Service Delivery Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System

by
Sarabeth Zemel
Neva Kaye
National Academy for State Health Policy

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Systems Reform in Juvenile Justice

Prepared by Sarabeth Zemel and Neva Kaye of the National Academy for State Health Policy.

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Portland, Maine Office:
10 Free Street, 2nd Floor
Portland, Maine 04101
Phone: (207) 874-6524
Fax: (207) 874-6527

Washington, DC Office:
1233 20th St., NW, Suite 303
Washington, D.C. 20036
Phone: (202) 903-0101
Fax: (202) 903-2790

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Introduction

More than 90,000 young people are in juvenile justice facilities each day,[1] and more than 2 million youth are arrested every year.[2] The evidence suggests that more than 70 percent of the youth in the juvenile justice system have a mental health and/or substance use disorder, such as disruptive behavior disorders, substance abuse disorders, anxiety and mood disorders.[3] In addition, these youth may also have many physical health needs.

Medicaid can be important to juvenile justice-involved youth both as a way to finance and to access physical and behavioral health services; significant numbers of juvenile justice-involved youth depend on Medicaid coverage.[4] Medicaid and juvenile justice agency policies are important because they impact the services that youth receive while they are in institutional or secure settings, as well as affecting the services youth receive once they return home or to the community. Agency policies can also play a role in ensuring that care and services provided to youth while in the juvenile justice system continue once they transition back to the community. Policies that ensure continuity of care can ultimately improve the lives of these children and increase their ability to remain in the community.

The National Academy for State Health Policy (NASHP) fielded two surveys about health care and Medicaid policies for youth in the juvenile justice system. This paper is the last of three briefings containing survey findings. In this paper, we report survey findings relating to Medicaid and juvenile justice agency policies around financing services and ensuring youth receive continuous care as they transition from an institution or leave the juvenile justice system entirely. These survey findings are presented in two major categories:

1. Findings regarding how states pay for services for youth involved in the juvenile justice system, including:
    - Evidence-based practices, and
    - Settings in which Medicaid-funded services are allowed.
2. Findings regarding how states ensure that youth receive continuous care as they transition from the juvenile justice system to the community, including:
    - Policies around discharge planning;
    - Health records transfer;
    - Medication supply; and
    - Appointments with health care providers.

How Do States Pay for Services for Youth Involved in the Juvenile Justice System?

Many children involved with the juvenile justice system qualify for, or currently receive, Medicaid coverage. As indicated earlier, youth in the system often have high health needs, and Medicaid can finance the many physical and behavioral health services these children require. Medically-necessary clinical services, such as evidence-based practices (EBPs) can be covered by Medicaid, although there may be limits to this coverage. For children under age 21, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements establish a definition of medical necessity. (For more about EPSDT, see NASHP's previous report *"A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth."*) Federal law also places limits on where juvenile justice-involved youth may be placed and where Medicaid can pay for services provided to them.

There is wide variation among Medicaid agencies in the types and number of settings that juvenile justice-involved youth may be placed and receive Medicaid-funded services

Youth involved with the juvenile justice system can be placed in a variety of community and institutional settings both pre- and post-adjudication, as well as when on probation. Federal law prohibits states from using federal Medicaid funds to pay for services for an individual who is an "inmate of a public institution,"[5] a term that is defined in federal law and regulation. There is an exception that allows Medicaid reimbursement for these youth when they are a patient in a medical institution.

Policy guidance issued by the federal government has attempted to clarify the rules around the prohibition against using Medicaid funds for inmates of a public institution, but the guidance has been conflicting at times, and has led to differences in how states interpret the policy of using federal Medicaid funds to pay for services for this population. For example, federal Medicaid regulations leave room for Medicaid to continue to pay for services until the final disposition of a case.[6] Some states have interpreted this to mean that federal Medicaid funds are available for services while youth are in detention. While an interpretation from the Centers for Medicare and Medicaid Services (CMS) during the last administration suggests the agency would not approve state pursuit of this policy, it is possible that this may change in the future.[7]

This issue was discussed in a previous issue brief focusing on survey findings relating to Medicaid enrollment and retention policies for youth involved in the juvenile justice system. Our survey findings indicated that many states use Medicaid eligibility policies to comply with the prohibition against using Medicaid funding to pay for inmates of public institutions.[8] In this paper, it is important to note that we focus on payment for services.

All responding Medicaid agency allowed juvenile justice-involved youth in some types of juvenile justice settings to receive Medicaid-reimbursed services.[9] However, there was wide variation among agencies in the number of settings that youth were able to receive Medicaid-funded services. Among the 25 reporting Medicaid agencies, the average number of allowable settings was four, ranging from a high of seven to a low of one.

Medicaid agencies most frequently reported that youth in community settings received Medicaid-funded services—21 of the 25 responding Medicaid agencies (or 84 percent) reported that that juvenile justice-involved youth in day treatment could remain enrolled in Medicaid (See Table 1). As youth moved across the spectrum and came closer to being an "inmate of a public institution" fewer Medicaid agencies reported allowing youth to receive Medicaid-funded services—only seven Medicaid agencies (or 28 percent) allowed youth in a detention center awaiting final disposition to receive Medicaid-funded services.

Almost half of responding Medicaid agencies report they reimburse for all or part of evidence-based practices for juvenile justice-involved youth

Evidence-based practices (EBPs) are standardized treatments that controlled research has shown to result in improved outcomes for youth. Two of the most recognized EBPs for juvenile justice-involved youth with disruptive behavior disorders—Functional Family Therapy (FFT) and Multisystemic Therapy

Table 1: Settings in which the State Pays for Medicaid Services for Juvenile Justice-Involved Youth

	Medicaid Agency Responses (N=25)	
	Number	Percent
Day Treatment	21	84%
Group Home	20	80%
House Arrest	18	72%
Private Institution	16	64%
Public Institution with Fewer than 16 beds	16	64%
Pre-Adjudication Detention Facility	7	28%
Private Boot Camp	4	16%

(MST)—are time-limited, community-based interventions that can help youth with specific disorders and who are involved with the juvenile justice system or are at risk of entering the system.[10,11] In research measuring the costs and benefits of evidence-based options for youth in the juvenile justice system, Washington state has shown that FFT saves the state $31,821 per youth, while MST saves the state $18,213 per youth.[12] Although Medicaid may not be able to pay for all components of these services, it may be able to pay for at least part of them, depending on the structure of a state's Medicaid plan and whether the service is determined to be medically necessary for the child.

Table 2: Medicaid Reimbursement for Evidence-Based Practices

	Medicaid Agency Responses (N=21)	
	Number	**Percent**
Multi-Systemic Therapy	11	52%
Family Functional Therapy	9	43%
Other	5	24%

Eleven of 21 Medicaid agencies (or 52 percent) reported they deliver MST services to juvenile justice-involved youth using Medicaid funds.[13] Nine Medicaid agencies (or 43 percent) reported that they deliver FFT services to youth using Medicaid funds.

Five Medicaid agencies reported they deliver other mental health evidence-based or promising practices targeting juvenile justice-involved or at-risk youth using Medicaid funding. For example:

- The Michigan Department of Community Health reported Medicaid reimburses for parent management training, trauma-focused Cognitive Behavior Therapy, and wraparound services at some of their Community Mental Health Services Programs.
- The Texas Health and Human Services Commission reported it reimburses for other EBPs, such as Cognitive Behavior Therapy, under the agency's Resiliency and Disease Management program.[14]

Few juvenile justice agencies reported that they deliver evidence-based practices without drawing down Medicaid funds

Most reporting juvenile justice agencies reported that they do not deliver EBPs without drawing down Medicaid funds, indicating that Medicaid may be an important source of financing for EBPs. Only 7 of 26 juvenile justice agencies (or 27 percent) reported they deliver MST services without Medicaid funds, while 5 juvenile justice agencies (or 19 percent) reported they deliver FFT services without Medicaid funds. Six juvenile justice agencies reported they deliver other EBPs without using Medicaid funds.

Table 3: Juvenile Justice Agencies Not Using Medicaid Funds to Deliver Evidence-Based Practices

	Juvenile Justice Agency Response (n=26)	
	Number	**Percent**
Multi-Systemic Therapy	7	27%
Family Functional Therapy	5	19%
Other	6	23%

Opportunities for increasing the use of Medicaid-qualified services for juvenile justice-involved youth

States and the federal government can play a role in expanding the use of Medicaid funding for Medicaid-qualified services for youth in a variety of settings in the following ways:

- **Clarify federal policy on Medicaid reimbursement for inmates of a public institution.** Clarification from the Centers for Medicare and Medicaid Services (CMS) might help states to understand the federal rules around this prohibition, and ensure that youth in appropriate juvenile justice placements who are also enrolled in Medicaid receive services through the program.
- **State Medicaid agencies can adopt or expand reimbursement for evidence-based practices for juvenile justice-involved youth.** Evidence-based practices (EBPs) such as MST and FFT, and others, yield good results for youth and are cost-effective for states. Medicaid can be a way to finance these services for juvenile justice-involved youth who qualify for Medicaid. However, evidence-based practices are often a package of services, including some components that do not fit into current Medicaid service categories. States can adopt or expand Medicaid reimbursement for EBPs by reviewing their Medicaid state plans; cross-walking their state plan to the components of EBPs to identify components of services that can be reimbursed by Medicaid; and providing state

funding for services that cannot be covered by Medicaid. Maintaining fidelity to the model through provider training and quality assurance activities is also important when adopting the use of EBPs, or successful outcomes may not be achieved.

- **Clarify federal policy on the use of Medicaid financing for evidence-based practices for juvenile justice-involved youth.** Guidance from federal agencies, like CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA), on how states can use Medicaid financing to support and expand the use of EBPs could help states in their efforts to provide effective services for juvenile justice-involved youth.

How Do States Ensure that Youth Receive Continuous Care As they Transition from the Juvenile Justice System to the Community?

There are a variety of policies or procedures that agencies can adopt to promote continuity of care for youth transitioning from the juvenile justice system to the community. For example, discharge or special planning conducted with youth, their families, and juvenile justice agency staff, such as a case worker, can help to continue treatment plans begun in an institution. Transferring health records to community providers also helps to ensure youth continue to receive services after they leave the system. Finally, ensuring youth have an appointment with a health care provider and giving them an adequate supply of medications before they return home are also important steps to ensuring continuity of care. Both juvenile justice and Medicaid agencies can play a role in these practices.

A youth's case worker or parole officer is primarily responsible for release planning of mental health and physical health services for youth transitioning from the juvenile justice system

Both Medicaid and juvenile justice agencies frequently reported that a youth's case worker or parole officer is primarily responsible for release planning. Sixteen of 24 Medicaid agencies (or 67 percent) reported that a youth's case worker was primarily responsible for release planning for youth leaving an institution, while 14 Medicaid agencies (or 61 percent) reported a case worker was responsible for release planning for youth leaving the system completely (e.g. leaving parole). (See Table 4.) Parole officers were also frequently cited as responsible for release planning. Six Medicaid agencies also cited other actors as responsible for release planning, such as the youth's family, juvenile justice officials, and agency benefit specialists.

Juvenile justice agencies also frequently reported that a youth's case worker or parole officer was primarily responsible for release planning. Fifteen of 30 juvenile justice agencies (or 50 percent) reported a youth's case worker was primarily responsible for release planning for youth leaving an institution and 15 of 29 juvenile justice agencies (or 52 percent) reported the case worker was responsible for youth leaving the system completely. Parole officers were also frequently reported as having primary responsibility for release planning. (See Table 5.)

Ten juvenile justice agencies reported other actors responsible for release planning for youth leaving an institution, while 11 agencies reported other actors were responsible for release

Table 4: Responsibility for Release Planning for Youth Transitioning from Juvenile Justice System Reported by the Medicaid Agency

	Child moving from a public institution to the community Medicaid Agency Response (n=24)		Child leaving the juvenile justice system completely Medicaid Agency Response (n=23)	
	Number	Percent	Number	Percent
Individual's Case Worker	16	67%	14	61%
Parole Officer	8	33%	10	43%
Health Care Provider	2	8%	2	9%
Managed Care Contractor	2	8%	1	4%
Other	6	25%	6	26%

Table 5: Responsibility for Release Planning for Youth Transitioning from Juvenile Justice System Reported by the Juvenile Justice Agency

	Child moving from a public institution to the community JJ Agency Response (n=30)		Child leaving the juvenile justice system completely JJ Agency Response (n=29)	
	Number	Percent	Number	Percent
Individual's Case Worker	15	50%	15	52%
Parole Officer	13	43%	14	48%
Health Care Provider	2	7%	2	7%
Managed Care Contractor	4	13%	3	10%
Other	10	33%	11	38%

planning for youth leaving the system completely. These other actors included youth's family and probation officers. For example, the Connecticut Department of Children and Families reported while the primary responsibility for release planning is with the parole social worker, it is done as a team with family and client involvement.

Virtually all juvenile justice agencies conduct discharge planning related to youth's mental or physical health needs as they transition from the juvenile justice system

All 29 responding juvenile justice agencies reported they conduct discharge planning related to youth's mental or physical health care needs as they transition from an institution to the community. Twenty-one of 27 juvenile justice agencies (or 77 percent) reported they conduct discharge planning for youth transitioning from the system completely.

Many states shared examples of their youth discharge planning. For example:

- The Connecticut Department of Children and Families reported discharge planning policies for youth on parole. Contracted medical and mental health providers work with family/child and community providers to set follow-up appointments or long term care as needed. Parole staff is involved and knows youth's follow-up appointments.
- The Utah Department of Social Services reported there is a Division of Juvenile Justice Services' (DJJS) policy that the case manager must develop an individualized treatment/supervision plan for each youth, which is then implemented and monitored with input and collaboration from the youth, family, and other members of the treatment team from entry to termination from custody.
- The Oregon Youth Authority uses Multi-Disclipinary Teams (MDTs) for developing case plans for youth leaving the system. The MDTs may include a health care provider if they choose to participate. If not, and the youth/family approves, the provider receives a copy of the transition/discharge plan and treatment records, to facilitate a referral for ongoing services. Youth with particularly complex needs are staffed with additional resource personnel from OYA's central office to develop a specialized plan for their care upon release.
- The Missouri Department of Social Services reported that all youth receive a transition meeting prior to leaving residential care. In this meeting, the youth, family and Division of Youth Services staff plans the child's aftercare to include how to best meet any health or medical needs.

Few Medicaid agencies or their managed care contractors do any special planning to meet the health needs of youth transitioning from the juvenile justice system

Few Medicaid agencies reported they or their managed care contractors do any special planning to meet the health needs of juvenile justice-involved youth transitioning from the system. Four of 23 Medicaid agencies (or 17 percent) reported they do special planning for youth leaving a public institution and moving to the community. Only five of 22 Medicaid agencies (or 23 percent) reported they conduct special planning for youth leaving the system completely. For example, Florida's Agency on Health Care Administration reported that for Medicaid

enrollees who were in a managed care plan prior to incarceration, their managed care plan is required to provide coordination of services.

Half of responding juvenile justice agencies transfer youths' health records and assessments to community providers, while most Medicaid agencies do not

Only about half of responding juvenile justice agencies reported that they transfer health records or assessments for youth transitioning from the juvenile justice system. Fourteen of 27 juvenile justice agencies (or 52 percent) reported they transfer youths' health records and assessments to community providers when they leave an institution, while even fewer juvenile justice agencies – 9 of 26 (or 35 percent) – reported they transfer records of youth leaving the system completely. Seven juvenile justice agencies specifically reported that Medicaid does not play a role in the policies or procedures involving health records transfer for youth.

Almost all responding Medicaid agencies reported that they do not have policies or procedures in place to facilitate continuity of care by transferring youths' health records and assessments to community providers for youth leaving the juvenile justice system. The Office of Vermont Health Access reported they transfer health records for youth leaving an institution or leaving the system completely, while the Wyoming Department of Health agency specified that they are currently in the process of developing a total health record. Arkansas' Department of Youth Services reported that the Department of Medical Services is exploring the possibility of implementing electronic health records for the juvenile population in an effort to enhance the continuity of care for children and youth involved with the juvenile justice system.

Most juvenile justice agencies have policies and procedures in place to ensure youth have adequate supplies of prescribed medication when they transition from the juvenile justice system, while most Medicaid agencies do not

Most juvenile justice agencies reported having policies in place to ensure youth have an adequate supply of prescription medication when they transition out of the juvenile justice system. Agencies cited a variety of policies, ranging from providing a four-day supply of prescribed medication to giving youth a 30 day supply, or writing a prescription for medication. Twenty-five of 28 juvenile justice agencies (or 89 percent) reported that youth receive medication when they leave an institution, while fewer agencies – 18 of 27 (or 67 percent) – reported they have a policy or procedure in place to ensure youth leaving the system completely have an adequate supply of medication.

In contrast, most responding Medicaid agencies reported they did not have policies in place to ensure youth leaving the system had an adequate supply of medication. Only four of 22 Medicaid agencies (or 18 percent) reported they had policies in place to give youth leaving an institution or the system completely a supply of medication or written prescription. Several states reported that ensuring youth have an adequate supply of medication was the responsibility of the juvenile justice agency rather than the Medicaid agency.

Most juvenile justice agencies have policies and procedures in place to ensure youth transitioning from the system have an appointment with a health care provider, while most Medicaid agencies do not

Over half of responding juvenile justice agencies reported they have policies to ensure youth transitioning from the juvenile justice system have an appointment with a health care provider. Nineteen of 28 agencies (or 68 percent) reported they have policies ensuring youth leaving an institution have an appointment with a provider. Seven of these juvenile justice agencies reported that appointments with health care providers are part of youth's treatment or case plan, or an appointment will be scheduled if youth's individualized case plan calls for it. Thirteen of 27 juvenile justice agencies (48 percent) reported they have policies ensuring youth leaving the system completely have an appointment with a provider.

The Connecticut Department for Children and Families (DCF) Bureau of Justice Services is an example of a juvenile justice agency with such a policy.[15] The agency reported that in addition to supplying children with adequate amounts of medication to cover them until the first appointment in the community, the HomeCare program funded by the Court Support Services Division and DCF provides gap filling services and facilitates getting appointments for children returning to the community. Another example is the Pennsylvania Youth Development Center and Youth Forestry Center (state-operated systems) which has Transitional Services Coordinators who establish dates and times for appointments with providers prior to youth leaving these programs.

Only a few Medicaid agencies reported they had policies in place to ensure that youth transitioning from the system had an appointment with a health care provider. Three of 22 Medicaid agencies (or 14 percent) reported youth leaving an institution have an appointment with a health care provider, while only

two of 22 agencies (or 9 percent) reported youth leaving the system completely have an appointment with a provider. Several Medicaid agencies reported that ensuring youth have an appointment with a health care provider was the responsibility of the juvenile justice agency.

Opportunities for increasing continuity of care procedures for juvenile justice-involved youth

States seeking to provide more effective and continuous care for youth as they transition from an institution to the community, or leave the system entirely, could:

- **Ensure that juvenile justice agencies have policies in place to facilitate continuity of care for youth returning to the community.** Juvenile justice agencies can ensure that children have a schedule with a health care provider as they return to the community; that health records and assessments are transferred to community providers; and that the youth has a supply of prescription medication when leaving an institution. Moreover, juvenile justice agencies can incorporate Medicaid enrollment procedures into a youth's release/discharge planning by working with Medicaid agencies to allow juvenile justice agency staff to assist with the Medicaid application process and enroll eligible youth in a managed care plan prior to their release. (For more information, see NASHP's earlier paper *Medicaid Eligibility, Enrollment and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System.)*
- **Ensure juvenile justice agency staff understand and know how to apply Medicaid policies designed to ensure continuity of care.** Medicaid agencies can explicitly allow juvenile justice agency personnel to assist children leaving an institution to apply for Medicaid and offer training to juvenile justice personnel to enable them to provide effective assistance. State Medicaid agencies may also have policies in place that allow payment for an emergency supply of medication that juvenile justice agency staff could use during release procedures to ensure that youth have a supply of needed medications when they are released.

Conclusion

Medicaid and juvenile justice agencies have a role in delivering behavioral and physical health care services. Both agencies can also play a part in ensuring care and services given to youth while in the system continue once they transition back to the community. These survey findings indicate that although some Medicaid agencies play a role in delivering care and services to juvenile justice-involved youth, Medicaid can potentially play a larger role. The opportunities described in this paper, from using Medicaid to reimburse for the delivery of evidence-based practices to incorporating Medicaid enrollment procedures into release planning, offer states ideas for increasing Medicaid agency involvement in providing services to youth involved in the juvenile justice system.

Notes

1 Sickmund, Melissa, Sladky, T.J., and Kang, Wei. (2008) "Census of Juveniles in Residential Placement Databook." Available at http://www.ojjdp.ncjrs.gov/ojstatbb/cjrp/.

2 *OJJDP Statistical Briefing Book*. Online. Available: http://ojjdp.ncjrs.gov/ojstatbb/crime/qa05101.asp?qaDate=2007. Released on October 24, 2008.

3 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), 2.

4 See 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). As amended and related enactments through January 1, 2007.

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

7 For a more thorough examination of the issue, see Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Portland, ME: National Academy for State Health Policy: July 2008).

8 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).

9 We did not define each of these settings; rather, Medicaid agencies relied on their own state definitions when answering this question.

10 For more on MST see Cathy Surace, Medicaid Coverage of Multisystemic Therapy, *NAMI Beginnings*, Winter 2008. For more information about FFT see the National Center for Mental Health Promotion and Youth Violence Prevention' s fact sheet on Family Functional Therapy at http://www.promoteprevent.org/Publications/EBI-factsheets/FFT.pdf.

11 In both surveys we also asked respondents about whether their agency covered Assertive Community Treatment (ACT) for children. We do not include results here, as ACT is not considered an "evidence-based practice" for children or teens.

12 Steve Aos, Marna Miller, and Elizabeth Drake, *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. (Olympia: Washington State Institute for Public Policy, 2006).

13 Five agencies reported "N/A" for all EBPs listed; therefore they are not included in this count.

14 Information about the Texas Resiliency and Disease Management program is available at http://www.dshs.state.tx.us/mhprograms/RDM.shtm.

15 The Bureau of Juvenile Services is part of a comprehensive state agency whose four mandates are child protection, child mental health, prevention, and juvenile justice.

16 The Kansas Health Policy Authority and the Kansas Juvenile Justice Authority worked together to fill out the Medicaid agency survey. All information reflected in their survey response was counted as a Medicaid agency response. Likewise, Medicaid and juvenile justice agencies under the New Hampshire Department of Health and Human Services worked together to fill out the juvenile justice agency survey, and all data contained in their survey response were counted as a juvenile justice response.

About the Models for Change Initiative and this Survey:

Models for Change: Systems Reform in Juvenile Justice has grown out of the juvenile justice grantmaking of the John D. and Catherine T. MacArthur Foundation. In 2004, the Foundation launched the *Models for Change* initiative to bring about systemic reform at state and local levels. (See http://www.macfound.org and http://www.modelsforchange.net.) 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 other states to learn from and emulate. Models for Change has awarded grants to support juvenile justice reform in twelve more states through action networks focusing on key issues. 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's performance and ensuring successful individual outcomes.

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 physical and behavioral health coverage and health care for juvenile justice-involved youth. To that end, from December 2008-February 2009, NASHP fielded surveys about health care and Medicaid policies for youth in the juvenile justice system to state Medicaid and juvenile justice agencies. This paper is the second of three issue briefs containing survey findings, and focuses upon Medicaid eligibility, enrollment and retention policies for youth involved in the juvenile justice system. An earlier issue brief focused on inter-agency collaboration, and the last issue brief in the series will focus on delivery policies for improving the health and well-being of youth involved in the juvenile justice system.

Methodology

We conducted email surveys of the 50 states' and the District of Columbia's Medicaid and juvenile justice agencies using survey tools that were developed with the help of state Medicaid and juvenile justice officials and national experts. Surveys were returned from 26 Medicaid agencies and 31 juvenile justice agencies; we received a response from both agencies in 14 states and one agency in 29 states, for a total of 43 state responses.[16] We asked states about collaboration between the two agencies; Medicaid eligibility, enrollment, and retention policies; and service delivery policies for each agency. We asked states to respond referencing policies in place as of November 2008 and data from the most recent last fiscal year. NASHP staff reviewed responses for internal consistency. A draft of this paper was sent to respondents mentioned in this paper, and reviewed by the national experts who assisted in drafting the survey instruments as well as state officials with expertise in both Medicaid and juvenile justice issues.

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