Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System

by
Sarabeth Zemel
Neva Kaye
National Academy for State Health Policy

ModelsforChange
Systems Reform in Juvenile Justice

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

The preparation of this document was supported by the John D. and Catherine T. MacArthur Foundation. www.macfound.org.

December 2009

NATIONAL ACADEMY *for* STATE HEALTH POLICY

ModelsforChange
Systems Reform in Juvenile Justice

Models for Change

Models for Change is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. Models for Change seeks to accelerate progress toward a more effective, fair, and developmentally sound juvenile justice system that holds young people accountable for their actions, provides for their rehabilitation, protects them from harm, increases their life chances, and manages the risk they pose to themselves and to the public. The initiative is underway in Illinois, Pennsylvania, Louisiana, and Washington, and through action networks focusing on key issues, in California, Colorado, Connecticut, Florida, Kansas, Maryland, Massachusetts, New Jersey, North Carolina, Ohio, Texas, and Wisconsin.

About the National Academy for State Health Policy

The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan, non-membership organization dedicated to helping states achieve excellence in health policy and practice.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions.
- Conduct policy analyses and research.
- Disseminate information on state policies and programs.
- Provide technical assistance to states.

The responsibility for health care and health care policy does not reside in a single state agency or department. NASHP provides a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Medicaid
- Long-term and chronic care.
- Public health issues, including obesity.
- Quality and patient safety.
- Insurance coverage and cost containment.
- Children's health insurance and access to comprehensive services.

NASHP's strengths and capabilities include:

- Active participation by a large number of volunteer state officials.
- Developing consensus reports through active involvement in discussions among people with disparate political views.
- Planning and executing large and small conferences and meetings with substantial user input in defining the agenda.
- Distilling the literature in language useable and useful for practitioners.
- Identifying and describing emerging and promising practices.
- Developing leadership capacity within states by enabling communication within and across states.

For more information about NASHP, visit www.nashp.org

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

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

Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a Survey of Juvenile Justice and Medicaid Policies Affecting Children in the Juvenile Justice System

Introduction

Youth involved in the juvenile justice system have extensive health needs. Mental health disorders, including serious mental illness, are prevalent.[1] Substance abuse is widespread,[2] and physical health problems are common among this population.[3]

Medicaid is important for juvenile justice-involved youth as both a way to finance health care and as a mechanism to access physical and behavioral health services. The evidence obtained through this project shows that significant numbers of system-involved youth depend on Medicaid coverage.[4] Agency policies that help youth enroll or retain their Medicaid coverage while they are in the juvenile justice system make it easier for these children to access critical physical and behavioral health services once they leave the system and return home. This could ultimately improve the lives of these children and increase their ability to remain in the community. Better coordination between Medicaid and juvenile justice agencies around these eligibility and enrollment issues can also result in more efficient and effective use of resources available to Medicaid and juvenile justice agencies.

The National Academy for State Health Policy (NASHP) fielded two surveys about health care and Medicaid policies for youth in the juvenile justice system. This paper is the second of three issue briefs containing survey findings. In this paper, we report survey findings relating Medicaid enrollment and retention policies for youth involved in the juvenile justice system and provide examples of promising practices used by state Medicaid and juvenile justice agencies. Survey findings are presented in three major categories:

1. How states identify youth in the juvenile justice system that already have Medicaid coverage, which is necessary for Medicaid to finance mental and physical health services for youth in certain placements.

2. How states use eligibility policies to comply with federal law prohibiting Medicaid reimbursement for services provided to youth while they are inmates of a public institution.
3. Medicaid enrollment policies, including identifying Medicaid-*eligible* youth, special enrollment procedures when youth are leaving the juvenile justice system, presumptive eligibility, and suspending Medicaid eligibility rather than terminating it when youth enter a public institution.

How Do States Identify Medicaid-Enrolled Youth Who Are Also in the Juvenile Justice System?

Both Medicaid and juvenile justice agencies have reasons to identify children who are involved with both systems; however, each agency has different purposes for identifying them, and as a result, the agencies identify these children at different times. Medicaid eligibility is important to the juvenile justice agency because Medicaid covers many of the health and behavioral health services these children may need, not only to maintain or improve their health status, but to avoid institutionalization. The Medicaid agency, on the other hand, is responsible for administering the program within federal guidelines. Federal law forbids federal Medicaid funds from being used to pay for "care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[5] Failure to adhere to this law may result in states having to return funds to the federal government. Almost all Medicaid agencies ensure that they comply with this federal law by changing children's eligibility as they move in and out of an institution—either ending or suspending eligibility at appropriate times. As a result:

- It is most critical to the juvenile justice agency to identify Medicaid-enrolled (and Medicaid-eligible) children when they enter the juvenile justice system and when they exit a public institution.
- It is most critical to the Medicaid agency to identify when children who are covered by Medicaid enter or exit a public institution.

Overall, 32 of the 43 states (or 74 percent) that responded to our survey reported being able to identify juvenile justice-involved youth who were enrolled in Medicaid.[6]

Most juvenile justice agencies take steps to identify Medicaid-enrolled youth in the juvenile justice system

Most state juvenile justice agencies—24 of 29 respondents—reported they were able to identify youth in the system that were enrolled in Medicaid. Two of the remaining five agencies reported some ability to identify such youth:

- The Texas Juvenile Probation Commission reported that county agencies can identify these youth.
- The Alaska Department of Health and Social Services, Juvenile Justice Division, reported that they can identify whether youth have a Medicaid enrollment number, but are unable to easily determine whether the number is valid and the child is currently enrolled.

All five of the agencies that could not identify Medicaid-enrolled youth believed doing so would benefit their agency. Two agencies specifically said that identifying Medicaid-enrolled children would help better meet the health needs of these youth, while two agencies believed identifying Medicaid-enrolled youth would have an economic benefit to the agency/state.

What Levels of Government are Involved in the Juvenile Justice System?

Although states vary widely in structure, many states have multiple levels of government involved in their juvenile justice system. For example:

- **Counties** via the operation of juvenile courts, the operation of county detention facilities, the operation of alternatives to incarceration and the provision of parole and probation services;
- **States** via their operation of juvenile institutions for youth who commit more serious offenses and the provision of probation serves; and
- **Private entities** that contract with county or state government to operate programs as alternatives to incarceration in a public institution.

Table 1: Mechanisms by which the Juvenile Justice Agency Identifies Medicaid-Enrolled Youth

	Juvenile Justice Responses (N=24)	
	Number	Percent
Matching Records from Medicaid Agency, Child Welfare, Foster Care, or County Agencies	15	63%
Screen/Identify at Intake if Child is Covered by Medicaid	14	58%
Copy of Current Medicaid Card from Parent or Child	11	46%
Indicator in File	6	25%
Verifying with a Third Party (HMO, Fiscal Agent, etc.) who has Access to Medicaid Status Information	5	21%
Communication from Court	2	8%
Other	5	21%

Mechanisms by which the juvenile justice agency identifies Medicaid-enrolled youth

Fourteen of the 24 state juvenile justice agencies (or 58 percent) that reported they could identify Medicaid enrolled children said they used more than one method to identify these children. The most frequently reported method (15 agencies) was matching records with other agencies (See Table 1). Almost the same number (14 agencies) reported they screen/identify youth at intake to identify Medicaid enrollment.

Five juvenile justice agencies reported using another method for identifying these youth. All of these agencies reported having direct access to the Medicaid agency's database in some way.

- New Mexico's juvenile justice agency, overseen by the Children, Youth and Families Department, has direct access to the database that Medicaid eligibility workers use.
- The Pennsylvania Bureau of Juvenile Justice Services, overseen by the Department of Public Welfare (which also houses Medicaid) uses a centralized database to identify the Medicaid status of these youth.
- The Oregon Youth Authority (OYA) has a Department of Human Services Medicaid eligibility specialist outstationed in its agency. This worker has access to the state's Medicaid Management Information System (MMIS) and is able to enter data on all OYA youth.
- The New Hampshire Department of Health and Human Services and Connecticut Department of Children and Families also reported having online access to Medicaid eligibility files.

Difficulties identifying Medicaid-enrolled youth who are in the juvenile justice system

Nine out of 21 juvenile justice agencies (or 43 percent of respondents) reported they had no difficulties identifying this group of children. Nine respondents reported a specific difficulty:[7]

- Six juvenile justice agencies reported that they had difficulty ensuring the Medicaid enrollment information or case file data—such as date of birth or social security number—was accurate and up-to-date, or that Medicaid enrollment information was consistently documented in case files.
- Two agencies—the Louisiana Office of Juvenile Justice and the Connecticut Department of Children and Families—cited difficulties obtaining information from parents about children's Medicaid enrollment. The Connecticut agency specified that sometimes parents inadvertently provide inaccurate information.
- One agency—the Texas Juvenile Probation Commission—reported difficulty in not having access to the Medicaid system to review at the county level.

Almost half of Medicaid agencies identify at least some Medicaid-enrolled youth involved in the juvenile justice system

Almost half of responding Medicaid agencies—12 of 25—reported they could identify Medicaid-enrolled youth who were in the juvenile justice system. Among the 12 Medicaid agencies able to identify juvenile justice-involved youth, ten specified which groups of juvenile justice-involved youth they could

identify.[8] Among these ten:

- Six Medicaid agencies reported they could identify children whose eligibility was terminated or suspended because they became inmates of a public institution.[9]
- Two Medicaid agencies could identify children whose Medicaid eligibility began after they were discharged from a public institution.
- Two Medicaid agencies could identify youth involved in the juvenile justice system who were not inmates of a large (16 or more beds) public institution.
- Two Medicaid agencies could identify children who were arrested and awaiting adjudication.
- One agency, the Wyoming Department of Health, reported they could identify children who were in court-ordered placements.

In addition, 11 Medicaid agencies (including one agency that reported identifying some groups of juvenile justice-involved youth) reported reasons they do not identify Medicaid-enrolled youth who are involved in the juvenile justice system. Three Medicaid agencies offered multiple reasons why they do not identify Medicaid-enrolled youth involved in the juvenile justice system.

- Seven agencies reported that they did not do so because the information was not reported to Medicaid by another entity (such as a local or state juvenile justice agency).
- Three agencies cited technical limitations of the Medicaid Management Information System (MMIS).
- Two agencies reported that identifying these children was not essential to program administration.
- Delaware's Division of Medical Assistance reported that the state's juvenile justice agency tracks this information.
- The Texas Health & Human Services Commission reported that juvenile justice-involved youth, who are on probation and not incarcerated, are like any other youth receiving Medicaid, so there is no reason to distinguish between them.
- The California Department of Health Services reported that it is in the process of updating its eligibility system to suspend Medicaid eligibility for incarcerated youth, so they would be able to identify some of these youth in the future.

Mechanisms by which the Medicaid agency identifies Medicaid-enrolled youth

Twelve Medicaid agencies specified the methods they use to identify juvenile justice-involved youth—five of these agencies (or 42 percent) reported they use more than one method. The only method reported by more than half was identifying youth through an indicator in eligibility files (See Table 2). One-third of the agencies that could identify juvenile justice-involved youth reported that they did so based on written communication, but there was no clear pattern in the source of those communications. Two Medicaid agencies cited other ways of identifying these youth:

- Washington's Health and Recovery Services Administration reported it has liaisons between juvenile justice facilities and the Medicaid agency, and is working on other ways of improving communication between agencies and facilities.

Table 2: Mechanisms by which Medicaid Agencies Identify Medicaid-Enrolled Youth

	Medicaid Agency Responses (N=12)	
	Number	**Percent**
Indicator in Eligibility File	8	67%
Written Communications	4	33%
From the State Juvenile Justice Agency	3	25%
From the County or Local Juvenile Justice Agencies	3	25%
From Detention Facilities	3	25%
From Courts	2	17%
A Match of Records from Child Welfare, Juvenile Justice and/or County Agencies	2	17%
Other	2	17%

- The Arizona Health Care Cost Containment System reported the agency keeps a database of children who have been reported as detained and their eligibility status at different times in the process.

Opportunities for better identifying Medicaid-enrolled youth

States seeking to improve identification of Medicaid-enrolled youth who are also involved in the juvenile justice system could take the following steps:

- **Improve Data Sharing between Medicaid and Juvenile Justice Agencies.** The most commonly cited difficulty by juvenile justice agencies in identifying Medicaid-enrolled youth was making sure Medicaid enrollment information was up to date or contained in case files. Improving data sharing between agencies could help juvenile justice agencies identify youth already enrolled in Medicaid.
- **Clarify the Role and Responsibility of Each Agency**. The most frequently reported reason that Medicaid agencies did not identify youth in the juvenile justice system was that youth's involvement in the system was not reported to them. Clarifying the role of each agency in identifying youth and the point in time they should transmit that information to one another would help ensure that each agency obtains this information when they need it.
- **Screen Youth at Intake for Medicaid Enrollment.** Another way to improve identification of Medicaid-enrolled youth is ensuring that juvenile justice agencies screen or ask for enrollment information when youth enter the juvenile justice system.

How Do States Use Eligibility Policies to Comply with the Federal Prohibition Against Using Medicaid to Pay for Services Provided to Inmates of Public Institutions?

Youth involved with the juvenile justice system can be placed in a variety of community and institutional settings both pre- and post- adjudication as well as while on probation. As stated earlier, federal law prohibits states from using federal Medicaid funds to pay for care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).[10] Almost all states use Medicaid eligibility policies to comply with this federal prohibition by terminating or suspending Medicaid eligibility when youth are 'inmates of a public institution' and reinstating eligibility when they leave that status.

What is Adjudication?

Adjudication is the stage in juvenile court proceedings when a youth's case is presented to the court, and arguments, testimony, and evidence is given in order to determine whether they committed an alleged offense. A youth may either be found innocent or be adjudicated delinquent. If adjudicated delinquent, the judge can recommend that the youth take voluntary action toward change (such as therapy or rehabilitation services) before the disposition hearing. The disposition hearing determines the specific sanctions against the youth.

Federal law defines an "inmate of a public institution." Policy guidance issued by the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration, attempted to clarify these rules, but some confusion and differences remain in how states interpret the policy for youth involved in the juvenile justice system. For example, in some states, children who are temporarily placed in a detention facility while awaiting adjudication retain their Medicaid eligibility until their case is adjudicated. In other states, children lose their Medicaid coverage when they enter the detention facility, even if their case has not yet been adjudicated. Indeed, our survey found that states vary in how they interpret that situation and others—both in terms of what they consider to be a 'public institution' and who they consider an 'inmate.' The variations have consequences for states and juvenile justice-involved youth. More liberal Medicaid policies can increase the availability of funding to pay for services provided to children in the juvenile justice system. More liberal policies may also result in fewer changes to an individual youth's eligibility—and thus reduce the potential for being disenrolled during transitions. On the other hand, more conservative interpretations make it unlikely that a state will incur a disallowance for failure to follow federal Medicaid rules around allowable expenditures.[11] (Please see NASHP's *Improving Access to Health Coverage for Transitional Youth* for more explanation and analysis of the federal rules and guidance around Medicaid coverage of youth in the juvenile justice system.)

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

All responding Medicaid agencies allowed juvenile justice-involved children in some types of placements to remain enrolled in Medicaid.[12] There was wide variation among agencies in the settings in which juvenile justice-involved youth were able to remain enrolled in Medicaid. Among the 25 reporting Medicaid agencies, the average number of allowable settings was four, ranging from a high of seven to a low of one.

As anticipated, Medicaid agencies most frequently reported that youth in community settings retain Medicaid coverage—22 of the 25 reporting Medicaid agencies (88 percent) reported that juvenile justice-involved youth in day treatment could remain enrolled in Medicaid (See Table 3). As youth more clearly met the definition of "inmate of a public institution" fewer Medicaid agencies reported allowing youth to retain Medicaid eligibility—only eight Medicaid agencies (32 percent) allowed youth in a detention center that are awaiting adjudication to remain enrolled in Medicaid.

The family or juvenile justice agency is most likely to be responsible for reporting that a youth has been detained or committed

There was strong agreement among Medicaid and juvenile justice agencies about which actor is responsible for reporting when a youth is detained or committed. Both agencies most frequently reported that the family and juvenile justice agencies are responsible for reporting when a youth is detained (See Table 4). Among these two options, however, Medicaid agencies most frequently reported that the family/individual is responsible while juvenile justice agencies most often reported that they are responsible for informing Medicaid.[13]

Juvenile justice agencies also reported that the enrollee/family or state juvenile justice agency is most frequently responsible for informing the Medicaid agency when a child is committed (See Table 5). Their responses regarding commitment were very consistent with those regarding detention. (We did not ask Medicaid agencies for information regarding responsibility for reporting commitment.)

Table 3: Settings in which the State Allows Juvenile Justice-Involved Youth to be Enrolled in Medicaid

	Medicaid Agency Responses (N=25)	
	Number	Percent
Group Home	22	88%
Day Treatment	21	84%
House Arrest	19	76%
Public Institution with Fewer than 16 Beds	18	72%
Private Institution	17	68%
Pre-Adjudication Detention Facility	8	32%
Private Boot Camp	6	24%

Table 4: Responsibility for Informing the Medicaid Agency when Youth Are Detained

	Medicaid Agency Responses (N=25)		Juvenile Justice Responses (N=28)	
	Number	Percent	Number	Percent
Enrollee/Family	16	64%	10	36%
State Juvenile Justice Agency	10	40%	12	43%
Child Welfare Agency	7	28%	8	29%
County or Local Juvenile Justice Agency	5	20%	6	21%
Detention Facilities	5	20%	3	11%
Courts	2	8%	0	0%
Probation Officer	2	8%	3	11%
State Medicaid Agency	1	4%	2	7%
Other	4	16%	4	14%

Table 5: Responsibility for Informing Medicaid when Youth Are Committed

	Juvenile Justice Responses (N=28)	
	Number	Percent
State Juvenile Justice Agency	14	50%
Enrollee/Family	11	39%
Child Welfare Agency	6	21%
County or Local Juvenile Justice Agencies	3	11%
Probation Officer	3	11%
Corrections Facility	2	7%
Other	4	14%

Detention vs. Commitment

Detention is the temporary custody of youth who are accused of a delinquent offense and require a restricted or secure environment while awaiting final court disposition. Commitment refers to the placement of youth into a secure facility as part of a court-ordered disposition. Placement in a detention facility typically occurs before a court adjudicates a case, while placement in a commitment facility typically occurs after a judge decides a case.[14]

Opportunities for enrolling more juvenile justice-involved youth in Medicaid

States seeking to enroll or retain greater numbers of juvenile justice-involved youth in Medicaid could take the following steps:

- **Re-examine and Modify State Eligibility Policies**. States seeking to enroll more youth involved in the juvenile justice system into Medicaid could examine the eligibility policies they use to enforce the prohibition against using Medicaid to cover inmates of a public institution. States could consider liberalizing their own definition of an inmate of a public institution within the framework of current federal policy guidance.
- **Clarify Federal Policy**. Clarification from the Centers for Medicare and Medicaid Services could also help states understand the federal rules, and ensure juvenile justice-involved youth retain their Medicaid eligibility in allowable settings. This could also eliminate gaps in coverage and allow youths to access Medicaid services as they move from an institution to the community.

What Strategies Do States Use to Ensure that Medicaid-Eligible Youth are Enrolled in the Program as They Transition to the Community?

Transitioning from institutional settings back to the community or home is a critical time for juvenile justice-involved youth. As youth move through the juvenile justice system—sometimes bouncing between settings multiple times before leaving the system completely—there are many opportunities for them to lose their Medicaid eligibility. We found that some states are paying special attention to this critical time and have established policies to identify children in the system that are eligible for Medicaid, but not yet enrolled. States are also using enrollment procedures that will allow youth to quickly and easily enroll into Medicaid. These procedures include presumptive eligibility, suspending eligibility rather than terminating it, and establishing special enrollment procedures, like requiring case managers or probation officers to fill out Medicaid applications for youth who are about to leave an institution.

Less than half of juvenile justice agencies report they screen or identify Medicaid-eligible youth at intake

Identifying youth *eligible* for Medicaid is an important first step to enrolling them in Medicaid. The juvenile justice agency can play a role in identifying (and even enrolling) these youth. Only 12 of 28 juvenile justice agencies (or 43 percent) reported they screen or identify youth at intake to identify youth who may be eligible for Medicaid.

Some juvenile justice agencies report that juvenile justice agents fill out presumptive eligibility applications

Presumptive eligibility is a state option in Medicaid that allows qualified entities to determine, based on a simplified calculation of family income, whether a child is likely to be eligible for Medicaid. States have the flexibility to deem agencies that provide services, such as juvenile justice programs, as qualified entities.[15] Youth can receive temporary Medicaid eligibility pending a final eligibility determination by the Medicaid agency. This is important because the faster youth get enrolled into Medicaid, the more quickly they will be able to access services after they transition away from the system. As of January 2009, 14 Medicaid agencies had adopted presumptive eligibility for children.[16] Presumptive eligibility can also be implemented in state-financed health programs that do not use Medicaid funds, or even other benefit programs.

Eight juvenile justice agencies reported that they allowed juvenile justice agents, such as juvenile justice agency staff, detention facility staff, or probation officers to complete presumptive eligibility applications, although not necessarily within Medicaid programs. For example, the New Mexico Medicaid agency allows staff from the Children, Youth and Families Department to make Medicaid presumptive eligibility determinations for juvenile justice-involved youth.[17] (For more about New Mexico's program see NASHP's publication, *A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth*.) However, none of the Medicaid agencies with presumptive eligibility that responded to our survey reported that they specifically allow juvenile justice agents to complete presumptive eligibility applications. There was no overlap in the state representation of juvenile justice agencies that reported that juvenile justice agency staff completed presumptive eligibility applications and the Medicaid agencies who reported they did not allow juvenile justice agents to fill out presumptive eligibility applications.

Most juvenile justice agencies report they have special procedures to facilitate enrollment into Medicaid for juvenile justice-involved youth, while most Medicaid agencies report they do not for this population

Most responding juvenile justice agencies reported they had special procedures to facilitate Medicaid enrollment for youth transitioning from the system. Twenty-three of 30 juvenile justice agencies (or 77 percent) report they have special procedures to facilitate Medicaid enrollment for youth when they transition from a public institution to the community (such as moving from detention or secure corrections to home or community-based treatment). Eighteen juvenile justice agencies (or 60 percent) reported special procedures for youth leaving the juvenile justice system completely (such as being released from parole). In addition, the Idaho Department of Juvenile Corrections reported that it is working on developing procedures to facilitate Medicaid enrollment for youth leaving a public institution.

Special procedures most often cited by the juvenile justice agencies included case managers or other agency staff helping youth re-enroll. However, the level of assistance varied among agencies. Some juvenile justice agencies reported simply giving the child or child's family a Medicaid application, others reported explaining to youth the potential of enrolling in Medicaid, while other agencies reported having a formal process for agency staff filling out Medicaid applications for every youth leaving custody. Particularly strong agency procedures include:

- The Texas Juvenile Probation Commission, the state agency overseeing local juvenile probation departments, collaborated with five local juvenile probation departments and the State Medicaid office to create the Institutional Transitional Medicaid Program (ITMP). In the ITMP, youth are screened for Medicaid eligibility at intake to the facility and again no later than 45 days prior to the projected date of discharge. If the family to which the youth is returning is eligible or the family is already enrolled in Medicaid, then an application or renewal form is submitted by the juvenile probation office to the state Medicaid office on behalf of that youth and family.
- The New Hampshire Department of Health and Human Services reported the Department of Children, Youth and Families (the agency in charge of determining Medicaid eligibility) fiscal staff are notified whenever a child's placement changes. When a youth leaves detention to go to a group or residential placement, the fiscal staff immediately determines Medicaid eligibility.

However, most Medicaid agencies reported they do not have special procedures to facilitate Medicaid enrollment when youth leave an institution or when they are released from parole. Only eight of 23 Medicaid agencies (or 35 percent) reported having special procedures to help youth enroll in Medicaid when they transition from a public institution to the community. Nine Medicaid agencies (or 39 percent) reported they have special procedures for youth leaving the juvenile justice system completely.

Like the responses from juvenile justice agencies, most of the special procedures reported by Medicaid agencies involved assisting youth in applying for Medicaid, ranging from the agency facilitating enrollment for the child to giving the youth's family a Medicaid application. Examples of agency procedures include:

- The Washington Health and Recovery Services Administration reported that youth at both transition points can apply for Medicaid up to 45 days prior to release and there is an expedited eligibility determination process in place.
- The Arizona Health Care Cost Containment System reported they have an agreement with the Department of Juvenile Corrections to predetermine Medicaid/CHIP eligibility so enrollment can be posted the day of release. The agency also reports having a process in participating counties where county detention staff reinstates suspended eligibility on the day of a youth's release.
- The Colorado Department of Health Care Policy and Financing reported that a bill passed by the state legislature in 2008 requires juvenile justice commitment facility staff to assist the youth's family in applying for Medicaid coverage no later than 120 days before the youth's release date.[18]

More than half of juvenile justice agencies report having special policies to meet youth's physical or mental health needs

Many juvenile justice agencies reported they had special policies to screen for Medicaid eligibility, or had special procedures in general, for youth with physical or mental health needs.[19] Thirteen of 18 juvenile justice agencies (or 72 percent) reported having special policies for youth moving from a public institution to the community. Seven juvenile justice agencies (or 39 percent) reported having special policies for youth leaving the juvenile justice system completely. However, many of these agency procedures were the same as the procedures reported for facilitating Medicaid enrollment without regard for special health needs (see page 10). Examples of special procedures reported by juvenile justice agencies include:

- For youth leaving a less restrictive level of care, the North Dakota Department of Corrections and Rehabilitation, Division of Juvenile Services reported that it does not discharge them from custody until a case plan is in place that takes their mental and physical health needs into consideration.
- The Oregon Youth Authority evaluates all children for every possible program or benefit for which they may qualify. All "special needs" youth are known to the Oregon Youth Authority disability analysts and the Medicaid eligibility specialist. These agency staff stay in close contact with the probation/parole officers to keep track of where youth are in the system.

States are increasingly suspending rather than terminating Medicaid eligibility when juvenile justice-involved youth enter a public institution

Federal law prohibits Medicaid payments for care or services for certain inmates of public institutions. States can either terminate or suspend an individual's Medicaid eligibility when the agency learns that an enrollee in the juvenile justice system has been incarcerated. If a state terminates eligibility, then the child must reapply for Medicaid upon release and wait for an eligibility determination before accessing Medicaid services. Suspending Medicaid eligibility allows the state to restore Medicaid benefits relatively quickly—and allows the youth to quickly access services—upon release. Although suspension still requires a Medicaid agency to re-determine eligibility prior to putting the youth back on Medicaid,[20] it can reduce the burden of reapplying for coverage on the youth and family.

Among the 25 responding Medicaid agencies, the Arizona Health Care Cost Containment System reported that in most counties it suspends, rather than terminates, eligibility when youth enter a public institution. The New York Department of Health suspends eligibility for youth who are incarcerated in a New York State Department of Correctional Services or local correctional facility (not in juvenile justice facilities). The Oregon Youth Authority also reported its state Medicaid agency suspends eligibility for juvenile justice-involved youth. An additional six agencies reported that they were in the process of implementing—or interested in pursuing—such a policy.

- Three Medicaid agencies—the California Department of Health Services, Colorado Department of Health Care Policy and Financing, and the Florida Agency for Health Care Administration reported they are in the process of implementing policies and procedures to allow for the suspension of Medicaid eligibility when youth enter a public institution.
- Ohio's Department of Youth Services reported its state Medicaid agency was about to begin reinstating Medicaid coverage for individuals, including juvenile justice-involved youth, leaving public institutions who were enrolled in Medicaid at the time they entered a public institution.
- Two state Medicaid agencies reported that they were looking at the feasibility of instituting a suspension policy.

Most states reported that they do not suspend eligibility due to technology or fairness concerns

The responding Medicaid agencies that do not currently suspend eligibility when youth enter a public institution cited a variety of reasons for why they do not.[21] Agencies were most likely to report they do not suspend eligibility because it would be difficult to do under their current Medicaid Management Information System (MMIS) (eight Medicaid agencies) or because they wanted to maintain consistent practices across all enrolled populations (eight agencies). Other reasons reported include the following:

- Five Medicaid agencies did not believe there is a benefit in suspending eligibility rather than terminating it.
- Three reported it is difficult to administer a suspension policy due to having to report enrollment data to the federal government.
- One specifically cited the expense of making changes to MMIS as a deterrent to adopting a policy of suspended eligibility.

Five Medicaid agencies also reported other reasons for not suspending eligibility. For example, the Michigan Department of Community Health reported it maintains Medicaid eligibility for youth with restricted medical services.

Opportunities to ensure eligible youth enroll in Medicaid as they transition back to the community

Survey findings indicate enrollment procedures could be more effective for the juvenile justice population in the following ways:

- **Identify Youth who Qualify for Medicaid but who Are Not Yet Enrolled.** According to the survey results, only twelve juvenile justice agencies reported they screen at intake in order to identify Medicaid-eligible youth. Agencies could allow juvenile justice agents, such as case managers or probation officers, to screen children for Medicaid eligibility, and then assist with the application process, which could help ensure continuity of care, and allow youth to access medical care once they leave an institution. Medicaid eligibility questions also could be integrated into standardized screening tools that are already being used to identify youth with mental health or chemical dependency issues.
- **Adopt Specialized Outreach Designed to Reach Youth in the Juvenile Justice System**. Allowing quick Medicaid enrollment when youth are preparing to return to the community or home makes it more likely for them to be able to continue treatment or care that was begun while in an institution or other setting. Although presumptive eligibility for children is only currently used by 14 Medicaid agencies, it is one enrollment measure that could be very effective for juvenile justice-involved youth. Juvenile justice agency staff or caseworkers could also be trained to fill out Medicaid applications, especially if the Medicaid program uses a simplified eligibility form. Outreach procedures would be particularly effective for this population if they explicitly defined a role for juvenile justice agency staff in the process.
- **Suspend Eligibility.** States are increasingly using this mechanism, but few Medicaid agencies reported having such policies currently in place. By suspending eligibility, youth do not have to reapply for Medicaid, so they may access benefits and needed care more quickly once they return to the community. Suspension policies can benefit both the youth and the state by potentially reducing the paperwork burden on the Medicaid agency, as well as the child or family. However, suspending eligibility still requires the Medicaid agency to re-determine eligibility prior to re-instituting youth's Medicaid coverage.[22] Suspension may also require changes to Medicaid data systems that may be both expensive and time-consuming for agencies to implement.

Conclusion

Medicaid policies that govern program eligibility, enrollment and retention can play an extremely important role in allowing these youth to access Medicaid services both in—and once they leave—the juvenile justice system. These survey findings show that both juvenile justice and Medicaid agencies are establishing policies and working together to help youth remain enrolled in Medicaid while they are *in* the juvenile justice system, or to ensure they are enrolled in Medicaid as soon as they leave; however, more can still be done. The barriers and opportunities presented here—from clear federal policies around the definition of an "inmate of a public institution" to the use of enrollment tools like presumptive eligibility or procedures to enroll youth in Medicaid before they transition from the system—offer states ways to use Medicaid enrollment and retention policies to help juvenile justice-involved youth maintain access to critical physical and behavioral services through Medicaid and ultimately improve their health and well-being.

About the Models for Change Initiative and this Survey:

Models for Change: Systems Reform in Juvenile Justice has grown out of the juvenile justice grantmaking of the John D. and Catherine T. MacArthur Foundation. In 2004, the Foundation launched the *Models for Change* initiative to bring about systemic reform at state and local levels. (See http://www.macfound.org and http://www.modelsforchange.net.) The initiative seeks to develop replicable, system-wide changes in states that can serve as models for reform in other jurisdictions. The core *Models for Change* states – Pennsylvania, Illinois, Louisiana, and Washington – were chosen based on a variety of criteria, including their political and fiscal commitment to reform, support for reform both in and outside the juvenile justice system, and the likelihood that other states would follow their lead. The initiative's goal is to accelerate progress towards more rational, fair, effective, and developmentally sound juvenile justice systems, and thus develop models for other states to learn from and emulate. Models for Change has awarded grants to support juvenile justice reform in twelve more states through action networks focusing on key issues. The MacArthur Foundation and its partner states recognize that addressing the health needs of system-involved youth is an important part of improving the overall juvenile justice system's performance and ensuring successful individual outcomes.

NASHP has been a member of the *Models for Change* initiative since September 2007. We provide guidance and information about Medicaid policy to help *Models for Change* states improve access to physical and behavioral health coverage and health care for juvenile justice-involved youth. To that end, from December 2008-February 2009, NASHP fielded surveys about health care and Medicaid policies for youth in the juvenile justice system to state Medicaid and juvenile justice agencies. This paper is the second of three issue briefs containing survey findings, and focuses upon Medicaid eligibility, enrollment and retention policies for youth involved in the juvenile justice system. An earlier issue brief focused on inter-agency collaboration, and the last issue brief in the series will focus on delivery policies for improving the health and well-being of youth involved in the juvenile justice system.

Methodology

We conducted email surveys of the 50 states' and the District of Columbia's Medicaid and juvenile justice agencies using survey tools that were developed with the help of state Medicaid and juvenile justice officials and national experts. Surveys were returned from 26 Medicaid agencies and 31 juvenile justice agencies; we received a response from both agencies in 14 states and one agency in 29 states, for a total of 43 state responses.[23] 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.

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

3 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.

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

5 Social Security Act §1905(a)(28)(A). As amended and related enactments through January 1, 2007.

6 A state was counted as having the ability to identify juvenile justice-involved youth enrolled in Medicaid if either the state's Medicaid or juvenile justice agency responded affirmatively.

7 Although not exactly a difficulty in identifying Medicaid-enrolled youth, several juvenile justice agencies reported here that

youth lose most of their Medicaid benefits or lose coverage completely when they enter correctional facilities. One agency mentioned that this was problematic because of the significant health, mental health and substance abuse needs.

8 The Kansas Health Policy Authority reported the agency can identify Medicaid-enrolled youth, but did not specify the specific types of youth. The Texas Health and Human Services Commission reported that the Texas Youth Commission (TYC) can identify Medicaid-enrolled youth, but did not specify the specific types of youth. TYC intake staff has access to a computer matching system that lists the entitlements that the youth's family was receiving prior to commitment.

9 The Arizona Health Care Cost Containment System reported that it can only identify youth whose Medicaid eligibility has been terminated or suspended after being detained.

10 Social Security Act §1905(a)(28)(A). As amended and related enactments through January 1, 2007.

11 A disallowance is a determination by CMS not to provide federal Medicaid matching funds because a state's Medicaid expenditures does not meet federal requirements for matching payments. See Social Security Act, Section 1116(d).

12 Ten Medicaid agencies reported that they did not know whether Medicaid enrollment was allowed for youth in some settings and reported "N/A" for at least one setting. This may be due to the fact that Medicaid agencies are not familiar with the various settings in which youth may be placed.

13 This is somewhat consistent with an earlier 2003 national survey of Medicaid policies regarding youth in detention, where Medicaid agencies reported that the beneficiary or family most often notified Medicaid when a youth was detained; however, state juvenile justice agencies did not respond to the question, indicating a lack of knowledge on their part. Alison Evans Cuellar, et al. "Medicaid Insurance Policy for Youths Involved in the Criminal Justice System," *American Journal of Public Health* 95, no. 10 (Oct. 2005).

14 Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Portland, ME: National Academy for State Health Policy, July 2008), 12-15, 25.

15 For more information, see Schwartz and Glascock, *Improving Access to Health Coverage for Transitional Youth,* 19.

16 Donna Cohen Ross and Caryn Marks, *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2009).

17 Carrie Hanlon, Jennifer May, Neva Kaye, *A Multi-Agency Approach to Using Medicaid to Meet the Health Needs of Juvenile Justice-Involved Youth* (Portland, ME: National Academy for State Health Policy, 2008).

18 Session Laws of Colorado 2008, Second Regular Session, 66th General Assembly, Chapter 381 available at http://www.state.co.us/gov_dir/leg_dir/olls/sl2008a/sl_381.htm.

19 Only juvenile justice agencies that reported they have special procedures to facilitate Medicaid enrollment for youth in the juvenile justice system were asked to respond to this survey question.

20 Letter from Sue Kelley, Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State Department of Health, Sept. 14, 2000.

21 Eight Medicaid agencies cited multiple reasons for why they do not suspend Medicaid eligibility. Two agencies did not answer why they do not suspend eligibility.

22 Letter from Sue Kelley.

23 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.

ACKNOWLEDGEMENTS

We wish to thank the John D. and Catherine T. MacArthur Foundation for its support of this project, as well our project officer, Laurie Garduque. Many thanks go to the state Medicaid and juvenile justice officials who gave their time in completing the surveys. In addition, this project benefited greatly from the individuals who reviewed or piloted the survey instruments, as well as reviewed drafts of this paper. They include:

- Jane Beyer, Senior Counsel, Washington State House of Representatives
- Joe Cocozza, Director, National Center for Mental Health and Juvenile Justice
- Glenace Edwall, Director, Children's Mental Health Division, Minnesota Department of Human Services
- MaryAnne Lindeblad, Director, Division of Healthcare Services, Health and Recovery Services Administration, Washington State Department of Social and Health Services
- Minor Morgan, Chief, Juvenile Justice Entitlement Bureau, New Mexico Children, Youth and Family Department
- John Morris, Director of the Human Services Practice, Technical Assistance Collaborative, Inc.
- Jacqueline R. Scott, Senior Program Director, National Academy for State Health Policy
- John Tuell, Director Child Welfare-Juvenile Justice, The Child Welfare League of America

Finally, thanks go to NASHP's own Chris Cantrell for his work to support tracking and analysis of survey data.

ModelsforChange
Systems Reform in Juvenile Justice

www.modelsforchange.net

An initiative supported by the John D.
and Catherine T. MacArthur Foundation
www.macfound.org