435.1010. See definition of inmate of public institution, Section b.

37 For a full discussion of the detention issue, see Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth*.

38 For more information, see Dan Belnap, *A Medicaid Primer for Juvenile Justice Officials* (Portland, ME: National Academy for State Health Policy, April 2008).

39 Finance, Systems, and Budget Group of the Centers for Medicare & Medicaid Services. *2006 Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2006*. (Washington, D.C.: U.S. Department of Health and Human Services, 2006), 1. Retrieved 28 October 2008. http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf.

40 Kaiser Commission on Medicaid and the Uninsured. *Health Coverage for Low-Income Children*.

41 Finance, Systems, and Budget Group of the Centers for Medicare & Medicaid Services. *2006 Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2006*, 4. AK and WY are the two states that did not participate in Medicaid managed care.

42 Neva Kaye, Jennifer May, and Andy Snyder, *New Opportunities and Continuing Challenges: A Report from the NASHP EPSDT Forum*, 6.

43 Alison Evans Cuellar et al., "Medicaid Insurance Policy for Youths Involved in the Criminal Justice System." *Am J Public Health*. 95, no. 10 (October 2005): 1707–1711.

44 In the field of health care, evidence-based practices or EBPs, typically refer to prevention or treatment approaches that are grounded in "documented scientific evidence" rather than tradition or anecdotal evidence; what is considered to be 'evidence' varies. See SAMHSA's National Registry of Evidence-based Programs and Practices. What is Evidence-Based? Retrieved 11 November 2008. http://www.nrepp.samhsa.gov/about-evidence.asp.

45 Alison Evans Cuellar et al., "Medicaid Insurance Policy for Youths Involved in the Criminal Justice System."

46 Ibid.

47 Bureau of Interagency Coordination. Illinois Department of Healthcare and Family Services. Retrieved 12 November 2008. http://www.hfs.illinois.gov/providerprograms/factsheet.html. The Medicaid Matching Fund Program enables the county court offices to use federal dollars for residential mental health services delivered under the Medicaid Rehabilitation Option and rendered by Department of Children and Family Services (DCFS) contracted facilities.

48 Louisiana Legislature. *Children and Youth Planning Boards Act*. Act 555 of 2004. Retrieved 17 October 2008. http://www.laomhlegacy.org/legis/HB1363.pdf.

49 All information in this section is from phone interviews of Washington Department of Social and Health Services Children policy makers by Jennifer May and Carrie Hanlon, March 2008, and phone interview with a policy maker from the Center for Children and Youth Justice by Jennifer May and Carrie Hanlon, April 2008.

50 A formal agreement between King County Superior Court and Washington State DSHS/Health Recovery Services Administration defines each party's responsibilities for specified Medicaid administrative services. An Administrative Match Agreement provides partial federal reimbursement to entities for performing administrative activities that support the goals of the Medicaid state plan.

51 Due to a state moratorium on new contracts, King County Superior Court is the only Court in the state with a Medicaid Administrative Match (MAM) contract.

52 New Mexico Children, Youth, and Families Department, "New Mexico Child Welfare Information System Third in the Nation to Fulfill Obligation and Receive Federal Approval: Computer Application Streamlines Receipt of $1.6 Annually to New Mexico," August 10, 2007. Retrieved 20 October 2008. http://www.cyfd.org/news_releases/SACWIS%20PS%20release%20aug07.doc.

53 Alison Evans Cuellar et al., "Medicaid Insurance Policy for Youths Involved in the Criminal Justice System," 1710.

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60 Community Care Community Health Behavioral Organization. "North Central State Option HealthChoices Program: Children and Youth, Juvenile Probation and County Assistance Office Informational Sessions." Retrieved 17 October 2008. http://www.ccbh.com/pdfs/Providers/healthchoices/articles/NC_CAO_JPO_Presentation.pdf.

61 Washington's Juvenile Rehabilitation Administration (JRA) is within the umbrella social service agency, the Department of Social and Health Services (DSHS). The organization mission is to protect the public; hold juvenile offenders accountable for their crimes; and reduce criminal behavior through a continuum of preventive, rehabilitative, and transition programs in residential and community settings. For more information visit the JRA Home Page at http://www1.dshs.wa.gov/jra/.

62 "Multi-systemic therapy (MST) provides an intensive home/family and community-based treatment for individuals who are at risk of out-of-home placement or are returning home from placement and their families. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services include an initial assessment to identify the focus of the MST interventions to be used with the individual and family. Specialized therapeutic and rehabilitative interventions are available to address specific areas of need such as substance abuse, delinquency, violent behavior etc. Services are primarily provided in the home, but workers also intervene at school and in other community settings." Source: "New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines: Multi-systemic Therapy for Juveniles, per 15 Minutes." February 15, 2006. Retrieved 17 October 2008. http://www.bhc.state.nm.us/pdf/H2033MSTfinal021506.pdf.

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64 New Mexico Interagency Behavioral Health Collaborative. "Request for Proposals for Statewide Entity." RFP# 09-630-7903-0001. August 8, 2008. Retrieved 17 October 2008. http://www.bhc.state.nm.us/pdf/RFP2008/BHC_RFP8-7-08v2.pdf.

65 For more information see Juvenile Justice and Delinquency Prevention Committee (on behalf of The Pennsylvania Commission on Crime and Delinquency). *Pennsylvania Juvenile Justice and Delinquency Plan: Update*. (Harrisburg, PA: Commonwealth of Pennsylvania, March 2006), 22-23. Retrieved 17 October 2008. http://www.ncjj.org/stateprofiles/profiles/PAfullreport.pdf.

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68 For additional information, see also Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth*, 26.

69 U.S. House of Representatives Committee on Government Reform – Minority Staff Special Investigation Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States*.

70 See Louisiana Legislature, *Juvenile Justice Reform Act of 2003*. Act 1225. House Bill No. 2018. http://www.legis.state.la.us/leg_docs/03RS/CVT10/OUT/0000KTKP.PDF and Juvenile Justice Project of Louisiana, "Act 1225, The Juvenile Justice Reform Act of 2003: A Summary." Retrieved September 23, 2008. http://www.jjpl.org/PDF/Act_1225_summary.doc.

71 According to interviewees, the children's budget consists of money identified by various agencies serving children that the agencies can dedicate to address current cabinet priorities or initiatives, such as mental health and early intervention.

72 For more information on the Washington Children's Mental Health Initiative, see Washington State Department of Social and Health Research & Data Analysis Division, "Washington Children's Mental Health Initiative" April 1, 2005. Retrieved 4 November 2008. http://www1.dshs.wa.gov/pdf/ca/MHInitiativeStrat1.pdf.

73 Revised Code of Washington, sec. 71.36.060. House Bill 1088. Chapter 359, Laws of 2007.

Appendix: Interview Protocol

1. What is your state doing to promote/improve access to Medicaid services for youth in the juvenile justice system (but not in a secure facility)? How is that working?

    (a) What is your state's intake process and does it include questions about health insurance status? *(for juvenile justice officials only)*

    (b) When a child enters the juvenile justice system, at which point is their eligibility terminated/suspended?

2. What is happening in your state to facilitate access to Medicaid eligibility for potential beneficiaries exiting a secure facility?

3. Do you have any specialized managed care programs or special provisions within your contracts that are relevant to the needs of children in the juvenile justice system?

4. What barriers to using Medicaid for the health and mental health needs of kids in the system exist in your state? What would help to remove them?

5. What is the status of the working relationship between juvenile justice officials and Medicaid officials in your state? Or, how would you describe the working relationship between Medicaid and juvenile justice systems in your state?

6. In your opinion, what are opportunities and/or state policy improvements that would in effect promote a more collaborative working relationship between Medicaid and the juvenile justice systems, particularly around accessing and funding court ordered services for juvenile justice-involved youth?

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