Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System: Inter-Agency Collaboration

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ModelsforChange
Systems Reform in Juvenile Justice

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ModelsforChange
Systems Reform in Juvenile Justice

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Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System: Inter-Agency Collaboration

Both juvenile justice and Medicaid agencies have a shared interest in meeting the health needs of youth in the juvenile justice system. Evidence shows that youth involved in the juvenile justice system have health care needs that are both unmet and more extensive than average. This evidence suggests that more than 70 percent of youth in the juvenile justice system have a mental health disorder,[1] and approximately 27 percent have a serious mental illness.[2] Of those who meet criteria for one disorder, more than 60 percent of juvenile justice-involved youth also meet criteria for three or more mental health disorders, and girls are significantly more likely to have mental disorders than boys.[3] Juvenile justice-involved youth also have higher-than-average rates of substance abuse.[4] Additionally, youth in the system often have physical health problems, including asthma, ear infections, and improperly healed bone fractures.[5] Other health issues include exposure to sexually transmitted diseases and inadequate dental care.[6]

Medicaid is important to juvenile justice-involved youth both as a health care financing mechanism and as a way to access physical and behavioral health services. Although there is a lack of data to highlight just how important Medicaid is to juvenile justice-involved youth, through survey work discussed below, we now know that in some states, significant numbers of system-involved youth depend on Medicaid coverage. Although the percentages vary depending on the state, the way juvenile justice agencies define "youth involved in the juvenile justice system," or the type of services that are under the jurisdiction of the agency, at least one state agency reports that 100 percent of juvenile justice-involved youth under its control are enrolled in Medicaid. Collaboration between these agencies is important since such a high percentage of their populations overlap. Better meeting these youth's health needs could result in more efficient and effective use of the resources available to ***both*** agencies – and also ultimately help youth's well-being and their ability to remain in the community, as well as decrease recidivism.

Collaboration between Medicaid and juvenile justice system is important to addressing the barriers to physical and mental health coverage and care for juvenile justice-involved youth. A strong partnership between these agencies is critical to more effectively meeting the health needs of this population. Educating juvenile justice agencies and staff about Medicaid policies is important because the Medicaid program can finance mental and physical health services for juvenile justice-involved youth in certain placements, as well as being an important way for youth to receive services once they transition out of the system. Finally, the collection of information about the population served by both agencies can help inform agencies about the health needs of these youth.

In December 2008-February 2009, the National Academy for State Health Policy (NASHP) fielded two surveys about health care and Medicaid policies for youth in the juvenile justice system. We surveyed Medicaid and juvenile justice agencies and tailored each survey to issues related to serving juvenile justice-involved youth. This paper is the first of three briefings containing survey findings and focuses on three areas: (1) collaboration between Medicaid and juvenile justice agencies; (2) educating juvenile justice agencies about Medicaid policies; and (3) what Medicaid and juvenile justice agencies know about the population they both serve.

NASHP's goal for this project is for juvenile justice and Medicaid agencies to gain insight and knowledge about each other and improve the coordination between the two systems. In turn, it is our hope that better coordination between Medicaid and juvenile justice will produce system changes to more effectively meet the critical physical and mental health needs of juvenile justice-involved youth.

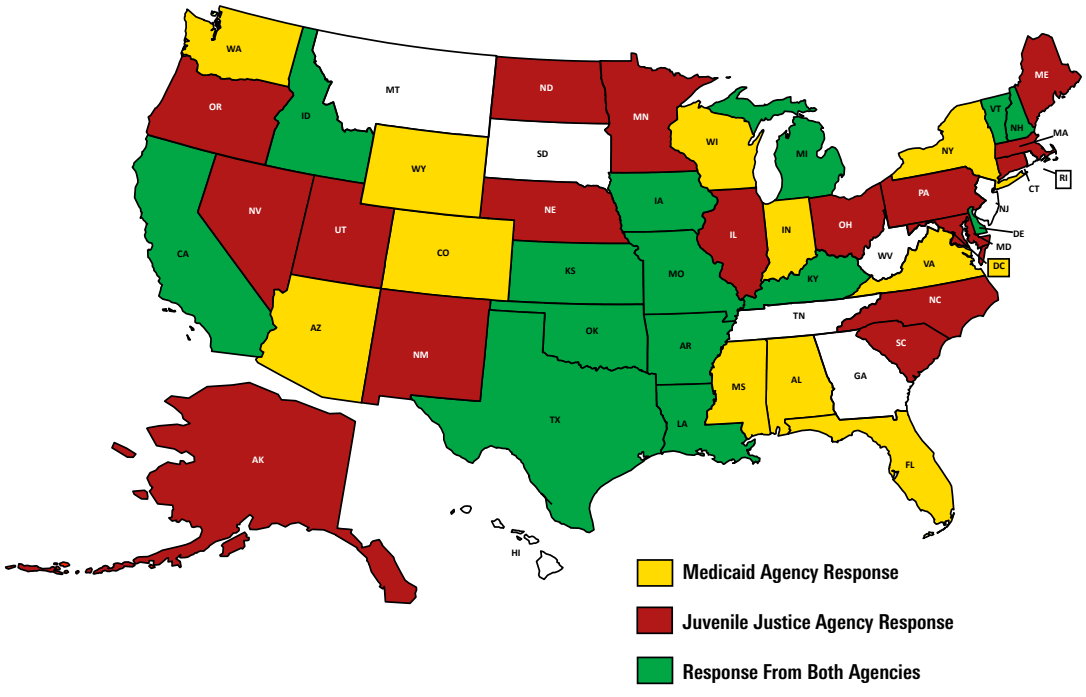
Methodology

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. The survey instruments were piloted by knowledgeable staff in each agency. (See NASHP's website for copies of these survey instruments.) 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.[7] 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.

We achieved a good survey response rate, receiving at least one agency response from almost all of the states. It is likely that without the severe budget situation in many states—some 47 states are facing shortfalls in their FY2009 and/or FY2010 budgets[8]—our response rate would have been even higher. Several Medicaid agencies cited their lack of resources—both in overall staff and staff time—as reasons they could not fill out this survey.

Responses from a Survey of Medicaid and Juvenile Justice Agencies
50 States and the District of Columbia



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 first of three issue briefs containing survey findings, and focuses upon the collaboration between Medicaid and juvenile justice agencies. Subsequent survey finding reports will focus on eligibility, enrollment and retention policies; and service delivery policies for improving the health and well-being of youth involved in the juvenile justice system.

We only surveyed the executive branch juvenile justice agency in each state. As explained in a subsequent section of this paper, some states put local or county-level authorities in charge of probation services, and sometimes detention facilities. Therefore, this may account for some variation in the way the juvenile justice agencies accounted for and provided data on "youth in the juvenile justice system."

Although some questions were asked on both surveys, this undertaking was not meant to test the agencies about what they know of each other. Rather, we wanted to find out the practices and policies that each agency has in place for inter-agency collaboration, the collection of information about youth in the juvenile justice system; eligibility and enrollment practices; and finally, the provision of physical and mental health care services. Cases where we received surveys from both state agencies and received different responses to the same question may be due to differing levels of knowledge or familiarity with these policies by the individuals filling out the survey. The discrepancy in answers between agencies may also be due to different perceptions about the needs of this population.

Background Information on Juvenile Justice and Medicaid Programs

Juvenile justice and Medicaid programs affect the lives of juvenile justice-involved youth. State- and county-administered juvenile justice programs govern the provision of services, treatment, and care coordination of services for this population. Medicaid provides comprehensive health coverage to more than half of all poor and low-income children, which also includes many youth involved in the juvenile justice system. To understand the role that these programs and agencies play in delivering physical and mental health care services to youth in the juvenile justice system, some information about them may be useful. For more background about these programs, please see NASHP's report, *A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth.*

Juvenile Justice

Every state has an executive branch agency with responsibility for administering services for youth in the juvenile justice

system. Depending on the state, the agency with this authority differs. It may be a social/human services agency, a separate juvenile corrections agency, or, infrequently, an adult corrections agency. States also differ in the degree to which local authorities control services.[9] Some states may be "centralized" and have one state agency in charge of services across the state, while "decentralized" states put local authorities in charge of probation services, and sometimes detention facilities. In still other states there is a mix of both state and locally-operated delinquency services.

Each state operates its own juvenile justice program. States administer and organize services in a variety of ways for juveniles who have been arrested for a delinquent offense and referred to court.[10] These services include detention (or temporary custody while awaiting a court's decision), probation ("conditional freedom"), placement in a residential program or secure facility after adjudication, and aftercare.[11]

The majority of youth awaiting trial are released rather than detained at a juvenile justice facility.[12] Less than a quarter of youth who are adjudicated delinquent are committed to a facility or institution to serve a sentence; most are ordered to probation in a community setting.[13] Detained and committed youth are usually housed in different facilities. Community settings—which include group homes and wilderness programs—vary in size and can be privately or publicly operated. Federal law requires that state juvenile justice systems provide timely and appropriate physical and mental health services to youth in the system, specifically those held in commitment facilities.[14]

Medicaid

Medicaid is an entitlement program that is administered by states within federal guidelines. Medicaid pays for medical assistance for certain individuals and families with low incomes.

An individual enrollee receives Medicaid services if: (1) the service is covered by the program (covered services); and (2) the individual enrollee qualifies to receive a covered service (medical necessity). For children under age 21, federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements establish a consistent set of covered services and definition of medical necessity across states. EPSDT ensures that each child's health and developmental needs are assessed through initial and periodic examinations and evaluations, and that health and developmental problems are identified and treated early.[15] EPSDT regulations also require Medicaid agencies to make available all covered services needed "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the [EPSDT] screening services."[16] The federal government shares the cost of qualified Medicaid services with states at a set rate that varies by state.

Longstanding federal law prohibits federal Medicaid funds from providing "care or services for any individual who is an inmate of a public institution."[17] This law is often understood to mean that Medicaid is not available to pay for services for youth in the juvenile justice system. However, states can receive federal Medicaid funding for youth in many juvenile justice settings.[18] These rules will be explained in detail in subsequent issue briefs in this series.

How can Medicaid fund services that juvenile justice-involved youth need?

- Services that promote early identification, such as screening for behavioral health or substance abuse, can be covered by Medicaid.
- Components of clinical mental health services, such as Multi-Systemic Therapy, can be covered by Medicaid when medically necessary.

For more information see NASHP's, *A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth.*

Findings

Cross-agency collaboration is important to addressing the barriers to physical and mental health coverage and care for juvenile justice-involved youth. As discussed earlier, this population has extremely high mental health and physical health needs. State Medicaid and juvenile justice agencies can communicate through formal or informal structures, like regular or ad hoc meetings, or enter into agreements, which allow them to work together on issues. Through collaboration, agencies can reduce fragmentation or duplication of services to this population and improve coordination between these agencies, ultimately helping to improve the health and well-being of these youth.

It is also important that juvenile justice staff and providers understand Medicaid policies, since Medicaid is a potential source of reimbursement for some services for youth in the juvenile justice system. Medicaid is also a critical way for youth

to obtain health care services after transitioning out of the juvenile justice system and returning to the community. Effectively managing this transition from the system to the community is extremely important for youth with physical or mental health needs, so knowing Medicaid agency eligibility or enrollment processes is a way for juvenile justice staff to assist these youth with this transition.

Formal Structures To Facilitate Collaboration Between Medicaid And Juvenile Justice Staff

Agencies reported several different ways of collaborating between Medicaid and juvenile justice staff. These structures include regular or ad hoc meetings; staff liaisons assigned to one agency or the other or shared staff between agencies; and interagency agreements or memoranda of understanding so that agencies can share data or work together on issues.

Most states—37 of the 43 states (or 86 percent) that responded to the survey—reported using at least one method of collaboration between Medicaid and juvenile justice agencies (see Table 1). Twenty-nine states reported having ad hoc meetings with one another, while 26 states reported having interagency agreements or memoranda of understanding. Slightly fewer—20 states—reported having assigned staff liaisons, only 14 reported regular meetings, and only two states—the South Carolina Department of Juvenile Justice and the Wyoming Department of Health—reported sharing staff between Medicaid and juvenile justice agencies. Six states reported having no formal structures in place.

Delaware's Medicaid agency reported having an assigned staff liaison facilitating contact between the two agencies. The Division of Medicaid and Medical Assistance reported that a juvenile justice agency contact is assigned as a point person for contact with the Medicaid agency regarding matters of coverage and eligibility for youth involved with the juvenile justice agency.

Most responding states reported more than one type of collaboration: Thirty states reported multiple types of collaboration between agencies. For example, the Oregon Youth Authority reported they have a Medicaid outstation specialist in the juvenile justice agency, and the two agencies engage in both regular and ad hoc meetings, including Mental Health Advisory Committee meetings, meetings of an Interagency Children's Services/Operations group, and other ad hoc groups that are convened as needed to deal with specific issues.

Twelve states reported having other types of structures that foster collaboration; however, many of these states did not report the types of collaboration we anticipated. We thought that states would highlight efforts being undertaken at the policy or planning level of the agencies. Instead, many states reported inter-agency collaboration efforts between Medicaid and juvenile justice that involved providing services or care to youth. For example, the Oklahoma Health Care Authority reports the state is working on a statewide care coordination project for children with complex needs covered by Medicaid who are also in Office of Juvenile Affairs (OJA) custody. The Nebraska Department of Health and Human Services reported that both agencies share an Administrative Service Organization (ASO).

Table 1: Formal Structures that Facilitate Collaboration Between Medicaid and Juvenile Justice Staff

	Medicaid Agency Response (N=25 respondents)		Juvenile Justice Agency Response (N=30)		Either Agency (N=43)	
	Number	Percent	Number	Percent	Number	Percent
Regular Meetings	6	24%	8	27%	14	33%
Ad Hoc Meetings	12	48%	20	67%	29	67%
Assigned Staff Liaisons	11	44%	13	43%	20	47%
Interagency Agreements or Memoranda of Understanding	13	52%	17	57%	26	60%
Shared Staff	1	4%	1	3%	2	5%
Other	6	24%	6	20%	12	28%
Use At Least One Method	19	76%	25	83%	37	86%
Use Multiple Methods	14	56%	20	67%	30	70%

Table 2: Agency Efforts to Educate Juvenile Justice System Staff or Providers about Medicaid Policies						
	Medicaid Agency Response (N=25 respondents)		Juvenile Justice Agency Response (N=30)		Either Agency (N=43)	
	Number	Percent	Number	Percent	Number	Percent
Conduct workshops targeted to juvenile justice staff	6	24%	13	43%	18	42%
Conduct workshops that are open to juvenile justice staff but not specifically targeted to their needs	4	16%	5	17%	9	21%
Provides written material targeted to juvenile justice staff	2	8%	17	57%	19	44%
Provides written material to juvenile justice staff that was prepared for a broader audience	3	12%	10	33%	13	30%
Other	12	48%	11	37%	21	49%
Engage in At Least One Effort	18	72%	25	83%	38	88%

Medicaid Or Juvenile Justice Agency Involvement In Efforts To Educate Juvenile Justice System Staff Or Providers About Medicaid Policies

There are many ways agencies can educate juvenile justice system staff or providers about Medicaid policies. Agencies can conduct general workshops, or those targeted to the needs of juvenile justice staff; provide targeted written materials, or materials prepared for a broader audience.

Most states—38 of the 43 states (or 88 percent) that responded to the survey—reported they are involved in efforts geared towards educating juvenile justice system staff or providers about Medicaid policies (see Table 2). Agencies are doing this in a variety of ways:

- Eighteen states reported they conduct workshops targeted specifically to juvenile justice staff.
- Nineteen states provide materials written specifically for juvenile justice staff.
- Nine states reported they conduct more general workshops that are open to juvenile justice staff but not directly targeted for their needs.
- Thirteen states provide materials to juvenile justice staff that are prepared for a broad audience.
- Four states reported that they are not involved in any education efforts, while one state could not identify whether they engaged in any education activities.

In Delaware, representatives of the client eligibility unit of the Department of Services for Children, Youth and Families, which oversees the juvenile justice agency, periodically conducts training for juvenile justice caseworkers regarding Medicaid eligibility for youth. A guide was developed for the juvenile justice staff that explains the special rules regarding eligibility, coverage and provider eligibility for Medicaid recipients who become involved with the juvenile justice system. Delaware also reports that the Cost Recovery Administrator from the Department of Services for Children, Youth and Families, which includes the juvenile justice agency, maintains routine contact with the policy and eligibility staff at the Medicaid agency to ensure there is common understanding between the two agencies regarding claiming and eligibility rules applicable to incarcerated youth.

Twenty-one states also reported that they are engaged in "other" types of education efforts. For example, the New Mexico Children, Youth and Families Department reports that learning about Medicaid policies is a required part of core training for new juvenile justice staff. The Florida Agency for Health Care Administration reports that utilization managers provide onsite technical assistance. The New York State Department of

Health distributes relevant administrative directives regarding Medicaid policies for children to the Office of Children and Family Services (the juvenile justice agency).

Data About Juvenile Justice-Involved Youth

Collecting data about youth in the juvenile justice system allows agencies to learn about the needs of these youth, and hopefully helps agencies to more effectively meet those needs. We asked juvenile justice agencies about the number of youth in the juvenile justice system and both agencies about the number covered by Medicaid. We also asked Medicaid agencies about the money spent on juvenile justice-involved youth who are enrolled in Medicaid, as well as the most frequently-occurring diagnoses for juvenile justice-involved youth enrolled in Medicaid.[19]

While juvenile justice agencies were able to provide data on the numbers of youth in the juvenile justice system, we received very few responses to the other questions, beyond "don't know" or "data is unavailable," which appears to indicate that neither agency routinely collects data about the group of youth who are served by both systems.

Medicaid-Enrolled Children In The Juvenile Justice System

Five Medicaid agencies were able to give us numbers of Medicaid-enrolled youth in the juvenile justice system.[20] These numbers ranged from 347 in Michigan to 1,170 in Alabama during fiscal year 2008. Twenty agencies did not know or their data was not available.

Ten juvenile justice agencies were able to report data on Medicaid-enrolled youth in the system.[21] These numbers ranged from 127 in Idaho to 9,896 in Oklahoma. Another 12 agencies gave us estimated numbers of Medicaid-enrolled youth. Seven juvenile justice agencies reported that they did not know this information. The range in figures is substantial, and can most likely be explained by the different ways that agencies defined "youth in the juvenile justice system" due to services the agency has under its control. For example, Idaho counted only youth in commitment facilities, whereas Oklahoma counted youth in detention, probation, commitment, and youth referred to the juvenile justice system.

We also asked juvenile justice agencies to report their total number of youth in the juvenile justice system. For juvenile justice agencies that were able to report both Medicaid-enrolled youth, and total youth in the juvenile justice system, we were able determine the percent of juvenile justice-involved youth who were covered by Medicaid. These percentages varied considerably, and some states reported data from different reporting periods although we asked states for fiscal year 2008 data; however, three of these seven states had 60 percent or more of juvenile justice-involved youth covered by Medicaid. The Massachusetts Department of Youth Services reported that 100 percent of youth in the juvenile justice system (those in commitment or detention) were enrolled in Medicaid.[22] The state reporting the lowest percentage of youth in the juvenile justice system enrolled in Medicaid still reported that almost a third of system-involved youth were covered by Medicaid; according to the Idaho Department of Juvenile Corrections, 29 percent of youth in commitment in the state were enrolled in Medicaid.[23] It is important to note that this does not mean that any of these states are paying for Medicaid services provided to this population—federal law prohibits Medicaid reimbursement for services provided in some settings—just that youth are enrolled in the program.

Suspending Medicaid Eligibility For Youth In The Juvenile Justice System

Federal law prohibits Medicaid payments for care or services for certain inmates of public institutions. Some states choose to terminate an individual's Medicaid eligibility when the agency learns a Medicaid enrollee in the juvenile justice system has been incarcerated. The youth is then required to reapply for Medicaid upon release and must wait for an eligibility determination before they may access services.

However, states do not have to terminate eligibility for Medicaid when youth are incarcerated. Instead, the state agency may suspend eligibility rather than terminate it. Suspended youth retain Medicaid coverage, but Medicaid will not pay for services until the youth's release. For more information, see NASHP's *Improving Access to Health Coverage for Transitional Youth.*

Money Spent On Juvenile Justice-Involved Youth Enrolled In Medicaid

Four Medicaid agencies were able to give us figures for the amount of money spent on juvenile justice-involved youth enrolled in Medicaid during the last fiscal year (FY 2008). These figures ranged from approximately $41,000 in Michigan to approximately $4.9 million in Alabama. Twenty-one agencies did not know or their data was not available.

Frequently-Reported Diagnoses For Juvenile Justice-Involved Youth Enrolled In Medicaid

According to a 2006 study, youth involved with the juvenile justice system experience high rates of various mental health disorders. Disruptive disorders, including conduct disorders were most common (46.5%), followed by substance use disorders (46.2%), anxiety disorders (34.4%), and mood disorders (18.3%).[24]

We asked Medicaid agencies about the three most frequently-reported diagnoses for juvenile justice-involved youth enrolled in Medicaid. Although we received few responses (20 of 25 states reported they did not know the most frequent diagnoses or their data was not available), the data we did receive seem to indicate that the disorders cited above are frequent among Medicaid-enrolled youth involved in the juvenile justice system.

We received responses from five states, and disruptive disorders and mood disorders were cited as top diagnoses. Other mental health disorders were also reported by respondent agencies. Only two agencies cited physical health conditions among their three most frequently-reported diagnoses.

Data Collection Is A Potential Area For Improvement

Medicaid and juvenile justice agencies are clearly working together in a variety of ways; however, one area where agencies could improve is the collection of information or data about youth served by both Medicaid and juvenile justice systems. Most Medicaid and juvenile justice agencies could not definitively report the number of juvenile justice-involved youth enrolled in Medicaid, and most Medicaid agencies could not report the amount of money spent on this population or the most frequent diagnoses of this population. By collecting and tracking these types of data, agencies could better understand the physical and mental health needs of this group, whether both systems are meeting the needs of these children, and potentially, allow for even better and more effective collaboration between these agencies in order to serve this population.

Conclusion

Collaboration between juvenile justice and Medicaid agencies has the potential to improve the health and well-being of youth involved in the juvenile justice system. Although we found that Medicaid and juvenile justice agencies in most responding states collaborate with each other, the level of collaboration differs among states. Several states are engaging in interesting collaborative efforts around care coordination or health service delivery, and this topic will be further explored in a subsequent briefing.

Collecting and sharing data about system-involved youth between these state agencies should also help improve the health of these youth, as gathering more information about their health needs should enable agencies to better meet these needs. We found that most states do not collect or were unable to provide us with the data that we asked for. However, these survey findings show that from the states that do routinely collect these data that youth served by both Medicaid and juvenile justice systems make up both a significant number and percentage of system-involved youth. This argues that collaboration between these two agencies is extremely important for improving the mental and physical health of this population.

Notes

1 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.

2 Ibid.

3 Ibid.

4 Mana Golzari, Stephen Hunt, Arash Anoshiravani, "The Health Status of Youth in Juvenile Detention Faciilties," *Journal of Adolescent Health* 38, (2006): 776-782.

5 Ronald Feinstein et al., "Medical Status of Adolescents at Time of Admission to a Juvenile Detention Center," *Journal of Adolescent Health* 22, (1998): 190-196.

6 Ibid.

7 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.

8 Elizabeth McNichol and Iris Lav, State Budget Troubles Worsen, (Washington, D.C.: Center on Budget and Policy Priorities, Updated March 13, 2009), available at http://www.cbpp.org/files/9-8-08sfp.pdf.

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

10 Unless otherwise noted, all information in this section is from Melanie King, "Guide to the State Juvenile Justice Profiles" Technical Assistance to the Juvenile Court: Special Project Bulletin (Pittsburgh, PA: National Center for Juvenile Justice, April 2006). Retrieved 18 May 2009. http://www.ncjjservehttp.org/NCJJWebsite/pdf/taspecialbulletinstateprofiles.pdf.

11 National Center for Juvenile Justice. "Glossary." State Juvenile Justice Profiles. 2006. Retrieved 18 May 2009. http://www.ncjj.org/stateprofiles/asp/glossary.asp.

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

13 Ibid.

14 42 USC § 14141(a) and U.S. Department of Justice, Civil Rights Division, Investigation of the Scioto Juvenile Correctional Facility, Delaware, Ohio, May 9, 2007. This letter finds "the constitution requires that youth in juvenile justice institutions receive adequate mental health care," as cited by Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Portland, ME: National Academy for State Health Policy, July 2008).

15 Kaiser Commission on Medicaid and the Uninsured, The Medicaid Resource Book (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2002), 60-61. Different rules apply to Medicaid for adults; states have more flexibility in terms of covered benefits and medical necessity definitions for adults. See pages 60-65 of The Medicaid Resource Book.

16 42 C.F.R. §441.50 *et seq.*

17 Social Security Act § 1905(a)(28)(A). As amended and related enactments through January 1, 2007. An inmate is one "serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities." 42 C.F.R. 441.33(a)(1), 453.1008(a)(1).

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

19 The Medicaid agency survey also asked agencies to report the number the Medicaid-enrolled youth whose Medicaid eligibility was terminated or suspended due to placement in a public institution. Likewise, the juvenile justice agency survey asked for these same data, as well as the number of youth screened for Medicaid eligibility. These findings may be discussed in a subsequent issue brief.

20 Although we asked agencies to report data for the most recent fiscal year (2008), some agencies reported data from other reporting periods.

21 Although we asked agencies to report data for the most recent fiscal year (2008), many agencies reported data from a different reporting period.

22 Massachusetts did not report a time period for this data.

23 Idaho reported data from January 2009.

24 Jennie Shufelt and Joseph Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, at 2.

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