

Medicaid for Juvenile Justice-Involved Children

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Medicaid for Juvenile Justice-Involved Children

Juvenile Justice Guide Book for Legislators



Introduction

Medicaid can help meet the unique health needs of juvenile justice-involved youth. Youth involved with juvenile justice systems often have significant, sometimes costly, health needs, in part because they may not have received regular or continuous medical care. Although data are incomplete and vary by state, evidence suggests that a high percentage of youth who are involved with the juvenile justice system are Medicaid-eligible.

This group also is inherently high-risk, usually across multiple indicators. For instance, many of them are truant or doing poorly in school, lack caring adults or a positive sense of community, and come from families with very low incomes. A 2010 Grantmakers in Health report, *Health Care for People Involved in the Juvenile Justice System*, sums it up this way: “[Juvenile offenders] often have a family background that includes abuse or neglect, unmet mental health and substance abuse needs, low family income, a limited or uneven history with the health care system, and probable eligibility for public insurance programs... In fact, many young people in contact with the juvenile justice system are also in contact with several other public systems, such as Medicaid, special education programs, foster care, or child protective services.”

The vast majority of young people who come into contact with the system are not incarcerated and remain eligible for publicly funded health insurance; therefore, this contact may offer states the chance to enroll vulnerable young people in Medicaid and put them on a path to well-being. The Office of Juvenile Justice and Delinquency Prevention’s 2010 Survey of Youth in Residential Placement found that two-thirds of youth reported a need for health care (e.g., dental, vision, hearing, illness, injury), but more than one-third said one or more of their health care needs were not addressed.





Compliance with Federal Reimbursement Regulations

It is important to note the difference between juvenile justice-involved youth and youth who are incarcerated. The setting or placement a young person is remanded to, if he or she is adjudicated delinquent, will affect which state agency pays for health care. Federal Medicaid dollars cannot be used to reimburse “care or services for any individual who is an inmate of a public institution.” A public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that serves no more than 16

residents, or a childcare institution for children who receive foster care or foster care payments.

Many more young people come into contact with the juvenile system than are actually incarcerated, which gives states an opportunity to enroll those who are eligible in public insurance programs. In 2008, 2.11 million people under age 18 were arrested, but a census in the same year showed that only 81,000 juvenile offenders were incarcerated.



Medicaid Overview

Medicaid, a state-federal partnership created by Congress in 1965, provides health care coverage to specific groups of low-income people. Participation in the program is optional, but all 50 states, the District of Columbia and the territories choose to do so. The states administer their Medicaid programs within federal guidelines, and the federal government is obligated to share in the cost. The federal share—called federal medical assistance percentage (FMAP)—ranges from 50 percent to around 75 percent of program costs and is based on a formula that is tied to the state's per capita income. Medicaid is an entitlement program, which means any person who is eligible based on minimum federal requirements must receive benefits; therefore, states cannot limit the number of people who enroll.

More than half of all Medicaid beneficiaries are children. Recent changes by the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 will require Medicaid programs to cover everyone, including children ages 6 to 18, in families with incomes up to 133 percent of federal poverty guidelines (\$24,352 for a family of three in 2009). States are not required to expand Medicaid until 2014, but some have chosen to do so early. The Children's Health Insurance Program also provides health insurance to some young people whose family incomes are too high to qualify for Medicaid but who are unable to afford or cannot access the private insurance market. Between these two programs, children in families with incomes at or above 250 percent of federal poverty guidelines (\$45,775 for a family of three in 2009) in 24 states

and the District of Columbia may qualify for public health insurance coverage.

Because income requirements can vary not only by state but also within states based on the age of the child, it is important that people working with vulnerable populations clearly communicate with young people and their families information about programs for which they may be eligible. Children within the same family may be eligible for different programs.

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Most young people qualify for Medicaid based on their family's income, but states also must cover “categorically eligible” youth who qualify under Title IV-E of the Social Security Act, including foster care children, adoption assistance children and some children with disabilities. States have the flexibility to expand coverage to young people with higher family incomes or, in some cases, outside traditional eligibility groups, and many have done so. Under the PPACA, beginning in 2014, states also must provide Medicaid coverage to young people up to age 26 who age out of the foster care system, regardless of their income.



Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) provides health care coverage for low-income children whose family incomes are too high to qualify for Medicaid. States receive an enhanced federal match for services provided through CHIP as an incentive to offer coverage. This federal match will increase 23 percentage points, subject to a 100 percent cap, between 2016 and 2019 under the PPACA, but states must maintain the income eligibility levels and enrollment procedures in place as of March 2010. States are allowed to limit enrollment and implement waiting lists to stay within budgetary limits.

Services Covered by Public Health Insurance Programs

Together, Medicaid and CHIP provided health care coverage to 40 million young people in FY 2009. Federal law requires that public insurance benefits for children be comprehensive. Under Medicaid, patients up to age 21 (and former foster children up to age 26 beginning in 2014) receive early and periodic screening, diagnostic and treatment (EPSDT) services, including vision and dental care, inpatient and outpatient hospital services, laboratory and x-ray

services, and more. If screenings show that children need follow-up services, federal regulations require Medicaid programs to "...correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

It is important that staff who are enrolling juvenile justice-involved youth understand the specifics about the state's Medicaid and CHIP programs, since young people may fall into a number of eligibility categories.

Mental Health

Some estimate that 69 percent of males and 81 percent of females in the juvenile justice system have at least one mental health disorder, and evidence suggests that mental health is the largest unmet health need among these young people. For those with severe mental health disorders (e.g., schizophrenia, bipolar disorder) lapses in health care have devastating effects on their ability to function in the community and may lead to recidivism. OJJDP's survey of Youth in Residential Placement indicates that only 47 percent of youth facilities provide mental health assessments for all residents; 88 percent of youth who receive mental health counseling do not meet with a mental health professional.

Ensuring access to health services through Medicaid can ease youths' transition between incarceration and re-entry into community life. Medicaid covers a broad range of services for children with mental health needs, including treatments to improve a young person's emotional and behavioral

functioning. Medicaid allows these services to be delivered in various community settings, in schools or even in the child's home. Additional services such as therapeutic foster care, services to build a young person's social, communication and life skills, and even education for parents of children with special health care needs are covered. Coordinating the range of services and providers is paramount, however. For young people whose living situations are unstable or whose lives are chaotic, like many who come into contact with the juvenile justice system—navigating multiple complex systems is impossible, especially given that many of them have severe mental health needs. Strategies to coordinate care are addressed later in this chapter. The mental health needs of juvenile offenders are addressed at length in the Mental Health Needs of Juvenile Offenders Chapter of this guidebook.

Substance Abuse

Adolescent substance abusers are more likely to engage in risky or delinquent behaviors that might bring them in contact with the juvenile justice system. According to a 2003 study of nine selected cities by the Arrestee Drug Abuse Monitoring Program (ADAM), approximately half of juvenile male arrestees tested positive for one or more drugs at the time of arrest; marijuana was most common.

According to the National Center on Addiction and Substance Abuse's 2004 report, *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind*, 78 percent of young people ages 10 to 17 arrested exhibited one or more of the following

characteristics: under the influence of alcohol or drugs while committing their crime, tested positive for drugs, arrested for committing an alcohol or drug offense, admitted having substance abuse and addiction problems, or shared some combination of these and additional drug-related characteristics.

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State Medicaid coverage for substance abuse rehabilitation and/or treatment services varies widely and can be highly complex. Each state's Medicaid agency can answer specific questions about the services it covers.

Reproductive Health

According to the National Center on Addiction and Substance Abuse, in 2007, up to 94 percent of young people held in detention centers have had sexual intercourse, compared to 48 percent of all high school students. Juvenile offenders also may have had many sexual partners and inconsistent or low rates of condom use, putting them at increased risk for sexually transmitted infections (STI). Data suggest that one-third of girls in juvenile justice facilities have been pregnant and one-quarter of young men report

having fathered a child; 40 percent of these have fathered more than one child.

The only time some young people see a health care provider is during their contact with the correctional system. This presents the public health system with an opportunity that frequently is not pursued, according to the 2004 Juvenile Residential Facilities Census. The report said that 19 percent of facilities offered STI testing on admission, and just 4 percent universally tested all youth for HIV. Some centers had no STI testing available.

The same 2004 census revealed that sexual risk-taking behavior commonly co-occurs with alcohol or drug use. Among young women ages 12 to 17 who were arrested in 2002, those who had been pregnant in the last 12 months were one and a half times more likely to have used alcohol or illicit drugs than girls who had not been pregnant.

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However, the census showed that only 18 percent of facilities provided universal pregnancy testing on admission. The data did not specifically address

drug/alcohol use during pregnancy. Serious health consequences for infants and financial implications exist for states when pregnant women use alcohol or drugs.

The National Commission on Correctional Health Care recommends that incarcerated juveniles receive contraception and age-appropriate information about it at an appropriate time prior to discharge, in accordance with local laws. Medicaid programs universally provide family planning services to program enrollees, including minors, and may provide these services once juveniles leave the facility. States are reimbursed for these services at a 90 percent match rate; the federal government pays 90 percent of the cost of family planning services, and the state pays 10 percent. Services generally include physical exams and laboratory tests related to reproduction; patient counseling and education; and contraceptive methods, procedures, devices or pharmaceuticals. Abortion is not federally reimbursable as a family planning service.

State laws vary regarding the necessity of a parent's or guardian's involvement in reproductive health services for minors. According to the Guttmacher Institute, all states and the District of Columbia allow minors to consent to STI services (testing and subsequent treatment for sexually transmitted infections), but only 26 states and the District of Columbia explicitly allow minors to consent to contraceptive services. Research demonstrates that ensuring the confidentiality of reproductive health services for young people greatly enhances the chance they will use them.

Oral Health

Tooth decay is more common in populations overrepresented in the juvenile justice system, including low-income and minority youth. State-level data suggest that unmet oral health needs are prevalent among juvenile justice-involved youth. Among the general population, 68 percent of youth have decayed permanent teeth by age 19. This common chronic illness can lead to pain, weight loss, trouble sleeping, missed school days, poor appearance, decreased self-esteem, and infections that can lead to serious illness and even death.

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Federal law requires Medicaid and CHIP programs to cover comprehensive dental services for children and adolescents. Federal law also allows states to provide dental-only coverage to children who meet the income eligibility requirements for CHIP but have health (but not dental) insurance through another source. Many Medicaid patients are unable to find dentists who accept public insurance, however. Dentists cite administrative burdens and low provider reimbursement rates as primary reasons for refusing Medicaid patients. The PPACA addresses these issues through workforce development programs and mechanisms that allow community health centers to contract with dental providers;

alternative health professionals who can perform basic dental health services; and public health outreach, including educational campaigns and school-based dental sealant programs.

Strategies for Increasing Enrollment of Juvenile Justice-Involved Youth on Public Insurance

Suspend, Rather than Terminate, Eligibility

Federal regulations do not require states to terminate Medicaid enrollment of those who become inmates of a public institution; rather, states have the option to suspend eligibility. This distinction is important, since the average length of incarceration—and ineligibility for Medicaid—for juveniles is only 3.5 months. Suspending rather than terminating enrollment allows young people to more easily return to care. The average processing time for a Medicaid application is 45 to 90 days or longer, but coverage for a young person whose eligibility has been suspended can be reactivated immediately.

According to the National Academy for State Health Policy, some state Medicaid agencies have decided not to suspend eligibility because of technical roadblocks with computerized Medicaid data systems, including the expense required to update the systems to allow a suspension option, and/or because they want to maintain procedural fairness across enrolled populations.

Continuous Eligibility

In states where Medicaid agencies are allowed to suspend incarcerated young people, continuous

eligibility offers a second layer of protection for young people's immediate access to care once they are released. Under continuous eligibility, children enrolled in Medicaid or CHIP are guaranteed coverage for 12 months, regardless of changes in family income. In 2009, 22 states offered this option in their Medicaid programs. Again, since the average length of incarceration for a juvenile is 3.5 months, incarcerated young people might not see a gap in coverage if their Medicaid eligibility is suspended and they live in a state that offers continuous eligibility.

Presumptive Eligibility

Presumptive Eligibility allows patients who are likely eligible for Medicaid or CHIP to apply through a simplified process so that, pending the outcome of their application, they have immediate access to care. This option is most commonly used with pregnant women.

The federal Department of Health and Human Services can approve “qualified entities,” such as a juvenile justice agency, to make a determination of presumptive eligibility. If the person is found ineligible, the state must cover the cost of the services provided under presumptive eligibility.

In 2009, 14 states practiced presumptive eligibility in Medicaid, and 11 use this option on all coverage for children, although the details vary greatly from state to state. It is important that juvenile justice agents know if their state Medicaid program offers this option, since it may help them deal with offenders' immediate health care needs. Examples include young women who are pregnant or people with severe mental health disorders.

Streamline Data Collection

States have various terms for streamlining data collection used to determine Medicaid eligibility, but the core function is to reduce the amount of information—often duplicative—young people and their families must provide to state programs. This process simplification could help any family applying for Medicaid, including justice-involved youth. Alabama, Louisiana and New Jersey use the Express Lane Eligibility Option, which allows Medicaid and CHIP agencies to use information the state already has collected through other programs (e.g., SNAP, formerly food stamps) and income tax records to verify eligibility. Louisiana and 15 other states use administrative renewals, where income verification is performed on behalf of the young person and his or her family, based on information received through other state systems. Twelve states do not require families to verify their incomes with their original application because it can be verified elsewhere. In 36 states, one application is used to determine eligibility for Medicaid or CHIP, and in 25 states, application forms can be filled out online.

Improve Data Sharing Between Medicaid, Juvenile Justice and Child Welfare Agencies

Ensuring that state agencies can communicate with each other and/or have some access to the other's records can provide a more streamlined system where young people have easier access to health care services. According to a survey conducted by the National Academy for State Health Policy, 24 of 29 state juvenile justice agencies polled were able to identify a detainee's Medicaid status through the state Medicaid agency. Conversely, Medicaid

agencies do not have similar ease of access. Of the 25 surveyed, only 12 could identify Medicaid-enrolled youth who were involved with the juvenile justice system. In some states, Medicaid agencies are under pressure to terminate youth who are incarcerated so they are not forced to repay the federal government for any services unlawfully reimbursed; privacy concerns exist for both agencies.

Effective agency coordination might also involve child welfare. Chapin Hall's Midwest Evaluation of the Adult Functioning of Former Foster Youth showed that more than half of their nationally representative sample of young people who were preparing to leave the foster care system had been in contact with the juvenile justice system. Family and/or environmental stress also may make it more difficult for young people to navigate daily life, much less multiple complex state systems. Unmet health needs or chronic conditions can make high-level functioning even more difficult.

Ensuring that staff from both agencies—including judges who sentence juvenile offenders—understand what facilities can house juveniles but allow them to remain eligible for Medicaid can save state resources. Judges who make decisions about child welfare placements also should be privy to health and juvenile records information to ensure that children and families who are in contact with several systems receive the appropriate support.



Data Sharing in California

California law requires juvenile justice agencies to notify the Medicaid agency about an inmate's release date, along with other information that would help the agency determine eligibility. Parents are notified of this process but need not participate unless they want eligibility determination stopped. If inmates are found eligible, they are issued Medi-Cal cards immediately upon release. Special, expedited actions are required for inmates with disabilities.

Train Juvenile Justice Staff to Screen for Eligibility

Under federal Medicaid regulations, funds are available to reimburse non-Medicaid government entities for administrative costs related to identifying and enrolling potentially eligible young people in Medicaid. Since so many of the youth who come in contact with the juvenile justice system are eligible for Medicaid, training agency staff to identify these youth and help them gain benefits at their first point of contact with the system may make the agency eligible for financial incentives. In 2009, \$40 million in federal grants were awarded to a variety of government and nongovernment entities to create public-private partnerships to identify and enroll

eligible children. Further, states now are eligible to receive performance bonuses if they enact simplified outreach and enrollment procedures and reach target enrollment levels. Nine states received performance bonuses in 2009, with a high pay out of \$39 million to Alabama.



Funding Medicaid Programs

Oregon's juvenile justice agency pays the salary of a Medicaid eligibility specialist. Stationed in the agency's central office, the specialist determines eligibility for youth in custody and enrolls or terminates juveniles based on adjudication. South Carolina and Wyoming report shared staff positions in the Medicaid and juvenile justice agencies, further streamlining the screening process and facilitating enrollment.

Texas screens all youth who make contact with the juvenile justice system for Medicaid eligibility, once at arrest and again during the trial process. A probation officer initially gathers the necessary information from the young person and his or her family to determine Medicaid eligibility. The process takes about 10 minutes. The officer then encourages the family to take the collected information to the Medicaid office and apply for benefits. In this instance, siblings or other children in the home may

also be enrolled in Medicaid. If the case requires a hearing, the juvenile justice agency is required to work with the Medicaid office and enroll eligible juveniles. In Texas, 97 percent of juveniles who come into contact with the system are not incarcerated. Those eligible typically gain access to health care through Medicaid quickly as a result of their contact with the system.



Conclusion

Medicaid can help meet the unique needs of juvenile justice-involved youth. For states working toward providing health care for system involved youth, it is important to accurately assess capacity and consider options available to them.

For references and additional resources, please see the **References, Glossary & Resources** section.



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