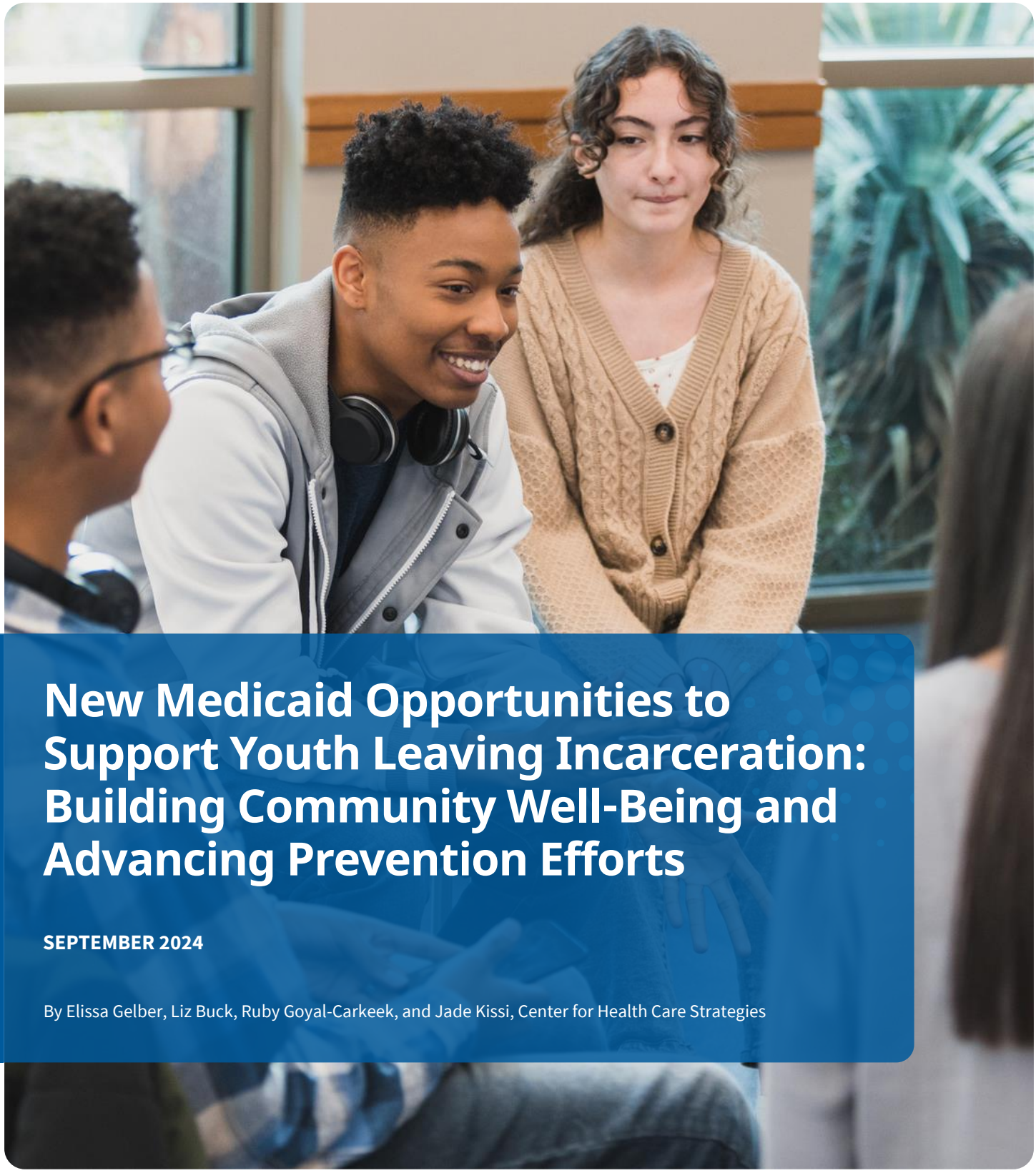
Center for Health Care Strategies



New Medicaid Opportunities to Support Youth Leaving Incarceration: Building Community Well-Being and Advancing Prevention Efforts

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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

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KEY TAKEAWAYS

- Unmet health and well-being needs contribute to and are escalated by youth incarceration. Well-coordinated services and supports can reduce justice system involvement and advance broader prevention and equity goals.
- The long-standing "inmate exclusion policy" has historically prohibited the use of Medicaid funding for youth transitioning from incarceration, contributing to poor outcomes.
- By January 1, 2025, all states will need to comply with Section 5121 of the Consolidated Appropriations Act of 2023, which partially limits the inmate exclusion policy and requires that certain supports and services be provided to youth transitioning from incarceration to the community.
- States can support youth, family, and community well-being through cross-system collaboration, partnerships with formal and informal community supports, and the expansion and leveraging of services and supports outside of the justice system.
- States that have developed prevention strategies and community-based care management interventions can serve as a model for other states implementing these requirements.

Introduction

Unmet health and well-being needs — needs related to physical, mental, and social health that impede youth's ability to thrive — are pivotal drivers of justice system involvement.[1] Incarceration exposes youth to a range of harmful experiences and exacerbates these needs. For youth of color, it is both more likely that their health and well-being needs will be unmet, and that these unmet needs will lead to incarceration.[2,3]

Despite this reality, the health and well-being needs of youth in and transitioning from incarceration have long been under-addressed. Though research has shown that more than 60 percent of youth who are incarcerated are eligible for Medicaid or the Children's Health Insurance Program (CHIP), the inmate exclusion policy has historically prohibited the use of federal funding for the care of individuals in carceral settings, leaving services and financing to the sole discretion of states, with inconsistent and limited oversight.[4]

For the tens of thousands of youth who return to their communities each year from carceral settings without access to appropriate supports to meet their health and well-being needs, the vast majority will continue to lack this care into adulthood.[5] Many will end up incarcerated again.[6]

Section 5121 of the Consolidated Appropriations Act of 2023 (CAA) establishes exceptions to the inmate exclusion policy for services for youth transitioning from incarceration, as well as for young adults formerly in foster care.[7,8] In addition, on April 17, 2023, the Centers for Medicare & Medicaid Services (CMS) issued guidance encouraging states to use 1115 waiver authority to cover services for youth and adults leaving incarceration.[9] Together, these changes provide new opportunities for states to use Medicaid funding to support youth transitioning from incarceration back to their communities.

This report, developed by the Center for Health Care Strategies (CHCS) with support from the Annie E. Casey Foundation, provides guidance for states on the implementation of these new opportunities. It examines the health and well-being needs of youth involved with the justice system in the United States; describes new federal requirements and opportunities to use Medicaid financing to improve transitions from incarceration to the community; presents best practices for implementing the changes in alignment with broader community well-being and public safety goals, highlighting examples from states; and offers practical steps that Medicaid and other state agencies can take to get started with implementation.

Based on CHCS' national scan of best practices and interviews with Medicaid, justice system, and behavioral health leaders, as well as community-based providers, this report identifies three promising strategies to improve outcomes for youth, families, and communities:

1. Develop or strengthen cross-system collaboration;
2. Prioritize meaningful partnerships with formal and informal community supports; and
3. Expand and leverage services and supports outside of the justice system.

Background: Unmet Health and Well-Being Needs and Justice System Involvement

Though there has been a sharp decline in the arrest and incarceration of youth over the last two decades, more than 35,000 youth continue to be held in carceral settings each day in the United States, and the percentage of youth confined pending adjudication has increased.[10] Often, youth who become involved with the justice system experience "co-occurring life difficulties or disabilities" that have "significant impacts on their emotional, mental, physical, and behavioral well-being."[11] Incarceration, in turn, escalates these needs, and makes future involvement in the justice system more likely.[12]

Youth in Incarceration

Youth who are incarcerated can be detained in or committed to one of several carceral settings. Most commonly, these include detention centers, long-term secure facilities, and secure residential facilities for juveniles, as well as adult jails or prisons. The vast majority of youth aged 18 and older who are incarcerated are held in adult jails or prisons.[13]

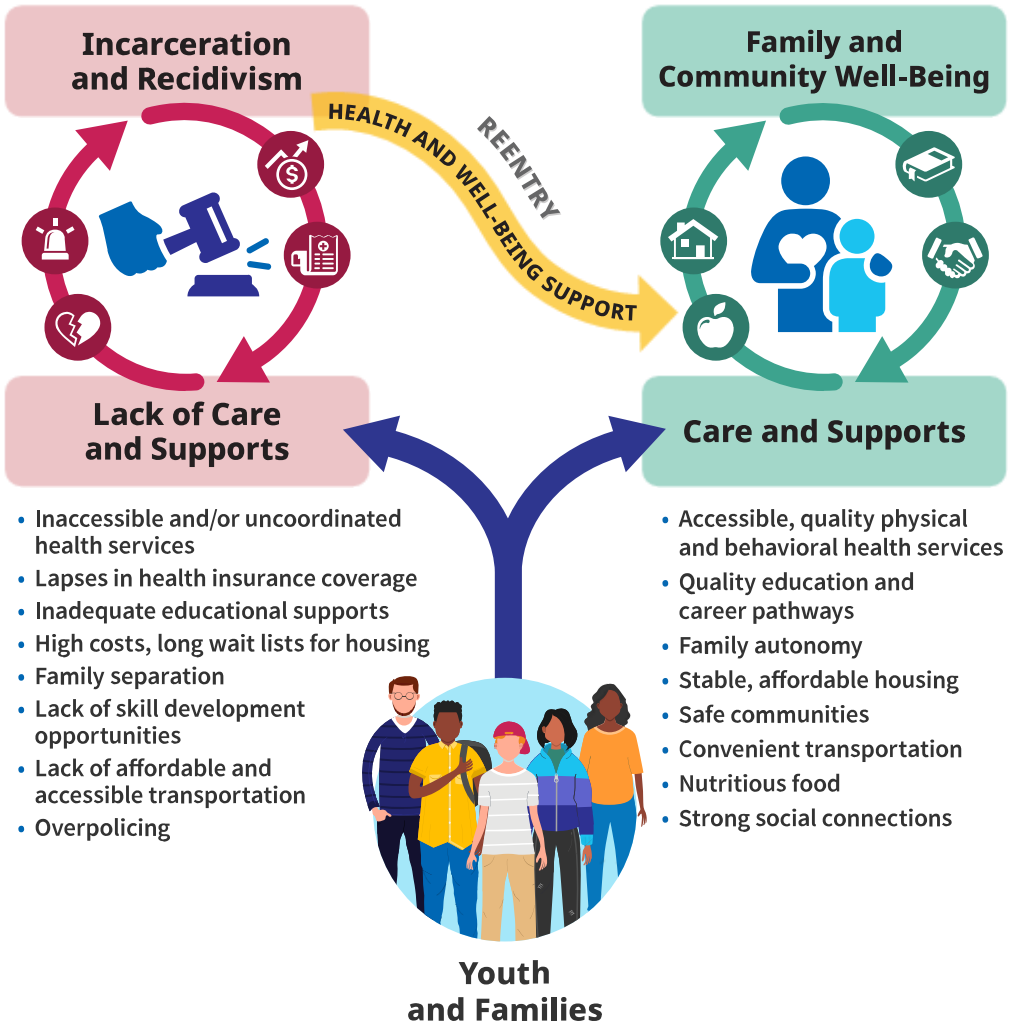
Fewer than one-third of youth who are incarcerated have been charged with serious or violent offenses.[14] More than 10 percent of youth are incarcerated due to technical violations of probation or the commission of one of a number of "status offenses" — behaviors that would not be unlawful for adults, but are deemed to be so for youth. Commonly, these charges are related to behaviors such as running away from home, skipping school, missing curfew, or general "incorrigibility." These behaviors are often normative for youth.[15] As the American Academy of Pediatrics has explained, the brain is not fully developed until age 26 and "developmental immaturity of the prefrontal cortex" may influence the behaviors that contribute to contact with the justice system.[16]

Disparities are pervasive in the justice system by nearly all measures, with the most egregious disparities at the point of incarceration. Youth of color are more likely than white youth to be detained, with Black youth being nearly five times more likely than their white peers to be detained or placed in carceral settings.[17] Black youth are also far less likely to be diverted from the juvenile justice system.[18] In addition to racial disparities, disparities also exist among gender and sexual minorities. LGBTQ+ youth are about two to three times more likely to experience incarceration.[19]

Unmet Health and Well-Being Needs

All families need "stability, safety, mastery, meaningful access to relevant resources, and social connectedness" (defined by the Full Frame Initiative* as the "domains of well-being").[20] When these needs are not met — due to factors such as food insecurity; unstable housing; lack of access to transportation; insufficient educational and recreational opportunities; and inadequate physical and behavioral health care services — youth are significantly more likely to become involved in the justice system.[21] Youth who enter the justice system are also more likely to have behavioral health needs and to have experienced trauma.[22] This may include trauma and loss stemming from separation from family, community, and other key supports due to involvement with the child welfare system.[23]

Exhibit 1. Reducing Incarceration by Building Youth, Family, and Community Well-Being



* For more information about the Full Frame Initiative's "five domain framework," see: https://www.fullframeinitiative.org/resources/five-domains-of-wellbeing-overview

Youth of color are more likely to have unmet health and well-being needs, and it is also significantly more likely that these unmet needs will lead to justice system involvement.[24] The enduring legacy of racism manifests today not only in biased policies and practices such as the over-policing of Black families, but in structural disadvantages that impact the health and well-being of people of color long before they encounter the criminal legal system.[25,26]

The confinement of youth away from their homes, communities, and support systems is traumatic in itself and often causes health and well-being to deteriorate. Incarceration and justice involvement contributes to poor health, negative educational and vocational outcomes and makes future entry into the justice system even more likely.[27]

Review of New Medicaid Opportunities for Supporting Youth Transitions from Incarceration

At least 60 percent of youth who enter carceral settings are eligible for Medicaid or CHIP.[28] The Social Security Act of 1965, which established Medicaid, barred the use of federal funds for services for "inmate[s] of a public institution," a policy commonly known as the "inmate exclusion policy."[29,†] Historically this resulted in the termination of youth's Medicaid coverage upon entry into carceral settings, with health care and financing left to the discretion of each state or locality. The inmate exclusion policy has contributed to a lack of comprehensive and coordinated care for youth transitioning to the community from incarceration.[30]

Recent legal and administrative changes at the federal level are designed to address the negative impacts of the inmate exclusion policy by expanding Medicaid's role in supporting youth transitioning from carceral settings, including through targeted case management.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018

The 2018 SUPPORT Act prohibits states from terminating Medicaid coverage for youth who are incarcerated, directing them to instead temporarily suspend Medicaid eligibility or benefits during this period.[‡,31] The SUPPORT Act also directed CMS to issue guidance on the use of Medicaid waivers to improve care transitions for individuals who are incarcerated and otherwise eligible for Medicaid.

[†] The legislation allows the use of federal funding for care only when an individual who is incarcerated is a "patient in a medical institution," which has been interpreted to apply to admission to inpatient care for a period of at least 24 hours. (Social Security Act of 1965, U.S.C. § 1396d)

[‡] The Consolidated Appropriations Act (CAA) of 2023 extended the requirement to suspend rather than terminate coverage to CHIP. H.R.2617 - 117th Congress (2021-2022): https://www.congress.gov/bill/117th-congress/house-bill/2617

Consolidated Appropriations Act of 2023

Signed into law on December 29, 2022, the CAA includes provisions that require or allow exceptions to the inmate exclusion policy. These provisions apply to:

- Youth under age 21 who are eligible for Medicaid;
- Youth under age 19 eligible for CHIP; and
- Youth under age 26 who are eligible for Medicaid because they were formerly in foster care (FFCC).[32]

Section 5121 of the CAA requires that beginning on January 1, 2025, state Medicaid agencies cover a set of services for youth who have been adjudicated and are transitioning from carceral settings. These services include physical and behavioral health screening and diagnostic services that meet "reasonable standards," and are indicated as medically necessary 30 days prior to release.[33] At a minimum, states must provide these services in accordance with Early Periodic Screening, Diagnostic, and Treatment (EPSDT) standards for youth under the age of 21 eligible for Medicaid.[§,**]

States must also provide targeted case management services (TCM) 30 days prior to release and for at least 30 days post-release. TCM services include:

- Assessment of need for medical, educational, social, and other services;
- Development of and updates to an individualized, person-centered care plan;
- Referral and service linkage to services and supports for behavioral health, health-related social needs, and other needs as identified in care plan; and
- Ongoing monitoring and follow-up activities.

In addition, under Section 5122 of the CAA, states have the *option* of using federal funds to provide a full array of Medicaid services for eligible youth pending disposition.

CMS Guidance on Consolidated Appropriations Act of 2023

On July 23, 2024, CMS issued guidance providing further clarity for states on CAA requirements.[34] The CMS guidance reinforces that states are required to implement Medicaid/CHIP eligibility processes and suspension policies, specific screening and diagnostic services, and TCM for eligible youth by January 1, 2025. According to the CMS guidance, the requirements apply to juvenile detention and secure juvenile settings, local jails, tribal jails and prisons, and state prisons. At this time, the requirements do not apply to federal prisons.[35]

[§] The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and specialty services. For more information see: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[**] States with separate CHIP programs are required to provide screening and diagnostic services pursuant to existing CHIP state plan or waiver. States can also seek state plan amendments to bring definitions for screening and diagnostic services into alignment for all youth covered by the CAA requirements: Medicaid eligible youth under 21, youth eligible for CHIP, and FFCC.

CMS makes clear that the services that are coordinated through TCM should not only address physical and behavioral health needs, but health-related social needs. According to CMS, such needs include, but are not limited to "social, educational, and other underlying needs," including "developing safe decision-making skills or building relationships," as well as "access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, and opportunities for meaningful employment or skill building."[37] The CMS guidance emphasizes the importance of working with community-based providers to deliver the services that are needed, given their effectiveness in building trust with youth and supporting connections to services in the community. The CMS guidance encourages the use of peer supports to effectively engage youth in services as part of TCM.

CMS guidance emphasizes the importance of Targeted Case Management, describing it as the "critical lynchpin to help connect eligible juveniles to all needed services upon release, including medical, social, and educational services."[36]

Finally, the CMS guidance makes clear that while providing services prior to release is critical, the implementation of these services should not result in a delay of youth's release or lead to further involvement in the justice system.[38]

According to the CMS guidance, to meet Medicaid requirements, states will need to submit by March 31, 2025, a state plan amendment (SPA) attesting to an operational plan to provide screening, diagnostic, and TCM services. States may need to submit additional SPAs to authorize services not currently within the scope of coverage (such as TCM), adjusted payment methodologies, and coverage for eligible youth.

To meet CHIP requirements, states will need to submit a SPA by the end of the state fiscal year in which January 1, 2025, falls to effectuate coverage of screening, diagnostic, and TCM services. States must also submit a SPA reflecting eligibility changes for youth who are incarcerated and enrolled in CHIP.[††]

States that choose to use federal financing for services for youth pending disposition of charges will need to submit a SPA electing coverage for any state Medicaid and CHIP plan services for those youth.

[††] The CMS guidance clarifies that incarceration status is a factor in eligibility for CHIP. Despite this, CMS concludes that youth can maintain continuous eligibility (CE) under CHIP and that incarceration is not a permissible reason to terminate coverage during a CE period. The CAA includes an exception for otherwise eligible youth for screening, diagnostic, and targeted case management services during the 30-days prior to release.

CMS Guidance on Medicaid Reentry Section 1115 Waiver Demonstration Opportunity

On April 17, 2023, CMS released guidance encouraging states to take advantage of new opportunities under 1115 waiver authority to cover additional services for youth and adults who are leaving incarceration, including extended case management (up to 90 days prior to release), prescription medication, and medication-assisted treatment (also referred to as medications for addiction treatment).[39] At least 23 states (plus the **District of Columbia**) now have pending or approved 1115 waivers for re-entry services. At least eight of these states — **California**, **Illinois**, **Kentucky**, **Massachusetts**, **New Mexico**, **Oregon**, **Utah**, and **Washington State** — have approved waivers that include these additional services specifically for youth.[40]

HHS Resources to Support Planning and Implementation

States can access additional resources to support planning and implementation of these requirements. By March 2025, the Department of Health and Human Services (HHS) will allocate an additional $113.5 million to support state planning efforts, including efforts needed to comply with Medicaid suspension requirements for youth. Some examples of the types of covered uses for the funding include investing in information technology to support effective care transitions, and establishing automated processes related to allowable services under Medicaid and CHIP.[41]

State Strategies to Support Youth Transitions from Incarceration that Advance Family and Community Well-Being

By addressing health and well-being needs, states have effectively supported youth returning to their communities and reduced youth involvement in the justice system. These states — including **New Hampshire**, **New Jersey**, **New Mexico**, **Oregon**, and **Utah** — have used approaches that bring together system partners, including Medicaid agencies, around a shared vision for family and community well-being. Through aligned funding, policies, and strategies, they have improved public safety, reduced incarceration, and advanced broader prevention goals. These same approaches can serve as blueprints as states consider how to implement new Medicaid requirements.

Through interviews with leaders from Medicaid, juvenile justice, and behavioral health agencies, as well as community-based providers (**see Exhibit 2**), three strategies emerged as particularly effective in improving outcomes for youth, families, and communities:

- Develop or strengthen cross-system collaborations;
- Prioritize meaningful partnerships with formal and informal community supports; and
- Expand and leverage services and supports outside of the justice system.

As with any federal statutory or regulatory shift, there are a range of approaches states can use to implement the new Medicaid requirements. States that are strategic in their approach can leverage the new Medicaid financing opportunities to reduce incarceration and advance broader prevention goals.

Exhibit 2. Strategies and Models Identified from State Interviews

State	System Partners Interviewed	Prevention and Diversion Strategies and Models
New Hampshire	Juvenile Justice (including clinical staff), Child Welfare, Behavioral Health, and care management providers	• Juvenile Detention Alternative Initiative (JDAI) model • System of Care (SOC) • Medicaid 1115 waiver for youth and adults Extended TCM (90 days pre-release)
New Jersey	NJ Juvenile Justice Commission, Family Support Organization, Rutgers University Training Consultant and former Liaison to Juvenile Justice for NJ Children's System of Care (CSOC)	• Juvenile Detention Alternative Initiative (JDAI) model • System of Care (SOC) • Family Peer Support Partners • Supports for health-related social needs (e.g. transportation)
New Mexico	Pediatrician (Health System)	• Peer led community-based pre-release planning • Family "whole person" care intervention
Oregon	Juvenile Justice	• Strong support from Governor that strengthens interagency/system collaboration • Medicaid 1115 waiver for youth and adults
Utah	Medicaid	• Strong interagency/system collaboration • Dedicated staff position to manage project Medicaid 1115 waiver for youth and adults

Develop Robust Cross-System Collaborations

> **A really important partnership for our care management entities has been with the education system.**
>
> — Jacqueline Davis, Management Entity Administrator, Northeastern Family Institute North Care (New Hampshire)

Meaningfully addressing the needs of youth transitioning from incarceration requires robust collaboration between juvenile justice agencies, departments of corrections, Medicaid, behavioral health, child welfare, education, agencies responsible for disability and developmental needs, substance use disorder services, and community-based organizations. The siloed nature of agencies' roles and responsibilities often leads to limited partnerships focused narrowly on compliance goals. States that view the new requirements as an opportunity to align strategies to meet family and community health and well-being needs will see the greatest benefits in the long term.

In many states, cross-system collaborations are at an early stage. Obtaining buy-in from different systems to work together around short- and long-term goals can facilitate progress. As cross-system relationships flourish, partnerships to develop infrastructure for shared accountability and joint investment in results will be realized.

State examples of robust cross-system collaborations include:

- **Prioritize cross-system partnerships with community providers**.
  In **New Hampshire**, behavioral health and justice system leaders have a history of working together with community providers to decrease reliance on the justice system. New Hampshire's Department of Health and Human Services; Juvenile Justice Services agency; Division of Children, Youth, and Families; and a community-based care management organization, have developed partnerships focused on a shared vision for youth and their families. Through their work together, state agency leaders and community partners embody the values and principles of the System of Care (SOC) approach — an organizing framework based on the delivery of services and supports that are family and youth driven, culturally competent, and community based.[42] This is reflected in the way services are provided to youth and families.

  The New Hampshire SOC team, which includes community-based providers, meets regularly with state agencies to help families bring their children home from incarceration and reduce the number of youth who are detained in these settings. The state has been successful in reducing the number of youth in its Sununu Youth Services Center from a total of 144 to 14, largely through court diversion and prevention efforts. The state contracts with community-based providers for case management, which positions the state to use Medicaid funding for TCM as of January 1, 2025.

- **Build on existing cross-agency relationships**. In **Oregon**, the state has been able to build on existing partnerships to collaboratively plan for implementation of the new requirements. The Oregon Health Authority (the state's Medicaid agency), Oregon Department of Corrections, and Oregon Youth Authority (the state's juvenile justice agency) had already been working together for several years on the state's 1115 waiver application to provide 90 days of pre-release case management services for youth and adults leaving incarceration. These more established partnerships have been helpful as the state has considered ways to implement the new requirements that advance broader interagency goals and avoid the creation of duplicative processes. The Oregon Youth Authority is a cabinet-level authority reporting to the Governor, a structure that is helpful in obtaining the necessary support to implement changes in juvenile justice settings, from programming to Medicaid billing.
- **Assign oversight responsibility to drive cross-sector communication**. In **Utah**, the merging of the Department of Health and the Department of Human Services into one department enhanced opportunities for collaboration between the state's child welfare agency, Medicaid agency, and juvenile justice system. The state's Medicaid agency has sought to integrate requirements under the CAA within its own 1115 waiver application process. Given the need to align different agency practices to implement the new requirements, Utah's Medicaid agency assigned one staff member to serve as project manager. The assigned project manager for Medicaid worked with designated staff in other agencies, such as child welfare, juvenile justice, and adult corrections, to develop new processes, policies, and workflows. In addition, Medicaid's project manager worked with agency staff who oversee the CHIP program to develop new processes to ensure youth have CHIP coverage as appropriate.
- **Consider statewide cross-system coordination and single point of entry**. **New Jersey** is the first state to expand the Annie E. Casey Foundation's Juvenile Detention Alternative Initiative® (JDAI) to every county, and it has gained national recognition as a model for state-led detention reform.[43] As a result of these efforts, which rolled out in 2004, the number of youth in detention throughout the state has decreased by 68 percent (from 829 youth per day on average pre-JDAI to 268 youth in 2023). Youth of color account for 89 percent of this shift. In addition, the state's Juvenile Justice Commission (JJC) — established in 1995 to promote policies and practices that improve outcomes for youth involved with the justice system — emphasizes cross-system collaboration to support youth who have been adjudicated.[44] Youth in juvenile justice placement are assigned community program specialists who function as case managers. Additionally, the justice system partners with the Children's System of Care (CSOC), a division under the state's Department of Children and Families. Through CSOC's single point of entry, requests for biopsychosocial assessments can be made, detention alternative beds for youth can be accessed, and connections can be made to community-

based care management organizations (CMOs). CMOs are TCMs that are community-based, nonprofit organizations, and are integral to ensuring that care planning is individualized, that services are flexible and nimble to meet needs, through facilitation of child family teams, using a Wraparound model.[45] CMOs can support linkages to care and supports prior to transition back to the community, where applicable.[46]

Prioritize Partnerships with Formal and Informal Community Supports

Community supports play a critical role in reducing barriers to health and well-being for youth transitioning from incarceration. Prioritizing access to these supports is essential for facilitating successful and sustainable transitions to the community.

> **The director of the probation office sits on a committee with JDAI and she'll sit with the young people and ask, 'what do they want' and 'what do they need?'**
>
> — De Lacy Davis, EdD, Executive Director, FSO of Union County (New Jersey)

A focus on both formal and informal community services and supports to address health and well-being needs, driven by what youth and families self-report, is key. Supporting youth, and their families, as they transition home requires connection to culturally competent providers of physical and behavioral health screening, diagnosis, and treatment services, in addition to peer supports, mentors, recreation and community activities, faith-based supports, tutors, teachers, and friends. As CMS emphasized in its July 2024 guidance, strategies that bring existing, external community supports into carceral settings, as opposed to approaches that build services within carceral settings, are preferred. These strategies minimize the risk of incentivizing the use of carceral facilities for the purpose of accessing care and create bridges for youth to trusted resources in the community.

State examples of partnerships with informal and formal community supports include:

- **Prioritize care coordination and navigation supports**. In **New Mexico**, a pediatrician has developed a care team model comprised of peers and clinical staff, who engage youth with multiple stays in detention, with the goal of meeting the unmet needs that contributed to youths' involvement in the juvenile justice system.[47] Care navigators build relationships with youth in the program while they are detained, to build trust and ensure engagement in care post-release. Upon release from the detention center, the care team engages youth and their entire families in care. For families with substance use disorders, the model has demonstrated that if parents have access to effective care coordination and navigation support for their own conditions, youth are more likely to engage and succeed in treatment. Youth enrolled in this program have been significantly more likely to avoid re-incarceration, with a 20 percent re-incarceration rate compared to 70 percent for youth not in the program.

- **Support access to services, including transportation**. In **New Jersey**, the state offers stipends and funding for transportation for families to support engagement in re-entry and care planning. The JJC works with partners to encourage family bonds while a youth is incarcerated; parents have access to social workers and are encouraged to visit with youth. The state also funds community program specialists from community-based organizations to work with youth while they are confined and upon release. These specialists partner with youth, their families, and probation staff and play a key role in providing transitional planning and linkage to care in the community.

> **Often young people are more worried about their parents with unmet needs than they are about themselves. And if they see their parent getting better from SUD treatment, it is encouraging.**
>
> — Andy Hsi, MD, ADOBE Program Director (New Mexico)

Expand and Leverage Services and Supports Outside of the Justice System

As states move to implement the new Medicaid requirements and the financing of services in carceral settings becomes a possibility, they must ensure that youth are not inadvertently confined or referred to the justice system to access services. In some states, the lack of sufficient supports to meet the behavioral health needs of youth in the community has led to unnecessary incarceration through the justice system, leading it to become a de facto provider of behavioral health care. Ultimately, the availability of a cohesive array of services and supports for youth and families in the community will be crucial for success. As Medicaid funding becomes available for critical transitional services, states and localities can reinvest state and local resources towards broader prevention and diversion efforts.

> **Families shouldn't have to go to a court and have a judge order their kid to go into treatment that they're desperately asking for.**
>
> — Amy McCormack, Associate Bureau Chief for Field Services, New Hampshire Division for Children, Youth and Families and Juvenile Justice Field Services

State examples of expanding and leveraging of services and supports outside of the justice system include:

- **Seek upstream opportunities to prevent incarceration**. In **New Mexico**, the Director of Bernalillo County's local juvenile detention center needed assistance in reducing youth recidivism. This aligned with the goals of a local pediatrician to reduce adverse childhood experiences and create a care model that provided intensive care coordination, and educational advancement, while also incorporating primary care and timely psychiatric access. Through the ADOBE program, New Mexico Medicaid was able to collaborate with a small group of willing partners to invest in diversion opportunities and begin funding community-based care management services that

contribute to prevention. The ability to address the holistic needs of the youth and their families, including health-related social needs, has resulted in decreased re-entry into the justice system.

- **Improve access to behavioral health services outside the juvenile justice system**. Mobile Response and Stabilization Services (MRSS) are increasingly available in many states. MRSS, a 24/7 response system to a family-defined crisis, has proven to be a timely intervention to de-escalate and stabilize youth and their families. In **New Jersey**, law enforcement can refer youth and their families to MRSS through the CSOC to ensure youth and families are connected to these critical resources in a time of need, or as an alternative to filing a complaint, preventing justice system involvement (referred to as "stationhouse adjustment.") In addition, MRSS can prevent a violation of probation complaint when behavioral health needs are indicated. States mainly use Medicaid to fund MRSS and can braid and blend funding from various sources to provide broader access.

> **Treatment should be voluntary and involve youth and family voices as much as possible.**
>
> — Joelle Kenney, Manager of JDAI and System Reform Unit with the NJ Juvenile Justice Commission

- **Interrupt the school-to-prison pipeline**. Across the nation, school disciplinary policies can lead to referral to law enforcement and contribute to justice system involvement into adulthood, particularly for youth of color.[48] In many states**,** including **New Jersey**, schools can refer youth to MRSS as an effective intervention in lieu of suspension or expulsion. **Connecticut** has a School Based Diversion Initiative (SBDI) that works with schools to identify behavioral health needs and build connections to community-based services as an alternative to arrest or school disciplinary measures. SBDI also helps schools reform their policies to reduce student involvement with law enforcement. SBDI schools have reduced court referrals by 29 percent and connected 55 percent more students to behavioral health services (as measured by calls to 2-1-1 Mobile Crisis Intervention Services).[49] In Connecticut, SBDI is jointly funded and overseen by cross-system partners: Judicial Branch Court Support Services Division, the state's Department of Education, and the Department of Mental Health and Addiction Services.

Getting Started: Medicaid Action Steps to Address the Needs of Youth Transitioning from Incarceration

States are at very different stages in implementing the new CAA requirements. As identified below, there are immediate, concrete steps states can take to prepare and plan for implementation. Many of these will help states identify who is eligible for these new Medicaid covered services and advance cross-sector strategies that can improve health, well-being, and public safety.

- ✓ **Determine existing relationships between Medicaid, juvenile justice agencies, departments of corrections, and local jails.** To effectively implement the new requirements, state Medicaid agencies, juvenile justice agencies, state departments of corrections, and local jails will need to engage in cross-system collaboration and planning, which may require the development of new formal relationships. State Medicaid agencies should consider expanding or joining established collaborative efforts that address justice involvement, including current 1115 waiver planning for justice-involved populations, SOC efforts, or juvenile and criminal justice reform initiatives.

- ✓ **Determine eligible populations for new requirements.** Children and youth under 21 eligible for Medicaid or CHIP and involved with juvenile justice and adult correctional systems will be eligible for these transition services. Former foster care youth under 26, a mandatory Medicaid eligible category, are also eligible for these services. Medicaid agencies, juvenile justice agencies, state departments of corrections, and local jails can work collaboratively to determine the population of youth eligible for services. This can help Medicaid agencies and correctional partners determine appropriate workflows and staffing to ensure compliance.

- ✓ **Evaluate current Medicaid assessment, suspension/termination, enrollment, and service capacity.** Under the CAA, states will be required to improve processes related to Medicaid coverage for youth in carceral settings, which includes temporarily suspending eligibility or benefits, redetermining eligibility without requiring new applications, and restoring coverage upon release. Many state Medicaid agencies have some, but not all, of these operational and technical processes developed. Determining current practices across carceral settings will be critical. State Medicaid agencies will also be required to cover TCM for youth 30 days pre- and at least 30 days post-release from facilities. Determining what community-based partnerships exist and how these organizations may play a role in providing case management services will be foundational to successful implementation.

- ✓ **Determine data-sharing capabilities and capacity.** State agencies may need to expand data-sharing efforts to effectively facilitate enrollment and connections to care upon release. States should review existing data use agreements between agencies and determine whether new requirements will require amendments to existing agreements or generate new ones, while maintaining compliance with HIPAA and 42 CFR Part 2.

- ✓ **Identify and engage other key partners.** States should take the time now to identify and engage partners with whom collaboration will be essential. Important partners include, but are not limited to, state child welfare agencies, departments of behavioral health, Systems of Care, and managed care organizations. The early engagement of community partners and providers is also vital.

Exhibit 3 highlights additional action steps state Medicaid agencies — in partnership with juvenile justice agencies, state departments of corrections, and local jails — can pursue with state partners to prepare for implementation of the new requirements.

Exhibit 3. CAA Requirements and Initial State Action Steps for Medicaid Partners in Collaboration with Juvenile Justice Agencies, State Departments of Corrections, Local Jails, and Other Partners

CAA REQUIREMENTS	RECOMMENDED ACTION STEPS
Coverage for any screening or diagnostic service that meets reasonable standards or that are indicated as medically necessary — including a behavioral health screening or diagnostic service — 30 days prior to scheduled release (or no later than one week or as soon as practical following release).	• Determine current screening processes within carceral settings. • Assess whether there are gaps related to screening or diagnostic services based on new requirements. • Ensure assessment processes are evidence-based and based on youth and family strengths. • Determine capacity to bill Medicaid for screening/diagnostic services. • Ensure capacity to share behavioral health data with community-based providers.
Coverage of targeted case management services for eligible youth 30 days prior to release and at least 30 days post release.	• Determine existing partnerships with community-based organizations to provide case management and develop partnerships with community-based organizations if they don't yet exist. • Determine if existing barriers prevent community-based providers from delivering case management services in correctional facilities and work to ensure that community-based care managers can enter and engage. • Assess capacity for these providers to bill these services under Medicaid.
Suspend rather than terminate coverage for youth during incarceration.	• Understand current suspension or termination processes in juvenile and adult, state and local carceral settings. • Develop a consistent policies and procedure document outlining the Medicaid suspension and enrollment process. This document should be developed in partnership with Medicaid agencies, juvenile justice, and adult facilities.
Redetermine eligibility without requiring a new application and restore coverage upon release.	• Understand current eligibility determination and enrollment process and workflows across all correctional institutions with youth. • Determine staffing to support enrollment in Medicaid and CHIP, pre-release. • Develop process in partnership with juvenile justice and adult facilities to restore coverage pre-release without requiring new applications.
Optional for states: **Provide Medicaid and CHIP coverage to youth in correctional settings pending disposition of charges.**	• Determine eligible youth pending disposition of charges. • Assess budget implications for expanding Medicaid coverage for this population.

Conclusion

New federal legislation and CMS guidance establish exceptions to the inmate exclusion policy for the first time, allowing states to use federal Medicaid funding to address the unmet health and well-being needs of youth transitioning from incarceration. These changes provide states with an opportunity to improve outcomes for youth returning to their homes and communities and advance broader prevention goals. Given the over-representation of youth of color in the justice system, these changes provide a meaningful opportunity to address racial disparities.

> **[Youth belong] in their communities, with the people who love them, and who they're used to being around.**
>
> — Lisa Macaluso, Deputy Director of Policy, Research and Planning, New Jersey Juvenile Justice Commission

States should take immediate steps to prepare for these new requirements that are effective January 1, 2025. Through the practices outlined above — cross-system collaboration, meaningful partnerships with formal and informal community supports, and the expansion and leveraging of existing services and supports outside of the justice system — states can integrate implementation efforts into a broader strategy to address youth and family well-being.

Youth thrive in supportive and caring communities where they can learn and grow. Through the practices outlined above — cross-system collaboration, meaningful partnerships with formal and informal community supports, and the expansion and leveraging of existing services and supports outside of the justice system — states can utilize new Medicaid opportunities to meaningfully address well-being needs, empowering youth to build healthy and constructive futures.

ENDNOTES

[1] Robert Wood Johnson Foundation (2020, December 17). *Well-Being: expanding the definition of progress: Insights from practitioners, researchers, and innovators from around the globe*. (Plough, A. (ed.)) Oxford Academic. https://doi.org/10.1093/oso/9780190080495.001.0001

[2] Ford, J. D., Chapman, J. F., Hawke, J., & Albert, D. (2007). *Trauma among youth in the juvenile justice system: Critical issues and new directions.* [Research brief]. National Center for Mental Health and Juvenile Justice. https://www.courts.ca.gov/documents/BTB25-1G-02.pdf

[3] Mendel, R. (2023, March 1). *Why youth incarceration fails: An updated review of the evidence.* [Report]. The Sentencing Project. https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence

[4] Kelly, T., Dankoff, J., Anoshiravani, A., DeBaun, M. R., & Barnert, E. (2024). Medicaid policy changes are set to allow coverage for some health services for youth in custody: What should pediatricians know?. *Pediatric Research,* 10.1038/s41390-024-03280-7. https://doi.org/10.1038/s41390-024-03280-7; See also: Scannell, C., Albertson, E. M., Ashtari, N., & Barnert, E. S. (2022). Reducing Medicaid Coverage Gaps for Youth During Reentry. *Journal of Correctional Health Care : The Official Journal of the National Commission on Correctional Health Care, 28*(1), 39–46. https://doi.org/10.1089/jchc.20.03.0011

[5] Luna, M. J., Abram, K. M., Aaby, D. A., Welty, L. J., & Teplin, L. A. (2024). Inequities in mental health services: A 16-year longitudinal study of youth in the justice system. *Journal of the American Academy of Child and Adolescent Psychiatry*, *63*(4), 422–432. https://doi.org/10.1016/j.jaac.2023.07.005

[6] Wang, L., Sawyer, W., Herring, T., Widra., E & Widra, E. (2022, April). *Beyond the count: A deep dive into state prison populations.* Prison Policy Initiative. [Press Release] https://www.prisonpolicy.org/reports/beyondthecount.html#youth

[7] Consolidated Appropriations Act, 2023, H.R.2617, 117th Congress (2021-2022). https://www.congress.gov/bill/117th-congress/house-bill/2617

[8] Centers for Medicare & Medicaid Services (2022, December 16). *Medicaid coverage of youth formerly in foster care changes under section 1002(a) of the SUPPORT Act.* [Slide deck]. https://www.medicaid.gov/sites/default/files/2022-12/former-foster-care-coverage-changes.pdf

[9] Tsai, D. (April 17, 2023). *Re: opportunities to test transition-related strategies to support community reentry and improve care transitions for individuals who are incarcerated.* Centers for Medicare & Medicaid Services. [State Medicaid Director Letter] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

[10] Sawyer, W., Wagner, P. (2024, March 14). *Mass incarceration: The whole pie 2024*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2024.html. On October 27, 2021, there were 24,894 youth (age 20 and under) confined in juvenile justice facilities (Office of Juvenile Justice and Delinquency Prevention, Easy Access to the Census of Juveniles in Residential Placement (EZACJRP). On December 31, 2022, and June 30, 2022, respectively, there were 2,300 youth confined in adult prisons or jails (Bureau of Justice Statistics, Prisoners in 2022 – Statistical Tables, Table 15; Jail Inmates in 2023 – Statistical Tables, Table 2). These data are generally believed to be underinclusive of all children and youth in carceral settings on any given day (https://www.sentencingproject.org/reports/too-many-locked-doors-the-scope-of-youth-confinement-is-vastly-understated)

[11] Youth.Gov (n.d) *Juvenile justice.* Interagency Working Group on Youth Programs. https://youth.gov/youth-topics/juvenile-justice

[12] Ford, et al. 2007. See also Mendel, 2023.

[13] Sawyer, et al. 2024. See also Sickmund, M., Sladky T.J., Puzzanchera, C., and Kang, W. (2021). *Easy access to the census of juveniles in residential placement.* National Center for Juvenile Justice. https://www.ojjdp.gov/ojstatbb/ezacjrp/. The age of majority for the purpose of criminal prosecution is established by individual states. In 2020, Vermont became the first state to expand juvenile court jurisdiction to 18-year-olds. See Interstate Commission for Juveniles. (n.d) *Age matrix.* Retrieved July 29, 2024, from https://juvenilecompact.org/age-matrix

[14] Sickmund, et al. 2021.

[15] Jafarian, M. & Ananthakrishnan, V. (2017, August). *Just kids: When misbehaving is a crime.* Vera Institute. https://www.vera.org/when-misbehaving-is-a-crime/how-status-offenses-lead-kids-into-the-justice-system

[16] American Academy of Pediatrics. (2021, August 16) Health group statement of support for instituting a minimum age of jurisdiction for juvenile justice involvement. https://downloads.aap.org/AAP/PDF/JJMinimumAgeHealthGroupStatement.pdf

[17] Puzzanchera, C., Sladky, T.J., and Kang, W. (2023). *Easy access to the census of juveniles in residential placement*. https://www.ojjdp.gov/ojstatbb/ezacjrp. See also: Office of Juvenile Justice and Delinquency Prevention, *National racial and ethnic (R/ED) disparities databook (2020)*. https://ojjdp.ojp.gov/statistical-briefing-book/data-analysis-tools/r-ed-databook;

and The Sentencing Project. (2021). *Bringing more teens home: Raising the age without expanding secure confinement in the youth justice system.* https://www.sentencingproject.org/app/uploads/2022/10/Bringing-More-Teens-Home-Raising-the-Age-Without-Expanding-Secure-Confinement-in-the-Youth-Justice-System-1.pdf

[18] The Sentencing Project. (2023). Black disparities in youth incarceration [Fact Sheet]. https://www.sentencingproject.org/app/uploads/2023/12/Black-Disparities-in-Youth-Incarceration.pdf

[19] Wilson, B. D. M., Jordan, S. P., Meyer, I. H., Flores, A. R., Stemple, L., & Herman, J. L. (2017). Disproportionality and disparities among sexual minority youth in custody. *Journal of Youth and Adolescence*, *46*(7), 1547–1561. https://doi.org/10.1007/s10964-017-0632-5

[20] Opthof, E., & Silverman, K. (2020, February 23). Adopting a well-being approach in health care: Benefits and considerations. Center for Health Care Strategies. *CHCS Blog.* https://www.chcs.org/adopting-a-wellbeing-approach-in-health-care-benefits-and-considerations

[21] Anoshiravani, A. (2020, January 16). Addressing the unmet health needs of justice system-involved youth. *The Lancet Public Health 5*(2), e83. https://doi.org/10.1016/S2468-2667(19)30251-8

[22] Hughes, N., Ungar, M., Fagan, A., Murray, J., Atilola, O., Nichols, K., Garcia, J., & Kinner, S. (2020, February). Health determinants of adolescent criminalisation. *The Lancet Child & Adolescent Health, 4*(2), 151–162. https://doi.org/10.1016/S2352-4642(19)30347-5

[23] Courtney, M., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 26*. Chapin Hall at the University of Chicago. https://www.chapinhall.org/wp-content/uploads/Midwest-Eval-Outcomes-at-Age-26.pdf

[24] Ford, et al, 2007. See also Mendel, 2023.

[25] The Sentencing Project. (2021). *The color of justice: racial and ethnic disparity in state prisons.* [Report] https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf

[26] Equal Justice Initiative. (2021, September 14). Black children five times more likely than white youth to be incarcerated. [Blog Post] https://eji.org/news/black-children-five-times-more-likely-than-whites-to-be-incarcerated

[27] Mendel, 2023.

[28] Kelly, 2024. See also Scannell, 2022.

[29] Social Security Act of 1965, U.S.C. § 1396d. https://www.law.cornell.edu/uscode/text/42/1396d. See also 2016 CMS SHO Letter 16-007 providing guidance to states on facilitating access to covered medical service and clarifying definition of applicable public institutions.

[30] Medicaid and CHIP Payment and Access Commission (MACPAC). (August 2021). *Access in brief: Health care needs and use of services by adolescents involved with the juvenile justice system*. [Issue Brief] https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Health-Care-Needs-and-Use-of-Services-by-Adolescents-Involved-with-the-Juvenile-Justice-System-1.pdf

[31] An act to provide for opioid use disorder prevention, recovery, and treatment, and for other purposes, H.R.6, 115th Congress (2017-2018). https://www.congress.gov/bill/115th-congress/house-bill/6 ; See also Centers for Medicare & Medicaid Services. (2021, January 19). *Implementation of at-risk youth Medicaid protections for inmates of public institutions.* [Letter] https://www.medicaid.gov/sites/default/files/2021-12/smd21002.pdf. The SUPPORT Act also directed CMS to issue guidance on how waivers can improve care transitions for people who are incarcerated but otherwise eligible for Medicaid. The SUPPORT Act required the Secretary of Health and Human Services to convene a group of stakeholders to help inform the design of a demonstration opportunity to improve care transitions for people leaving incarceration. Findings and identified promising practices from that convening were summarized in a report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE). See: https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf

[32] Consolidated Appropriations Act, 2023, H.R.2617, 117th Congress (2021-2022).

[33] Consolidated Appropriations Act, 2023, H.R.2617, 117th Congress (2021-2022).

[34] Tsai, D. Centers for Medicare & Medicaid Services. (2024, July 23). Provision of Medicaid and CHIP services to incarcerated youth. [State Medicaid Director Letter]. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

[35] Tsai D., July, 2023.

[36] Tsai D., July, 2023.

[37] Tsai D., July, 2023.

[38] Tsai D., July, 2023.

[39] Tsai, D., April, 2023.

[40] Kaiser Family Foundation. (2024, August 2). *Medicaid waiver tracker: Approved and pending Section 1115 waivers by state.* https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table1

[41] Baumrucker, E. P., Binder, C., Colello, K. J., Hahn, J., Houston, M. B., Mitchell, A., Sarata, A. K., Villagrana, M. A., & Voorhies, P. (2024, May 24). Consolidated Appropriations Act, 2024 (P.L. 118-42): *Medicaid and Medicare provisions* (CRS Report No. R48075). Congressional Research Service. [CRS Report]. https://crsreports.congress.gov/product/pdf/R/R48075

[42] Stroul, B. A., Blau, G. M., & Larson, J. (2021, May). *The evolution of the system of care approach for children, youth, and young adults with mental health conditions and their families*. Institute for Innovation and Implementation. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

[43] The Annie E. Casey Foundation. (2018, September 18). New Jersey becomes first state to implement JDAI statewide. *Annie E. Casey Foundation Blog*. https://www.aecf.org/blog/new-jersey-becomes-first-state-to-implement-jdai-statewide. See also: The Annie E. Casey Foundation. (n.d.). Juvenile Detention Alternatives Initiative (JDAI). https://www.aecf.org/work/juvenile-justice/jdai

[44] State of New Jersey Department of Law and Public Safety (n.d) Juvenile Justice Commission. https://www.njoag.gov/about/divisions-and-offices/juvenile-justice-commission-home

[45] National Wraparound Initiative. (n.d.) Wraparound basics or what Is Wraparound: An introduction. https://nwi.pdx.edu/wraparound-basics/#whatisWraparound

[46] New Jersey Department of Children and Families. (n.d.) Children's system of care. https://www.nj.gov/dcf/about/divisions/dcsc

[47] University of New Mexico School of Medicine. (n.d.) ADOBE program. https://hsc.unm.edu/medicine/departments/family-community/clinical-practice/adobe

[48] Camera, L. (2021, July 27). Study confirms school-to-prison pipeline. *U.S. News & World Report.* https://www.usnews.com/news/education-news/articles/2021-07-27/study-confirms-school-to-prison-pipeline

[49] Child Health and Development Institute. SBDI - school-based diversion initiative. (n.d) https://www.chdi.org/our-work/school-based-mental-health/sbdi