ModelsforChange
Systems Reform in Juvenile Justice

Innovation Brief

Facilitating Health Care Coverage for Juvenile Justice-Involved Youth

As states and juvenile justice stakeholders work to facilitate health coverage and access for system-involved youth, they can draw upon the experiences of their counterparts across the country to improve eligibility, enrollment, and outreach processes. Medicaid eligibility strategies in several states have already facilitated seamless coverage for juvenile justice-involved youth, and consumer assistance programs created by the Affordable Care Act (ACA) will provide additional resources to support continuity of care. Collaboration among Medicaid and juvenile justice systems and stakeholders will be essential to fully realizing the opportunities presented by health care reform.

The Issue

Youth involved in the juvenile justice system have extensive physical and behavior health needs. The majority have at least one mental health condition[1] and substance abuse is also very common.[2] Findings from a study of youth in residential settings found that two-thirds of youth in custody have a healthcare need.[3] Youth in the juvenile justice system remain at risk for fragmented care and supports and poor transitions from one placement setting to another.

Significant numbers of system-involved youth depend on Medicaid coverage.[4] But as youth move through the juvenile justice system, there are many chances for them to lose their eligibility for Medicaid coverage. This is because Medicaid law does not allow for payment of services in certain settings. Federal law forbids Medicaid funding for services for individuals who are inmates of a public institution (except as a patient in a medical institution).[5]

Innovations

MEDICAID ELIGIBILITY OPTIONS Some states have established policies that allow youth to quickly and easily enroll into Medicaid while they are still in an institution and preparing for discharge, so that by the time they leave, they are enrolled and able to access services the day they are released. These policies include suspending eligibility rather than terminating it, continuous eligibility, and presumptive eligibility.

Suspending eligibility Suspending Medicaid eligibility allows a state to restore Medicaid benefits relatively easily—and allows the youth to quickly access services upon release. Although suspension still requires a Medicaid agency to re-determine eligibility prior to activating the youth's enrollment, it can reduce the burden on the youth and family of reapplying for coverage.

Oregon The Oregon Youth Authority, the agency responsible for youth corrections, notifies the Oregon Health Authority (OHA) when a youth on medical assistance is incarcerated. Medical benefits are suspended and the case is coded to indicate the youth is still eligible if released within a year from the date of incarceration.

Parents of youth leaving facilities who were enrolled in Medicaid when they initially entered receive a notice stating that OHA will reinstate the youth's benefits if the parent comes to the benefits office within 10 days after the child returns home.

Ohio The state's Medicaid agency, the Office of Medical Assistance (OMA) is notified of youth in the custody of the Department of Youth Services (DYS) who are Medicaid eligible at the time of their incarceration and who are expected to be incarcerated for less than 12 months. OMA is responsible for determining the eligibility of youth incarcerated or awaiting adjudication in a DYS facility and can suspend and then restore Medicaid benefits for these youth upon release.

Continuous eligibility Continuous eligibility is a Medicaid policy option that allows children to maintain Medicaid or CHIP coverage for up to one year, even if the youth's family has a change in circumstance, such as in income or family status. Adopting a continuous eligibility policy is a win for both the youth/family and the state: Children can maintain health coverage and the state is able to minimize administrative burden and paperwork. As of January 2012, 23 state Medicaid programs and 28 CHIP programs have implemented this option.

Presumptive eligibility Presumptive eligibility is an optional state Medicaid policy that allows qualified entities to determine, based on a simplified calculation of family income, whether an individual is likely to be eligible for the program. Youth can receive temporary eligibility pending a final determination by the Medicaid agency. States can deem agencies that provide services, such as juvenile justice agencies, as qualified entities. In 2009, at least one state allowed juvenile justice agency staff to make Medicaid presumptive eligibility determinations for juvenile justice-involved youth.[6]

EXPEDITED MEDICAID ENROLLMENT In a survey the National Academy for State Health Policy fielded to juvenile justice and Medicaid agencies in 2009 under its *Models for Change* project, most responding juvenile justice agencies reported they had special procedures to facilitate Medicaid enrollment for youth transitioning from the juvenile justice system.[7] The strongest procedures employ a formal process for juvenile justice agency staff to fill out Medicaid applications within a specified timeframe for every youth leaving custody.

Oregon The Oregon Youth Authority (OYA) and the Oregon Health Authority (OHA) entered into an Interagency Agreement to facilitate seamless medical coverage for juvenile justice-involved youth. The OHA places a Medical Eligibility Specialist in the central OYA office. As an OHA employee, this out-stationed worker can access Medicaid enrollment files and make real time eligibility determinations for youth as they move in and out of OYA custody as well as coordinate other benefits, such as SNAP and TANF.

Washington As part of reentry planning, Juvenile Rehabilitation Administration (JRA) residential case managers and county detention facilities screen youth for Medicaid eligibility 45 days prior to release. Youth who are likely to be eligible are referred to the Economic Services Administration (ESA) for further Medicaid eligibility determination. The agency verifies and collects any additional required information needed for the application process, such as the number of people living in the household. The ESA expedites and either approves or denies the applications.

Colorado In 2008, Colorado enacted legislation to require facility personnel to assist youth leaving detention facilities to apply for Medicaid or the Children's Basic Health Plan (CBHP) benefits prior to their release.[8] The facility screens youth who will be released within the next 120 days, and identifies those who were on Medicaid or CBHP prior to incarceration. If the youth was not on Medicaid or CBHP, but is identified to be potentially eligible, the caseworker completes an application. By the time individuals leave the facility, they have a Medicaid or CBHP card and may begin accessing services immediately upon release.

Texas Legislation enacted in 2009 requires the Texas Health and Human Services Commission (HHSC) to ensure that youth in both secure and non-secure facilities are assessed for Medicaid eligibility before they are released. Forty-five days prior to a youth's release from a facility or residential placement, local juvenile justice staff provide information about the youth to the HHSC Centralized Benefit Services Unit via an online database. HHSC staff determine whether the youth has an active Medicaid file or if a new application must be completed.

OUTREACH Existing outreach initiatives for public coverage often focus on the entire family and young children. Below are a few distinct examples of outreach initiatives targeted to adolescents. Together, state Medicaid and juvenile justice agencies could adapt them to reach youth involved in the juvenile justice system, tailoring the venues and the messages.

Virginia The Virginia CHIP agency, Family Access to Medical Insurance Security (FAMIS), developed a teen-centered logo for outreach materials featuring a teenage enrollee to get the word out about eligibility and enrollment in health programs. The material's content and image were market-tested to achieve resonance with the target population. FAMIS has also partnered with the education system to designate one week a year for delivering a curriculum on health insurance. The state launched Facebook and Twitter accounts and dedicated a page on its web site to teens, designed using input from focus group participants.

New York In July 2013, the Osborne Association of New York was awarded a CHIPRA Cycle lll Outreach and Enrollment Grant from CMS to provide targeted outreach to youth involved in the justice system. The $800,000 award will support outreach to children with incarcerated parents who are identified in prison/jail visiting areas or through other family support programs, and youth leaving juvenile detention.[9] Peer Patient Navigators, trained by New York City Department of Mental Health and Hygiene staff, will assist eligible youth and their families enroll and retain Medicaid or CHIP coverage.

Oklahoma The Oklahoma Health Care Authority (OHCA) is using CHIPRA outreach grant funds to support SoonerEnroll, which aims to enroll the approximately 60,000 uninsured Oklahoma children who are eligible but not enrolled in the state's Medicaid program.[10] Over 750 public and nonprofit partner organizations such as Head Start, YMCAs, public schools, and community action agencies provide on-the-ground outreach, education, and application assistance. The OHCA gives SoonerEnroll partners technical and informational supports but does not provide funding for their outreach activities. Four regional outreach coordinators housed within local organizations work to build capacity for sustained community outreach.

Lessons

States can adopt eligibility options that provide for health coverage immediately upon a youth's discharge from a juvenile justice facility. Making changes to eligibility policy has been difficult for states given the modifications required in eligibility technology systems. Many Medicaid agencies are, however, currently revamping their entire information technology systems to implement the eligibility changes required by the ACA. Thus, it is an opportune time for states to adopt specific eligibility policies that improve access to health coverage for juvenile justice-involved youth.

Collaboration between Medicaid agencies and juvenile justice agencies is key to implementing these eligibility policies. Formal processes for juvenile justice agency staff to complete Medicaid applications for youth being discharged from facilities and for Medicaid agencies to designate expedited pathways for acting on them can enhance seamless transitions in coverage.

Partnerships between Medicaid agencies and entities that have prominence and trust in the lives of juvenile justice-involved youth and their families, such as community-based organizations, juvenile justice agencies, and probation officers and other elements of the court are essential to effective enrollment outreach. Also effective are outreach conducted at targeted events such as health fairs, school-sponsored activities and sports, and similar venues that

interact with youth in a direct and personal manner. Messages likely to resonate with families may reflect the challenges they face in accessing needed medications and treatments for their juvenile justice-involved youth.

Looking Forward

The ACA provides a new vehicle for individuals to obtain publicly supported health insurance—exchanges—where individuals and families can purchase federally subsidized health insurance. Medicaid agencies, CHIP programs and exchanges are required to screen for and determine eligibility for each other's publicly supported coverage options, thus establishing a no wrong door that allows individuals to enroll in health coverage programs through a single process. Eligibility for these health coverage options is based on income, making it likely that some individuals will transition back and forth between eligibility for Medicaid and exchange plans. Because of complex family situations, juvenile justice-involved youth and their families may be more likely than others to experience transitions and potential gaps in coverage.

Besides the exchange websites, the ACA established three consumer assistance programs to provide support to families eligible for Medicaid, CHIP, and coverage in the exchanges: navigators, in-person assisters, and certified application counselors. [11] These types of one-on-one assistance will be vital for families enrolling in coverage. Organizations that interact with juvenile justice-involved youth and their families can connect with these new assisters to help facilitate enrollment and smooth transitions in health coverage from one program to another. Assisters in states and communities can be found at localhealth.healthcare.gov.

Resources

Carla I. Plaza, *Lessons Learned from Children's Coverage Programs: Outreach, Marketing and Enrollment* (Washington, DC: National Academy for State Health Policy, August 2012). http://www.nashp.org/sites/default/files/outreach.lessons.children.pdf

Sarabeth Zemel and Neva Kaye, *Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System: Inter-Agency Collaboration* (Portland, ME: National Academy for State Health Policy, September 2009). http://www.nashp.org/sites/default/files/JuvJust.pdf

Sarabeth Zemel and Neva Kaye, *Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System* (Portland, ME: National Academy for State Health Policy, December 2009). www.nashp.org/sites/default/files/MacFound11-09.pdf

[1] Jennie Schufelt 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), 2. Available at http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf.

[2] Mana Golzari, Stephen Hunt, Arash Anoshiravani, "The Health Status of Youth in Juvenile Detention Facilities," *Journal of Adolescent Health* 28 (2006): 776-782.

[3] Andrea J. Sedlak and Karla S. McPherson, *OJJDP Juvenile Justice Bulletin*, April 2011, 5. Available at http://www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf.

[4] Sarabeth Zemel and Neva Kaye, *Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System: Inter-Agency Collaboration* (Portland, ME: National Academy for State Health Policy, September 2009).

[5] Social Security Act § 1905(a)(28)(A).

[6] New Mexico reported using juvenile justice agents to presumptively determine eligibility for Medicaid. Sarabeth Zemel and Neva Kaye, *Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System* (Portland, ME: National Academy for State Health Policy, December 2009).

[7] Sarabeth Zemel and Neva Kaye, *Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System* (Portland, ME: National Academy for State Health Policy, December 2009).

[8] Colorado House Bill 08-1046.

[9] Centers for Medicare & Medicaid Services. "Connecting Kids to Coverage Outreach and Enrollment Grants." Retrieved August 19, 2013. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-02.html

[10] Oklahoma Health Care Authority. "Community Relations." Retrieved August 19, 2013. https://www.okhca.org/individuals.aspx?id=14577.

[11] Katie Baudouin, Christina Miller, and Rachel Dolan, *Designing Consumer Programs: Resources from the Field* (Washington, DC: State Health Reform Assistance Network, February 2013), available at: http://www.statenetwork.org/resource/designing-consumer-assistance-programs-resources-from-the-field/.

Prepared by the National Academy for State Health Policy.
Authors: Sarabeth Zemel, Kimm Mooney, Diane Justice.

This brief is one in a series describing new knowledge and innovations emerging from *Models for Change*, a multi-state juvenile justice reform initiative. *Models for Change* is accelerating movement toward a more effective, fair, and developmentally sound juvenile justice system by creating replicable models that protect community safety, use resources wisely, and improve outcomes for youths. The briefs are intended to inform professionals in juvenile justice and related fields, and to contribute to a new national wave of juvenile justice reform.