

# Facilitating Access to Health Care Coverage for Juvenile Justice-Involved Youth

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**ModelsforChange**  
Systems Reform in Juvenile Justice

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## Models for Change

All young people should have the opportunity to grow up with a good education, get a job and participate in their communities. Creating more fair and effective juvenile justice systems that support learning and growth and promote accountability can ensure that every young person grows up to be a healthy, productive member of society.

*Models for Change: Systems Reform in Juvenile Justice*, a MacArthur Foundation initiative, began by working comprehensively on juvenile justice reform in four states, and then by concentrating on issues of mental health, juvenile indigent defense, and racial and ethnic disparities in 16 states. Through collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP), *Models for Change* expanded its reach and is now working to replicate and disseminate successful models of juvenile justice reform in 31 states.



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# Facilitating Access to Health Care Coverage for Juvenile Justice–Involved Youth

## Executive Summary

Youth involved in the juvenile justice system have extensive physical and behavior health needs. The majority have at least one mental health condition<sup>1</sup> and substance abuse is also very common.<sup>2</sup> Findings from a study of youth in residential settings found that two-thirds of youth in custody have a healthcare need.<sup>3</sup>

Medicaid can be important for juvenile justice-involved youth in both financing needed health care services and accessing needed care. Through opportunities presented under the Affordable Care Act (ACA), many Medicaid agencies are in the process of revamping their eligibility information technology systems and re-examining enrollment processes. With the establishment of the health insurance exchanges, states are also launching extensive outreach and consumer assistance programs for both public and private coverage. In light of these activities, it is an opportune time for states to adopt eligibility, enrollment, and outreach processes that improve access to health coverage for juvenile justice-involved youth.

This report outlines federal and state eligibility, enrollment, and outreach strategies that can help facilitate seamless coverage for system-involved youth. Adoption of these initiatives has the potential to improve the lives of juvenile justice-involved youth and their families, increase their ability to remain in the community, and ultimately, reduce recidivism. Key to the success of these strategies will be ongoing collaboration between the multiple state and federal agencies that interact with the juvenile justice population.

## Medicaid Eligibility Options to Ease Community Reentry

As youth move through the juvenile justice system, they are vulnerable to losing their eligibility for Medicaid coverage during transitions. This is because federal law prohibits Medicaid payments for care or services for adult and juvenile inmates of public institutions (except as a patient in a medical institution).<sup>4</sup> Many Medicaid agencies ensure compliance with federal law by terminating eligibility as a youth moves in and out of custody.

Some states, however, have established policies and procedures that allow youth who are still in institutions to suspend Medicaid enrollment or enroll in Medicaid as they are preparing for discharge, so that by the time they leave, they are enrolled and are able to access services. These policies and procedures include:

- **Suspending eligibility**, which enables the state to restore Medicaid benefits relatively quickly and allows the youth to access services upon release;
- **Continuous eligibility**, a policy that allows Medicaid and CHIP-enrolled children who enter and leave a juvenile detention facility during the 12-month period to maintain eligibility upon reentry into the community;
- **Presumptive eligibility**, which permits qualified entities to make temporary eligibility determinations for youth, pending a final determination by the Medicaid agency; and
- **Special enrollment procedures**, such as having a formal process for juvenile justice staff to fill out Medicaid applications within a specified timeframe for every youth leaving custody.

## Increasing Enrollment of Juvenile Justice-Involved Youth in Medicaid and CHIP

Capitalizing on the new attention to public and private health insurance options brought about by health reform, juvenile justice stakeholders will find the next year to be an opportune time to get juvenile justice-involved youth and their families enrolled in coverage. Applying lessons learned from successful outreach efforts to adolescents and other population groups of which juvenile justice-involved-youth are a part, states will be well positioned to implement targeted outreach initiatives to system-involved youth. The new consumer assistance programs created by the ACA—navigators, in-person assisters, and certified application counselors—will provide additional avenues through which states can provide targeted outreach and enrollment assistance.

Outreach strategies that will likely be successful in reaching juvenile justice-involved youth include targeted events such as health fairs, school-sponsored activities and sports, and other opportunities to interact in a direct and personal manner. In reaching families of juvenile justice-involved youth, messages that directly reflect the challenges they likely face in accessing needed medications or behavioral health treatment will have resonance. Establishing partnerships with 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 elements of the court system, is another key to successful outreach.

## Emerging Issues—Transitions in Coverage Between Medicaid, CHIP, and Exchanges

Despite the expanded health insurance options and new eligibility and enrollment systems made possible by the ACA, the potential remains that people eligible for new coverage will not be enrolled or not successfully transition from one form of coverage to another. Juvenile justice-involved youth and their families may be particularly vulnerable to loss of coverage as they transition between programs because of complex family situations and eligibility statuses. The consequences can be lack of access to needed health care and behavioral health treatment.

States can use certain resources to help reduce the effects of churn and ensure continuity of care, including single streamlined applications, navigators and other in-person assistance, and call centers. Alignment of benefit packages and provider networks between public programs and private plans in the health insurance exchanges can also help mitigate the effects of transitions.

## Evidence-Based Practices for Meeting the Needs of Juvenile Justice-Involved Youth

While opportunities provided through health reform can help facilitate access to services and supports for juvenile justice-involved youth, states are under increasing pressure from stakeholders to demonstrate the efficacy of these services. States can adopt a number of interventions that have been proven effective in treating the serious behavioral health needs of this population, including Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Treatment Foster Care (MDTFC). Other evidence-based practices, such as supported employment and supported housing, may prove particularly relevant for older youth leaving the justice system. Although financing these services can be challenging, several states have been able to leverage Medicaid funds to cover MST and FFT.

## Conclusion

As states and juvenile justice stakeholders seek to facilitate health coverage and access for system-involved youth, opportunities exist at both the federal and state levels that can 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 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.



# Facilitating Access to Health Care Coverage for Juvenile Justice-Involved Youth

## Introduction

Youth involved in the juvenile justice system have extensive physical and behavior health needs. The majority have at least one mental health condition<sup>5</sup> and substance abuse is also very common.<sup>6</sup> Findings from a study of youth in residential settings found that two-thirds of youth in custody have a healthcare need.<sup>7</sup>

Over the past decade, the juvenile justice system has adopted wide-ranging reforms that have resulted in fewer system-involved youth, a significant shift to community-based placements from reliance on institutions, and greater access to mental health treatments and other community-based supports. Despite these advances, youth in the juvenile justice system remain at risk for fragmented care and supports and poor transitions from one placement setting to another.

Health coverage is an important component of a community support system for juvenile justice-involved youth. It is the ticket to behavioral health treatment, medications, and physical health services. Coverage does not always translate into access to care, but it is an essential pre-condition.

Medicaid can be important for juvenile justice-involved youth in both financing needed health care services and accessing needed care. Through opportunities presented under the Affordable Care Act (ACA), many Medicaid agencies are in the process of revamping their eligibility information technology systems and re-examining enrollment processes. With the establishment of the health insurance exchanges, states are also launching extensive outreach and consumer assistance programs for both public and private coverage. In light of these activities, it is an opportune time for states to adopt eligibility, enrollment, and outreach processes that improve access to health coverage for juvenile justice-involved youth.

This issue brief explores several federal and state policies that can be employed to improve health care coverage and foster continuity of care. It also examines changes and opportunities presented through health reform that may have implications for juvenile justice-involved youth. Finally, it documents evidence-based practices that Medicaid and juvenile justice agencies can promote to improve service delivery for this population. Key to the success of these strategies will be ongoing collaboration between all agencies that interact with juvenile justice-involved youth.

The strategies outlined in this issue brief were informed by policy research conducted through July 2013 by the National Academy for State Health Policy through its Models for Change project, funded by the MacArthur Foundation and by discussions from an in-person meeting of federal and state officials held in July 2013. This diverse group of Medicaid and juvenile justice experts deliberated about ongoing challenges and new opportunities for improving outcomes for system-involved youth. The meeting's agenda and participant list are included in the appendix of this report.

## Medicaid Eligibility Options to Ease Community Reentry

Transitions from institutional settings back to the home or other community settings are a critical juncture for juvenile justice-involved youth. Reentry initiatives and aftercare services can help youth improve family relationships, teach them to live independently, impart important life skills, help reintegrate youth into school, and divert them away from engaging in harmful behaviors. Ensuring that youth have health care coverage and access to services, although not always a formal part of such initiatives, also plays an important role in successful reentry. Access to adequate health coverage may also reduce recidivism, as adult reentry programs have shown that individuals with access to health benefits, like mental health services and substance use treatment, have fewer future arrests.<sup>8</sup>

Through earlier work conducted by the National Academy for State Health Policy (NASHP) through its Models for Change project, we know that significant numbers of system-involved youth depend on Medicaid coverage.<sup>9</sup> 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 federal Medicaid funding from being used to pay for care or services for individuals who are inmates of a public institution (except as a patient in a medical institution).<sup>10</sup> Many Medicaid agencies ensure compliance with federal law by terminating a youth's eligibility as they move in and out of an institution.

Some states, however, have established policies and procedures 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 procedures for enrolling in Medicaid include suspending eligibility rather than terminating it, and establishing special enrollment procedures, like requiring case workers or probation officers to fill out Medicaid applications for youth who are about to leave an institution. The following sections describe each of these procedures and include examples of states that have adopted them.

## Suspending Eligibility

Federal law prohibits Medicaid payments for care or services for adult and juvenile inmates of public institutions (except as a patient in a medical institution).<sup>11</sup> When the Medicaid agency learns an enrollee has been incarcerated, it can either terminate or suspend an individual's Medicaid eligibility. If a state terminates eligibility, the youth must reapply for the program upon release and wait for an eligibility determination before accessing Medicaid services.

Suspending Medicaid eligibility allows the 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. States that suspend eligibility are required by statute to do an ex parte renewal, if possible, and only collect any new information from the individual or family.

States do not have to terminate an individual's Medicaid eligibility upon incarceration.<sup>12</sup> In a letter to state Medicaid Directors, The Centers for Medicare and Medicaid Services (CMS) encouraged states to suspend rather than terminate Medicaid coverage while a person is in an institution<sup>13</sup>, a message echoed by federal officials in attendance at the in-person meeting that informed this report. However, suspension of eligibility may prove difficult for agencies to implement. In 2009, NASHP's Models for Change project surveyed Medicaid agencies and learned that many states do not suspend eligibility when a youth enters a public institution because it is difficult to do under their current Medicaid Management Information Systems.<sup>14</sup> Others have encountered difficulty adopting it because related state eligibility policies present barriers.<sup>15</sup>

The Coordinating Council on Juvenile Justice and Delinquency Prevention, which coordinates federal programs and activities relating to juveniles and juvenile delinquency prevention, issued draft recommendations in December 2010 that encouraged federal agencies to develop guidance for states to help them modify Medicaid and CHIP eligibility systems to suspend, rather than terminate Medicaid and CHIP benefits, as well as to facilitate "reactivation" of benefits to be effective on the day of a youth's release to the community.<sup>16</sup>

## Oregon

In 2011, the Oregon legislature enacted SB 3536 that supports the integration of individuals back into the community. It requires the Oregon Health Authority (OHA) to suspend, rather than terminate, medical assistance for inmates of local correction facilities who are expected to be incarcerated for no more than 12 months. Although adult inmates were the intended beneficiaries, the language did not preclude it from applying to youth entering correctional facilities. Thus OHA decided to implement the policy for both youth and adults.

The Oregon Youth Authority, the agency responsible for youth corrections, notifies 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. The state reported that this policy change was implemented relatively easily and quickly.

## Ohio

In 2009, the Department of Youth Services (DYS) and the Department of Job & Family Services (ODJFS) entered into an Interagency Agreement to suspend Medicaid benefits for youth in the custody of DHS. The agencies implemented a process whereby ODJFS is notified of youth in the custody of DHS who are Medicaid eligible at the time of their incarceration and who are expected to be incarcerated for less than 12 months. ODJFS staff has the ability to suspend and then restore Medicaid benefits for these youth upon their release.

ODJFS had difficulty tracking youth upon reentry into the community because counties are responsible for making Medicaid eligibility determinations. To improve this process, the state submitted to CMS a Medicaid state plan amendment, approved in May 2013, that places responsibility for determining eligibility for youth incarcerated or awaiting adjudication in a DHS facility with the Office of Medical Assistance (OMA), the state's Medicaid agency. OMA is notified by DHS when a youth is placed in custody and subsequently suspends and restores benefits as necessary.

## 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 circumstances change, such as in income or family status. Without continuous eligibility, a state must establish procedures for families to report a change in circumstance that impacts eligibility for Medicaid or CHIP between regularly scheduled

renewals. Implementing a continuous eligibility policy creates a win for both the youth/family and the state: Children are able to maintain their health coverage and the state is able to minimize administrative burden and paperwork. As of January 2013, 23 state Medicaid programs and 28 CHIP programs have implemented this option.<sup>17</sup>

This option can benefit youth involved in the juvenile justice system. If Medicaid or CHIP-enrolled children enter and leave a juvenile detention facility during the 12-month period, their Medicaid eligibility remains in effect when they return to the community.

## 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. Through this process, youth can receive temporary eligibility pending a final determination by the Medicaid agency. This is important because the sooner youth are enrolled into the Medicaid program, the more quickly they will be able to access services when they transition from a juvenile facility.

States can deem agencies that provide services, such as juvenile justice agencies, as qualified entities.<sup>18</sup> In 2009, at least one state allowed juvenile justice agency staff to make Medicaid presumptive eligibility determinations for juvenile justice-involved youth.<sup>19</sup> States that are interested in adopting this strategy but have concerns about the potential for flooding the system with non-eligibles might want to consider using targeted presumptive eligibility by authorizing only juvenile justice facilities as qualified entities. States could also consider designating diversion programs as qualified entities.

The ACA envisions a health coverage eligibility process that is streamlined, seamless for applicants, and occurs in real time. Nevertheless, presumptive eligibility remains useful for reaching juvenile justice-involved youth who are in transition and their families. Beginning in 2014, this strategy will be available for every population subject to the modified adjusted gross income (MAGI) rules. Juvenile

justice agencies, if designated as qualified entities, would be able to grant temporary eligibility to both youth and family members in the same household who request it.

## Special Enrollment Procedures

In a survey that NASHP 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.<sup>20</sup> Special procedures most often cited were the use of case managers or other agency staff to help youth re-enroll into Medicaid. Yet the level of assistance varied among states. The strongest procedures employed a formal process for juvenile justice agency staff to fill out Medicaid applications within a specified timeframe for every youth leaving custody. Such collaborative enrollment efforts between Medicaid agencies and juvenile justice agencies are key to providing seamless transitions in coverage. The following state examples illustrate successful collaborative enrollment efforts achieved through a combination of policy levers.

### 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. Under this agreement, OHA places a Medical Eligibility Specialist in the central OYA office. As a salaried OHA employee, this out-stationed worker has access to Medicaid enrollment files and is able to 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. This arrangement reduces wait time since the specialist does not need to contact the youth's caseworker to suspend or restore benefits. In addition, the specialist serves as a point of contact for both caseworkers and youth and their families who have questions about eligibility and benefits.

The interagency agreement also established formal communication and information-sharing arrangements between the two agencies. An interface between the Juvenile Justice Information System and the Medicaid Management Information System allows OYA staff to access information on a youth's Medicaid and other social services benefits. The Oregon Youth Authority is also included in workgroups and discussions of changes to Medicaid services that would impact juvenile justice-involved youth.

### 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.<sup>21</sup> Colorado was able to quickly implement the new enrollment procedure in the following year. Under this process, the facility screens youth who will be released within the next 120 days, and facility staff identify 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 for either program, 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.

The Colorado Department of Health Care Policy and Financing (HCPF), the agency that administers the Medicaid and CBHP programs, conducts yearly trainings with the Division of Youth Corrections (DYC) on the process for submitting applications for health care coverage for in-custody youth who are preparing to leave facilities. HCPF has set up primary contacts for DYC in each of the county-based eligibility offices to respond to questions about Medicaid or CBHP eligibility or how to complete applications. This training and designation of specialized contacts ensures a greater likelihood that youth will be enrolled in Medicaid or CBHP prior to release from the facility.

## 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. The HHSC was required to establish a memorandum of understanding with both the Texas Youth Commission and Texas Juvenile Probation Commission to specify respective roles to ensure that committed, detained, or residentially-placed youth are assessed for eligibility for Medicaid or the Children's Health Insurance Program (CHIP).<sup>22</sup> In 2011, these two agencies were consolidated into the Texas Juvenile Justice Department (TJJD), which now administers the process for referring individuals to HHSC for eligibility screening.

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 HHSC's Centralized Benefit Services Unit via an online database. HHSC staff use this information to determine whether the youth has an active Medicaid file or if a new application must be completed. The goal is to ensure that eligible youth are enrolled in Medicaid or CHIP and can begin receiving services on the date of the individual's release from commitment, detention or placement.

## Implications of Health Reform for Juvenile Justice-Involved Youth: Eligibility and Enrollment Policies

On March 23, 2010, the Affordable Care Act (ACA) was signed into law. It represents the most far-reaching health care reform since creation of the Medicaid and Medicare programs in 1965. The ACA expands coverage to millions of individuals who do not have private insurance through their employers, or qualify for Medicaid and CHIP. In addition to the coverage expansions, the health reform law moves states to adopt other reforms—from modernizing information technology systems, to adding consumer protections to the private insurance market, and making delivery system reforms. Some of these reforms, including coverage expansions and revisions to Medicaid eligibility and enrollment systems, will have an impact on youth involved with the juvenile justice system.

### Opportunities for Expanding Coverage for Adolescents and Young Adults

When the ACA is fully implemented, all states will use a new income and household composition standard, called modified adjusted gross income (MAGI), which moves toward an income standard based on the tax system for Medicaid eligibility. As a result, state enrollment systems will rely more on electronic sources of data and will have access to certain federal program data to verify information that an applicant provides, rather than always requiring paper to back it up. All states must also maintain coverage for children from age one to 19 who are in families with incomes up to 133 percent of the federal poverty level (FPL). Youth who have aged out of foster care must remain eligible for Medicaid up to the age of 26, and children who lose Medicaid eligibility at renewal due to the new standard must be covered in a separate CHIP program for one year.

Under the ACA, a large population that was not formerly eligible for Medicaid coverage will now be eligible: adults with income up to 133 percent of the FPL without dependent children. In states that choose to implement the Medicaid expansion, young adults leaving the juvenile

justice system who may be too old to qualify for children's Medicaid or CHIP could become eligible for health coverage through this expansion option.

Some states have adopted the option to provide Medicaid and/or CHIP coverage to 19 and 20 year olds,<sup>23</sup> but the 2014 expansion has the potential to affect many more individuals. The Congressional Budget Office estimates that approximately 11 million individuals will qualify and enroll in Medicaid and CHIP under this expansion.<sup>24</sup> States will also receive a higher level of financing from the federal government for covering this new population: 100 percent match during 2014-2016, and a lesser rate thereafter, although still higher than the match rate they receive today.

In 2014, health insurance exchanges, run by either states or the federal government, will create a place for individuals, families, and small business to choose and obtain health insurance. Exchanges are expected to be the source of health insurance coverage for 24 million Americans.<sup>25</sup> Individuals and families who have income between 100 and 400 percent of the FPL and who lack access to affordable employer-sponsored insurance will be eligible for subsidies to help them purchase health insurance through the exchanges. These subsidies will be in the form of either advance premium tax credits or cost-sharing reductions.

The new exchanges also represent a coverage opportunity for justice-involved youth who may have income too high to qualify for Medicaid. For youth with income higher than 133 percent of the FPL, or \$11,170 for a single person,<sup>26</sup> the exchanges may offer access to federally subsidized health coverage.

### Opportunities for Improving Medicaid Eligibility and Enrollment Systems

Under the health reform law, the state health insurance exchange is required to screen and/or determine eligibility for Medicaid and CHIP,<sup>27</sup> thereby linking it to these state health coverage programs. States must also use a single application for Medicaid, CHIP, and subsidized coverage through the exchanges. These linkages are intended to create a “one stop shop” and “no wrong door” that allow

individuals to find and enroll in health coverage programs. These changes should also make it easier for juvenile justice-involved youth reentering the community to find and enroll in health coverage. States that screen for and enroll youth in Medicaid and CHIP prior to leaving juvenile facilities may want to consider broadening their procedures once exchanges are operational so that youth are screened for private insurance options in addition to public programs.

Health reform funding may make it financially easier for states to adopt eligibility system changes that benefit youth in public institutions, such as suspension. In 2011, CMS issued a funding opportunity that allows states to claim enhanced federal matching funds for the design, development, and implementation of eligibility system upgrades or to establish new technology that promotes efficiencies and system integration. This funding is only available until 2015, and hinges on states meeting certain criteria. Enhanced federal matching rates are 90 percent for design, development, installation, or enhancement of eligibility determination systems, and 75 percent for ongoing maintenance and operation.<sup>28</sup> Many states are currently developing new streamlined eligibility information technology systems and enrollment processes to prepare for coverage expansions and the new eligibility rules.

### **Increasing Enrollment of Juvenile Justice-Involved Youth in Medicaid and CHIP**

In addition to the coverage and benefit expansions authorized by the ACA, the law also includes support for state outreach and enrollment services. Effective outreach and application assistance will be vital to the success of both the expanded Medicaid program and the exchanges because not only will some people be eligible for public programs or private insurance subsidies for the first time, Medicaid enrollment processes will also be revised. Experience from similar expansions indicate that people who are already eligible but not enrolled in Medicaid are expected to become aware of their eligibility due to public outreach efforts and seek coverage.

Capitalizing on this new attention to public and private health insurance options, juvenile justice stakeholders will find the next year to be an opportune time to advance

initiatives to get juvenile justice-involved youth and their families enrolled in health care coverage. At the same time, these reforms will prove challenging as the exchanges and Medicaid expansion will add to the existing complexity of messaging about eligibility options.

While many of the eligibility options described in previous sections relate to easing reentry into the community for juvenile justice-involved youth, there are many system-involved youth in the community who have not been in the custody of a secure facility and who need health coverage. States and juvenile justice stakeholders might want to consider adopting targeted outreach efforts to make juvenile justice-involved youth and their families aware of coverage options and how to apply, regardless of whether the youth has been incarcerated.

### **New Opportunities for Consumer Assistance and Outreach**

The ACA established three main 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.<sup>29</sup> One-on-one assistance, regardless of the type of entity providing it, 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. As illustrated later in this section, some states are already planning to use these new consumer assistance programs to provide targeted outreach and enrollment services to juvenile justice-involved youth.

### **Lessons Learned from Effective Outreach Strategies**

Over time, states have developed outreach strategies to target particular populations: pregnant women; people of color; people with low literacy or limited English proficiency; people living in rural areas; and adolescents and older teens. Although juvenile justice-involved youth have not been a specific target of states' outreach efforts, strategies developed for population groups of which they are a part—such as adolescents and people of color—are particularly relevant.

As states' experience with implementing Medicaid and CHIP outreach and education initiatives have evolved, they have learned some key lessons about what works.<sup>29</sup> Successful state outreach strategies have adopted one or more of the principles outlined in *Lessons Learned from Children's Coverage Programs: Outreach, Marketing, and Enrollment*, published by the National Academy for State Health Policy: using targeted efforts rather than mass media; seeking out partners who are trusted sources within the target community; using technology through websites, ads placed in search engines, social media, enrollment tools available through mobile devices; keeping information easy to understand and act upon; and maintaining sustainable funding to build on over time.

Applying these principles, reaching youth involved in the juvenile justice system is more likely to be successful through targeted events such as health fairs, school-sponsored activities and sports, and other opportunities to interact in a direct and personal manner rather than relying on large scale campaigns through television or radio advertising. In reaching families of juvenile justice-involved youth, messages that directly reflect the challenges they likely face in accessing needed medications or behavioral health treatment will have resonance.

Establishing partnerships with entities that have prominence and trust in the lives of juvenile justice-involved youth and their families is another key to successful outreach. While partnerships with community-based organizations with which juvenile justice-involved youth and their families have an association are an obvious place to start, engaging elements of the juvenile justice system and social service agencies that have a vested interest in getting youth public insurance coverage for needed services would also be effective. Arming them with information about how youth can enroll in Medicaid and CHIP could yield successful results.

Joint initiatives between Medicaid and sister state agencies are often a vehicle for outreach to targeted populations. Medicaid agencies typically do not directly deliver services to individuals; they finance services and organize delivery systems such as managed care organizations and behavioral health specialty systems. Other state agencies specialize in services to specific populations and have

more direct connections to target populations. Successful strategies to increase health care coverage for juvenile justice-involved youth will leverage partnerships between Medicaid and juvenile justice agencies.

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 as needed. See [www.insurekidsnow.gov](http://www.insurekidsnow.gov) for more information on successful outreach strategies.

### **New York: Reaching Children Involved with the Justice System**

In July 2013, the Osborne Association of New York was awarded a CHIPRA Cycle III Outreach and Enrollment Grant from CMS to provide targeted outreach to youth involved in the justice system. The \$800,000 award supports 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.<sup>30</sup> 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.<sup>31</sup>

### **Oklahoma: Enrolling Eligible but Uninsured Youth**

The Oklahoma Health Care Authority (OHCA) is using CHIPRA outreach grant funds to support an outreach initiative called SoonerEnroll. It aims to enroll the approximately 60,000 uninsured Oklahoma children who are eligible but not enrolled in SoonerCare, the state's Medicaid program.<sup>32</sup> Over 750 public, private, and nonprofit partner organizations, such as Head Start, YMCAs, public schools, and community action agencies, provide on-the-ground outreach, education, and application assistance. Four regional outreach coordinators housed within local organizations work to build capacity for sustained community outreach. The OHCA gives SoonerEnroll partners technical and informational supports but does not provide funding for their outreach activities.



The SoonerEnroll initiative has also launched a statewide, youth-focused media campaign to overcome any stigma youth may have about enrolling in a government assistance health care program for people with low income. These TV, radio, and social media ads promote routine health care services for all youth under the age of 18 by highlighting stories of SoonerCare youth members.

### **Virginia: Teen-Centered Outreach Through Traditional and Social Media**

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.<sup>33</sup>

### **Outreach Coordination Between Medicaid and the Juvenile Justice System**

As previously discussed, engaging trusted elements of the juvenile justice system is key to successful outreach. The court system, particularly probation and parole offices, could be an important partner in facilitating health coverage for juvenile justice-involved youth. Various coordination arrangements among the court system, juvenile justice agencies, and Medicaid may prove beneficial in raising awareness among juvenile justice-involved youth and their families about insurance options. These practices include co-locating in-person assisters in juvenile courts and at probation/parole offices, training probation/parole officers on insurance options and making referrals, and requiring judges to inquire about both a youth's health status and health insurance coverage during juvenile court hearings. Kentucky and the District of Columbia, for example, both plan to co-locate application assisters within the court system and parole offices.

## **Emerging Issues—Transitions in Coverage Between Medicaid, CHIP and Exchanges**

Open enrollment in the health insurance exchanges began in October 2013, and in January 2014 when expansion of Medicaid eligibility takes effect, people will have new options for their health insurance coverage. States will also be implementing new eligibility determination standards and consumer assistance programs. While these changes are designed to increase and streamline access to coverage, some people eligible for new coverage will not become enrolled in Medicaid or exchange plans, or will not successfully transition from one form of coverage to another. Due to frequently complex family situations, juvenile justice-involved youth may be particularly vulnerable to loss of coverage. The consequences can be lack of access to needed health care and behavioral health treatment.

Family circumstances may change unexpectedly throughout the year and lower income families are expected to transition between Medicaid and exchange coverage. As many as 17 percent of children are projected to experience a change in circumstances that will lead to a transition between Medicaid, CHIP, and the exchanges.<sup>34</sup> It is at these transition points where youth are vulnerable to losing coverage. Youth involved in the juvenile justice system are traditionally more susceptible to falling off coverage because they have additional complexity in their eligibility status.

As noted, in some states Medicaid and juvenile justice agencies have established partnerships for facilitating ongoing Medicaid coverage or expedited enrollment in Medicaid prior to community reentry. With the establishment of exchanges, these partnerships could evolve to support enrollment into private plans offered through the exchange.

Key elements of juvenile justice systems and service providers can be taught to identify and address disruptions in continuity of care resulting from changes in covered benefits or provider networks during transitions from one form of health coverage to another. Due to the importance

of behavioral health treatment for this population, the juvenile justice system and community providers also have a large stake in ensuring continuity of coverage that will pay for services. Certain elements of health reform enrollment efforts will help facilitate transitions among programs, including:

**Single Streamlined Applications** that allow a family to submit the same information regardless of the program for which they are applying can take much of the burden off applicants and create a “no wrong door” approach to enrollment.

**Navigators and Other In-Person Assistance**, when combined with the requirement to allow applicants to designate an authorized representative to access their account information throughout their coverage period, can help families transition between programs.<sup>35</sup> Third party representatives may prove especially useful for families with members covered under different public and private programs.

**Call Centers**, while not new to public programs, will be important to families with questions during the application process and throughout their coverage. They are expected to serve more families than all other consumer assistance entities combined.<sup>36</sup> Call center employees will answer questions about eligibility requirements and application status; coverage and benefits; and accept reports of changes to household and income circumstances.

## Evidence Based Practices for Meeting the Needs of Juvenile Justice-Involved Youth

Health coverage provides juvenile justice-involved youth with access to health services and supports, which can be essential to successful diversion and community reentry. Access to high quality and appropriate behavioral health services is particularly important. According to a multi-state study funded by the MacArthur Foundation, 65-70 percent of juvenile justice-involved youth have at least one diagnosable mental health condition.<sup>37</sup> Juvenile justice-involved youth also have high rates of substance use,<sup>38</sup> often in combination with a mental illness.<sup>39</sup>

Securing health coverage is only the first step to meeting the physical and behavioral health needs of juvenile justice-involved youth. States need to assess whether the services and supports they are financing are effective in meeting the needs of this population. Increasingly states are turning to evidence-based practices (EBPs) to direct public investments in interventions and treatments to achieve positive results for juvenile justice-involved youth with behavioral health needs.

Evidence-based practices are grounded in a large body of research conducted in diverse environments that defines an approach to a treatment or intervention that, if rigorously implemented, has proven to be consistently effective. As purchasers of services, states have an important oversight role to ensure that the intervention or treatment is implemented in a standardized way. This is often referred to as maintaining fidelity to the model and is essential to achieving expected results. The MacArthur Foundation has developed a manual, [Turning Knowledge Into Practice](#), to help human services administrators implement EBPs.

Three evidence-based practices are widely recognized as being effective in addressing the serious behavioral health needs of juvenile justice-involved youth: Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Treatment Foster Care (MDTFC). Their efficacy in treating juvenile justice-involved youth and in

reducing recidivism is well established, as discussed in the following service profiles. MST and FFT are the evidence-based practices Medicaid programs are most likely to cover for this population.<sup>40</sup>

Research conducted on Washington State's implementation of FFT and MST documented improvements in the lives of troubled youth, a reduction in recidivism, and a return on investment.<sup>41</sup> The same study measured the costs and benefits of EBPs in comparison to traditional interventions and concluded that Washington saved \$31,821 per youth by implementing FFT and \$18,213 for MST.<sup>42</sup>

Each of the three EBPs is briefly described below. While they share common goals, they vary in their treatment components, service intensity, and to a certain extent, target population.

### **Multisystemic Therapy**

Multisystemic Therapy is a team-supported, home-based treatment for juvenile justice-involved youth. It is based on the philosophy that youth are deeply entrenched in "systems," including family, neighborhoods, peer groups, and school. To address behavioral health issues, all systems must be engaged. Intensive therapy is provided several times a week and provider team members are available to an individual and family on a 24-hour basis. The typical length of service is four months. MST has been researched in various settings with various populations, indicating similar outcomes across the adolescent age range (12–17 years), for males and females, and for African-American, Latino and white youth and families.

### **Functional Family Therapy**

Functional Family Therapy (FFT) is a short-term intervention, provided in an average of twelve sessions over three to four months in home, community, and office-based settings. It focuses on the family relationships of youth who are currently involved or at risk for involvement in the juvenile justice system. A variety of therapeutic techniques are used, including problem-solving, skill building, cognitive-behavioral therapy, and conflict management with the

goal of changing individual and family behaviors. FFT has been proven effective both as a treatment modality for youth with a range of juvenile justice involvement and as a prevention tool for children at risk of involvement.<sup>43</sup> Its effectiveness has been demonstrated within diverse racial and ethnic communities.<sup>44</sup>

### **Multidimensional Treatment Foster Care**

Multidimensional Treatment Foster Care (MDTFC) is targeted to youth with significant juvenile justice involvement and behavioral health needs, especially those who have been discharged from residential or institutional settings. Out-of-home placements are made for six to nine months with trained therapeutic foster families who implement a treatment-plan that both targets the child's behaviors and prepares the post-placement family for discharge. MDTFC is the only EBP out-of-home intervention for juvenile justice-involved youth.<sup>45</sup> It has been shown to reduce post-treatment institutionalization, reduce violent crime, and reduce substance use.<sup>46</sup> Research designs have included boys and girls, as well as African American, Latino, and Native American youth.<sup>47</sup>

### **Additional Services for Juvenile Justice-Involved Youth**

Coupled with the evidence-based practices that focus on diversion and reentry into the community, states should consider adoption of other EBPs that support youth as they transition into adulthood. Aftercare services provided through supportive housing and employment will be particularly valuable to older youth exiting the justice system.<sup>48</sup>

## Federal Financing Opportunities for Evidence-Based Practices

In a letter to directors of state child welfare, Medicaid, and mental health authorities (July 2013), CMS, SAMHSA, and the Administration for Children and Families (ACF) encouraged the use of focused screening, functional assessments, and EBPs in child-serving settings.<sup>49</sup> The letter describes various funding mechanisms available for services to children who have experienced complex trauma and have behavioral health needs. Although it focuses on foster care-involved youth, many of the funding opportunities can be applied to interventions for all Medicaid eligible children in other special circumstances. Medicaid and juvenile justice agencies as well as stakeholders should consider these funding opportunities in their efforts to scale up EBPs available to juvenile justice-involved youth.

## Conclusion

Health care coverage is essential for juvenile justice-involved youth to gain access to needed community supports. Medicaid agencies and state juvenile justice agencies have collaborated on strategies to facilitate coverage as youth reenter the community from juvenile facilities. Special procedures, like applying for Medicaid coverage prior to youth being released from facilities, and Medicaid policies that suspend rather than terminate eligibility are already helping youth in many states. The ACA provides new ways to increase enrollment of juvenile justice-involved youth and their families into public and private coverage. Now more than ever, collaboration among the agencies and organizations that serve this population will be needed to advance these opportunities to improve the lives of system-involved youth.

## Maintaining Fidelity to Evidence-Based Practice Models

To achieve positive outcomes from MST, FFT and MDTFC, providers must maintain fidelity to the specific program components that have been demonstrated to be effective. Maintaining quality and fidelity have proven challenging, but as policy becomes increasingly driven by performance measurement and outcomes, states are establishing data collection requirements to ensure quality. Both Louisiana and Oregon have implemented a program evaluation checklist created by the Corrections Institute at the University of Cincinnati to evaluate in-person and residential treatment programs. Additionally, Oregon is developing a separate tool to improve its measurement of program effectiveness.

# Appendix A



**Federal-State Dialogue on Improving Health Coverage  
For Juvenile Justice-Involved Youth  
Baltimore, MD | July 16, 2013**

**National Academy for State Health Policy  
With Support from the MacArthur Foundation**

**Purpose:**

To bring together officials from federal agencies and state Medicaid and Juvenile Justice agencies to identify federal and state policies and practices to facilitate health coverage and access for juvenile justice-involved youth. Since many of these youth are eligible for Medicaid or CHIP, overcoming barriers to program enrollment and improving retention of public coverage will enhance access to health care for themselves, their families, and the agencies that serve them. Federal and state policies will be explored that can be employed to improve health care coverage and foster continuity of care, particularly at critical points of transition such as reentry into the community. Also covered will be evidence based practices state Medicaid and juvenile justice agencies can promote to improve service delivery for this population.

Following the meeting, these expert deliberations will be captured in a report and webinar targeted to state officials and community based organizations to promote widespread adoption of coverage initiatives for juvenile justice-involved youth.

**8:00 AM**

**Breakfast Available**

**8:30 AM – 9:00 AM**

**Meeting Purpose and Charge to Participants**

Diane Justice, National Academy for State Health Policy

Laurie Garduque, MacArthur Foundation

*Topic:*

- Challenges to improving health care coverage and health care for juvenile justice-involved youth
- Need for federal and state policy solutions and practices
- Meeting goals and expectations

**9:00 AM – 11:30 AM**

**Enhancing Health Coverage and Retention for Juvenile Justice-Involved Youth through Medicaid Enrollment Options**

*Topic:*

- Important eligibility tools available to states, such as 12-month continuous eligibility and eligibility suspension, presumptive eligibility, and expedited enrollment practices specifically for juvenile justice-involved youth.
- Options and flexibility available to states, from the federal perspective.

- Implementation strategies and barriers to overcome.
- Technical policy changes states need to adopt to implement coverage improvements.
- Incorporation of eligibility policy reforms into state eligibility systems upgrades being made to implement the ACA.

The session will begin with overview presentations on eligibility options available to states, followed by presentations by state participants who will share their experiences with implementation. A discussion of all participants will follow.

Sarabeth Zemel, National Academy for State Health Policy  
 Sarah DeLone, Children and Adults Health Programs Group, Centers for Medicare and Medicaid Services  
 Patrick Beatty, Office of Ohio Health Plans  
 Daniel Schaub, Washington Department of Social and Health Services, Juvenile Rehabilitation Administration  
 Kim Bazan, Texas Health and Human Services Commission  
 Erin Fultz, Oregon Youth Authority

### **11:45 AM – 12:45 PM**

#### **Increasing Enrollment of Juvenile Justice-Involved Youth in Medicaid and CHIP**

*Topic:*

- Models of specialized outreach to Medicaid-eligible youth and their application to juvenile justice-involved youth.
- Applying the lessons of successful outreach initiatives targeted to other youth populations.
- Capitalizing on current public information campaigns to enhance enrollment in Medicaid, CHIP, and Health Exchanges.
- Coordination between Medicaid agencies, state and local juvenile justice agencies, child social services agencies.
- Engaging elements of the juvenile justice system and community organizations to facilitate Medicaid enrollment

The session will begin with an overview presentation on successful outreach strategies targeted to youth and teens, followed by a presentation on Oklahoma's approach to outreach. A discussion of all participants will follow.

Katie Baudouin, National Academy for State Health Policy  
 Ed Long, Oklahoma Health Care Authority

### **12:45 PM**

#### **Break – Buffet Lunch Available**

### **1:00 PM – 1:45 PM**

#### **Working Lunch: Evidence Based Practice for Meeting the Needs of Juvenile Justice-Involved Youth**

- Evidence based practices proven to effective in meeting the needs of juvenile justice-involved youth and their potential for Medicaid coverage

John Morris from the Technical Assistance Collaborative will review selected evidence-based practices and lead a discussion among all participants on how states can support these interventions and the potential for Medicaid financing.

### **1:45 PM – 2:30 PM**

#### **Emerging Issues—Transitions in Coverage Between Medicaid, CHIP and Exchanges**

- Potential challenges in coordinating coverage for youth moving from Medicaid to the Exchange and back again.
- Education and outreach on eligibility and enrollment in Exchange plans.
- Transition issues of particular importance to juvenile justice-involved youth: continuity of primary care, prescription drug coverage, behavioral health treatment.
- Mechanisms to promote continuity.
- Collaboration among the juvenile justice system, Medicaid, Exchanges, and consumer assistance entities.

During this session, all participants will identify potential challenges in securing continuous health coverage for juvenile justice-involved youth when the exchanges are established and ways to address them.

### **2:30 PM-3:00 PM**

#### **Call to Action, Next Steps**

#### **Guidance to states and the federal government on approaches to enhancing access to health coverage and health care for juvenile justice-involved youth: a facilitated discussion**

Diane Justice, National Academy for State Health Policy  
Laurie Garduque, MacArthur Foundation

# Appendix B



## Federal-State Dialogue on Improving Health Coverage for Juvenile Justice-Involved Youth

July 16, 2013

Hotel Monaco • Baltimore, MD

### Participant List

Nancy Ayers  
Deputy Administrators  
Office of Juvenile Justice and Delinquency  
Prevention

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Policy Specialist  
NASHP

Kim Bazan  
Senior Policy Advisor, Office of Social Services  
Texas Health and Human Services Commission

Patrick Beatty  
Deputy Director  
Ohio Department of Medicaid

Rhett Decoteau  
Section Chief, Medicaid Eligibility Policy  
Louisiana Health and Hospitals

Sarah deLone  
Senior Policy Advisor  
Centers for Medicare and Medicaid Services

Karl Doss  
Training and Technical Assistant  
Coalition for Juvenile Justice

Kenneth Finegold  
Social Service Analyst  
U.S. Department of Health and Human Services

Rebecca Flatow  
Public Health Analyst  
Substance Abuse and Mental Health Services  
Administration

Erin Fultz  
Community Resources Manager  
Oregon Youth Authority

Laurie Garduque  
Director, Justice Reform  
John D. and Catherine T. MacArthur Foundation

Larke Huang  
Senior Advisor, Lead, Trauma and Justice  
Strategic Initiative  
Substance Abuse and Mental Health Services  
Administration

Diane Justice  
Senior Program Director  
NASHP

Lisa Lee  
Deputy Commissioner  
Department of Medicaid Services

Danielle Lewis  
Acting Associate Director, Division of Eligibility  
Policy  
Department of Health Care Finance

Mary Livers  
Deputy Secretary  
Louisiana Office of Juvenile Justice

Ed Long  
Community Relations Manager  
Oklahoma Health Care Authority

Ned Loughran  
Executive Director  
Council of Juvenile Correctional Administrators

Linda Mellgren  
Senior Social Science Analyst  
U.S. Department of Health and Human Services

Kimm Mooney  
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Catherine Pierce  
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Daniel Schaub  
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Department of Social and Health Services

Robert Schwartz  
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Juvenile Law Center

Sarabeth Zemel  
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# ModelsforChange

Systems Reform in Juvenile Justice

[www.modelsforchange.net](http://www.modelsforchange.net)

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