Medicaid Insurance Policy for Youths Involved in the Criminal Justice System

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Juvenile justice and Medicaid agencies share an interest in serving delinquent youths, many of whom have a relatively poor health status. However, many state and local Medicaid policies result in these youths having no insurance coverage, making access to needed services difficult. A nationally representative survey of state and community juvenile justice and Medicaid agencies was conducted to assess Medicaid policies.

Evidence from the survey suggests that in some areas delinquent youths are actively disenrolled from Medicaid benefits, and in others little effort is made to connect them to Medicaid coverage. Discrepancies between justice agency and Medicaid agency responses point to poor communication and coordination. Overall, the survey identified several opportunities for policy intervention to enhance access to services for justice-involved youths. (*Am J Public Health.* 2005;95:1707–1711. doi:10.2105/AJPH.2004.056259)

ALL TOO OFTEN, PUBLIC agencies serve overlapping populations but pursue their missions without coordinating their efforts. One example is juvenile justice agencies and Medicaid programs, both of which serve youths who may have violated the law. These youths typically have poor physical and mental health status, with higher-than-average rates of substance abuse and psychiatric disorders as well as acute and chronic medical conditions.[1–7] High rates of illness, especially psychiatric disorders, may lead to higher medical costs and increased recidivism for juvenile justice, while poor care may exacerbate expenditures and case management services for Medicaid agencies. Thus, both systems have a shared interest in serving the health needs of these high-risk youths. In fact, however, the policy of the federal Medicaid program is to discontinue Medicaid benefits for incarcerated youths, which often means the loss of insurance coverage and more difficulty accessing services upon release.[8]

By federal law, state juvenile justice systems must provide timely and appropriate physical and mental health services to justice-involved youths, specifically those held in correctional facilities. Youths may be held in detention or commitment correctional facilities, depending on the stage of court processing. In 1999, juvenile courts handled nearly 1.7 million delinquency cases. Approximately 336 000 of these cases (20%) resulted in the youths being detained in a justice facility while awaiting further court processing.[8] In approximately 155 000 cases (9%), the youths were judged delinquent and placed in a commitment facility to serve a longer sentence. Typically, detained and committed youths are housed in separate facilities. The facilities vary considerably in size and ownership, with some being publicly and others privately operated.

Youths held in detention and those placed in correction facilities face the potential loss of Medicaid insurance benefits because federal law prohibits such benefits for incarcerated individuals. Medicaid is a federal–state partnership in which states design and administer their programs within broad federal guidelines. One federal stipulation is that no federal Medicaid funds can be used to pay for health care services to "inmates of a public institution."[9] Technically, states may not claim federal Medicaid matching funds for services provided to incarcerated youths. One way to comply with this rule is to drop incarcerated youths from the Medicaid benefit rolls entirely. There are only limited instances when Medicaid federal matching funds are available for services provided—for example, if a youth is transferred to a medical facility for inpatient services or if a youth has been "sentenced" to a community setting, such as probation, but is awaiting release from the detention facility.

The practice of dropping inmates from benefit rolls and discontinuing Medicaid benefits has been the subject of considerable policy debate.[9–12] Beneficiaries whose benefits are terminated are likely to face delays in reenrollment upon release because they face the burden of reapplying for eligibility. One concern is that without health insurance benefits, many individuals also will not receive timely health care after release. Without insurance, they may be deterred from seeking services or have more difficulty locating providers willing to treat their illness. Lack of timely care, in turn, could lead to flare-ups in medical or mental heath conditions, which could translate into higher health care costs and possibly higher rates of rearrest and diminished public safety.

The federal government has issued policy statements clarifying the exclusion of detainees and others in public institutions. Specifically, recognizing the difficulties for individuals in reapplying for benefits, the federal Medicaid program has encouraged states to "suspend" rather than "terminate" Medicaid benefits while a beneficiary is in a public institution.[13] While this distinction may seem subtle, suspension would lead to more rapid reinstatement of Medicaid benefits for detainees than termination. Other alternatives for

states to ease the transition to Medicaid benefits include assisting inmates with their applications, processing them prior to release, or giving special priority to applications from former inmates. In practice, both justice and Medicaid agencies must work in concert to fully implement either disenrollment or reenrollment policies. Because the agencies have very different missions and priorities, such coordination may not be common or complete.

The impact of Medicaid disenrollment policies on youths depends on the manner in which, and the extent to which, the policy is implemented. Lost in the policy debate has been the question of whether Medicaid disenrollment and reenrollment of justice-involved youths is common practice and, if so, in what form. A recent national survey of states and a representative sample of communities attempted to answer these questions. The study hypothesized that state and local Medicaid and justice agencies have very different understandings of Medicaid policies, indicating a lack of communication between policymakers and those on the front lines who implement them.

We summarize (1) responses to key questions about Medicaid disenrollment policies and practices, (2) agency efforts to enroll justice-involved youths in Medicaid rather than disenroll them, and (3) the use of Medicaid financing for services to youths in preadjudication detention facilities.

METHODS

Design and Sample

A telephone survey was conducted as part of the Adolescent Detainees and Medicaid (ADAM) study of the juvenile justice and Medicaid systems. The ADAM study had 3 goals: (1) to examine state policies for health care (including mental health care) in detention facilities; (2) to study how health care is delivered at the agency level; and (3) to determine Medicaid policies and how health care is financed in detention facilities. We present the data collected to meet the third goal.

The ADAM survey was conducted in 2003. It involved 4 sets of interviews—at the level of the state Medicaid program, the state juvenile justice agency, the local Medicaid program, and a local juvenile detention facility—in 92 primary sampling units (counties or subcounty units). Having both local and state responses allowed us to compare the relevant policies as well as their implementation. In the 92 primary sampling units, there were 81 complete and partial respondents to the local detention facility survey. These detention facilities were located in 34 different states. In most cases, youths in detention facilities have been detained while they await trial, making them similar to an adult jail population. These are not youths who have been found guilty and sentenced to commitment facilities. There were 50 complete and partial respondents to the local Medicaid program survey. The responding local Medicaid programs were located in 23 different states. In addition, to obtain national information at the state level, interviews were attempted in all 50 states plus the District of Columbia; in total, there were 46 respondents to the state-level justice agency survey and 46 respondents to the state-level Medicaid survey. Overall, all 50 states and the District of Columbia were represented in the combined local- and state-level data.

Procedures

To determine who was the appropriate juvenile justice system or Medicaid official to be interviewed, we conducted Internet searches of state Web sites and searched state profiles produced by the National Center for Juvenile Justice. In addition, we contacted each state Medicaid office. Information about the study and an interview summary were then sent to the initial informant in each state. Trained research assistants contacted each informant by telephone to review the study and determine who the best available informants would be.

Once the most appropriate informant was located, the study materials were faxed and a follow-up call was made to answer any questions about the study and schedule an interview. A "snowball" sampling technique was used to identify the appropriate person to answer specific questions or sections of the interview for which the primary respondent was not the best informant. Snowball sampling is a useful strategy when random sampling is inappropriate and the target population is dispersed or hidden.[14–17] These additional informants were then also contacted and interviewed. Telephone interview data were collected from the designated informants in each state between March and November 2003.

Survey Instrument

The telephone interview for the ADAM study was developed by modifying an interview from a project on adult correctional facility use of Medicaid. This study by Steadman and Morrissey (sponsored by the John D. and Catherine T. MacArthur Foundation) investigated the process of health and mental health service delivery and the financing mechanisms of such care in the correctional system (H. Steadman and J. Morrissey, unpublished data, 2002). We modified the questions to make them relevant to the care of adolescents in detention. Topic areas included, among others, the provision on health screening, health services and psychotropic medications to juvenile justice detainees, financing of health screening and health care services, Medicaid enrollment policy and practices at entry and at release, and Medicaid disenrollment policy and practices.

Each interview took approximately 40 minutes to complete. Following the interview, the project coordinator reviewed the module with the interviewer to ensure clarity and appropriate coding. Any uncertainties were resolved with a follow-up phone call to the informant.

Research assistants who were to conduct interviews received 8 hours of classroom training, which included the background of the project and its aims, an overview of the service sector systems involved, and a detailed review of the interview. In addition, a written training manual and background reading material were provided. Interview training involved 3 components, in which the trainee (1) role-played with an experienced interviewer, (2) observed an experienced interviewer completing an interview using a speakerphone, and (3) completed an interview using a speakerphone while being observed by an experienced interviewer. Each trainee was required to complete

TABLE 1—Medicaid Disenrollment Policy and Practice as Reported in a National Survey of State and Community Juvenile Justice and Medicaid Agencies: The Adolescent Detainees and Medicaid (ADAM) Study, 2003

Question	% of Agencies Responding Yes			
	Local Juvenile Justice (n = 80)	State Juvenile Justice (n = 46)	Local Medicaid (n = 50)	State Medicaid (n = 46)
Is there a written policy requiring disenrollment of youths in preadjudication detention?	8	28	48	46
Does detention center have a practice of disenrolling any youth?	4	33	46	46
Is compliance with disenrollment policy monitored?	0	11	22	15
Does detention staff receive training on policy/practice?	1	2	NA	NA
Does detention center notify Medicaid that a youth is detained?	4	17	53	59
Does detention center receive an incentive payment?	0	0	0	0
Is there a computer link between detention center and Medicaid?	6	13	8	13
Does detention center send census report to Medicaid?	6	4	12	9

Note. NA = not applicable.

all 3 training components on each of the instruments before being approved for interviewing. A tracking sheet was used to assess each trainee's completion status. Periodic observation by the project coordinator was used to assess ongoing reliability.

RESULTS

Medicaid Disenrollment

Respondents were asked about the existence of a Medicaid disenrollment policy. In addition, they were asked about specific implementation practices. Less than half of agencies reported a Medicaid policy of disenrolling youths in preadjudication detention (Table 1). State and local Medicaid agencies were more likely to report a such policy (46% and 48%, respectively) than state and local justice agencies (28% and 8%, respectively). Regarding specific implementation practices, 46% of both state and local Medicaid agencies claimed that facilities had a practice of disenrolling youths, while only 4% of local detention facilities and one third of state justice agencies claimed to have such a practice.

To disenroll beneficiaries, Medicaid programs must be made aware of which youths are in detention. A substantial proportion of state and local Medicaid agencies (59% and 53%, respectively) responded that they were notified about new detention episodes; by contrast, only 17% of state justice agencies and 4% of local agencies reported that they notified Medicaid agencies.

In examining disagreement between state and local responses at the individual state level, we limited our analysis to those 34 states in which we had responses from corresponding local agencies. In this analysis, we continued to find that state and local Medicaid agencies were more likely to report written policies (29% and 27%, respectively) than state and local justice agencies (21% and 12%, respectively). In 21% of states, the local and state Medicaid agency responses disagreed, while in 27% the state and local justice agency responses disagreed (data not shown).

In terms of disenrollment mechanisms, few agencies across respondent types reported that there were computer links between justice and Medicaid agencies or that justice agencies routinely forwarded census reports to the Medicaid program. Further, few reported that there were incentive programs for disenrollment or that compliance with the disenrollment policy was monitored (Table 1).

Medicaid Notification

Respondents also were asked who was responsible for notifying Medicaid that a youth was in detention (Table 2). Most justice agencies, whether local or state, did not respond to this question, indicating a lack of knowledge about the practice of Medicaid notification. The most common response among local and state Medicaid programs was the beneficiary or family.

Medicaid Enrollment at Entry

Although half of state Medicaid programs claimed to have a disenrollment policy, there is also evidence from justice agencies that youths are actively enrolled in Medicaid at entry into detention. Agencies were asked about Medicaid policies at the time of a youth's entry into detention.

TABLE 2—Expressed Beliefs of State and Community Juvenile Justice and Medicaid Agencies Regarding Medicaid Notification: The Adolescent Detainees and Medicaid (ADAM) Study, 2003

Whose Responsibility Is It to Ensure That Medicaid Knows When a Beneficiary Is Detained?	% of Agencies Responding Yes			
	Local Juvenile Justice (n = 81)	State Juvenile Justice (n = 46)	Local Medicaid (n = 50)	State Medicaid (n = 46)
Beneficiary/family	3	11	40	39
Local Medicaid agency	3	2	2	7
State Medicaid agency	0	2	4	7
Detention center	3	2	18	7
Other (courts, probation officers, child welfare, etc.)	4	11	30	20

TABLE 3—Responses of State and Community Juvenile Justice and Medicaid Agencies to Questions Regarding Medicaid Financing of Youths in Detention: The Adolescent Detainees and Medicaid (ADAM) Study, 2003

Question	% of Agencies Responding Yes			
	Local Juvenile Justice (n = 80)	State Juvenile Justice (n = 46)	Local Medicaid (n = 50)	State Medicaid (n = 46)
Is Medicaid used to cover any physical or mental health services for juvenile detainees?	58	46	62	54
Is Medicaid used to cover emergency services only?	18	22	6	4
Does juvenile detention facility or contracted providers submit Medicaid claims?	18	20	32	20

Approximately half of respondents reported asking youths about their Medicaid coverage when they entered the facility. Furthermore, 24% of local and 17% of state justice agencies reported submitting Medicaid applications on behalf of youths or encouraging their parents and guardians to do so (data not shown).

Medicaid Financing During Detention

Most respondents indicated that Medicaid pays for at least some mental or physical health services provided to youths in detention (Table 3). Responses were relatively consistent across agencies, although local agencies were more likely to report Medicaid financing than state agencies. Local Medicaid agencies also were the most likely to report that detention facilities or their contracting health care providers submitted claims for services to Medicaid.

Medicaid Enrollment Upon Release

We examined efforts to enroll youths in Medicaid upon release from detention. Most agencies responded that policies and practices to increase Medicaid enrollment among these youths were uncommon (data not shown). State Medicaid agencies were the most likely to report a practice of reenrollment (26%; data not shown), compared with 20% for local Medicaid agencies, 13% for state justice agencies, and 4% for local justice agencies. These figures represent a missed opportunity to reenroll youths eligible for Medicaid.

Supplying medications for youths taking psychiatric medications was another missed opportunity. Eighty-one percent of local justice agencies provided only a 1-day supply of medications upon release for adolescents who were taking psychiatric medications. Seventy percent of state agencies reported providing a 1-day supply and 7% reported providing a 2-day supply of medication upon discharge (data not shown). Furthermore, only 30% of local justice agencies and 41% of state justice agencies reported that adolescents taking psychiatric medications were provided a prescription for their medication upon release.

Conclusions

The ADAM survey found that Medicaid disenrollment occurs less often for youths in detention than is perhaps believed by advocates. Less than half of responding agencies indicated that they had a disenrollment policy. These findings also strongly suggest that although many states have a Medicaid policy of disenrolling youths in preadjudication detention, even where such policies exist, the implementation is relatively weak. Nevertheless, such policies probably make it more difficult for some youths to receive needed health and mental health services—services that might benefit both juvenile justice and Medicaid as well as the youths.

While we found limited evidence of widespread Medicaid disenrollment of youths in detention facilities, these results do not necessarily generalize to youths in commitment facilities. The average length of stay for juveniles in detention is 2 weeks, considerably shorter than the average of 5 months that youths judged delinquent spend in commitment facilities.[18] In addition, there are fewer youths in commitment facilities. It may therefore be considerably easier to implement Medicaid disenrollment policies in such settings.

Most justice agencies reported that youths in detention were asked about Medicaid coverage. It appears, however, that the purpose of this verification was primarily to bill Medicaid for eligible services provided to youths under detention. More than half responded that Medicaid was used to cover any physical or mental health services for juvenile detainees, providing further evidence that disenrollment is relatively uncommon in detention facilities.

Nonetheless, there is reason to be concerned about the health care of youths who become housed in detention facilities. Despite their reported high rates of physical and mental disorders, little effort is made to connect this high-needs population to insurance coverage or to services such as prescription medications. Lack of health insurance may be an important obstacle to having prescriptions filled. Active enrollment of youths in Medicaid upon their release into the community was relatively uncommon. Justice agencies in particular were less likely to respond that Medicaid eligibility was assessed or Medicaid applications were filed for youths upon release. Medicaid agencies were more optimistic in their assessment of reenrollment practices. This discrepancy between justice agency and Medicaid agency responses further points to areas of potential improvement in communications and coordination.

Mechanisms by which enrollment in Medicaid and access to services could be improved include helping youths to submit Medicaid applications, quickly determining Medicaid eligibility, and ensuring that eligible detainees have a Medicaid card in hand upon release. Federal law also permits states, under so-called "presumptive eligibility" rules, to authorize Medicaid coverage for individuals who have applied for benefits but whose eligibility has not yet been determined. These rules prevent individuals from being billed for

services during the determination period should their eligibility ultimately be denied.

Overall, the survey identified several opportunities for policy intervention to enhance access to services for justice-involved youths. These include eliminating Medicaid disenrollment policies where they exist, promoting the use of permissible Medicaid policies that facilitate enrollment into the program, and increasing the practice of extending medication supplies upon a youth's release. Having a source of payment for services upon release could remove a significant obstacle barring access for youths with health and emotional problems. In addition, convening a national panel of Medicaid and juvenile justice experts to make additional recommendations to resolve these problems could provide a basic operational framework for those in the field. ■

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Contributors

A. Evans Cuellar originated the study, conducted the analyses, and led the writing. K.J. Kelleher conceived of the ADAM survey and oversaw all aspects of its implementation. J.A. Rolls oversaw data collection for the study and assisted in interpreting the findings. K. Pajer assisted with the analyses. All authors helped to conceptualize ideas, interpret findings, and review drafts of the article.

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Human Participant Protection

The institutional review boards of Columbus Children's Research Institute and San Diego State University determined that the ADAM study was exempt from human subject review because no case-specific data on individual juveniles would be collected.

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