ISSUE BRIEF

Improving Health and Safety as Youth and Young Adults Leave the Justice System:

State Implementation of New Policies to Strengthen Continuity of Care at Reentry

Authors: Lisa Pilnik, Margot Cronin-Furman, and Vikki Wachino

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INTRODUCTION

Medicaid policy changes to promote continuity of care as youth and young adults return to their communities after incarceration offer an opportunity for states to help young people on a trajectory to healthy adulthood and improve community safety. Youth in the justice system have high rates of health conditions, as well as significant unmet developmental and social needs. Many of these youth and young adults are eligible for Medicaid or the Children's Health Insurance Program (CHIP), but historically, these programs have covered very few services when beneficiaries are incarcerated.

Policies that are now being implemented in every state establish Medicaid and CHIP coverage for a targeted set of services that start in the 30 days prior to release and continue after release from incarceration. These policies aim to strengthen continuity of care as youth and young adults return to families and communities. They apply to youth and young adults up to age 21 and former foster care youth up to age 26 who are enrolled in or eligible for Medicaid or CHIP and are incarcerated in youth facilities and adult prisons and jails. These reentry policies represent an opportunity to both provide services to incarcerated youth before release and facilitate safe transitions into community care upon release, improving peoples' health and public safety.

HARP asked two longtime juvenile justice leaders for their perspectives on how these health and reentry policies can improve the health and safety of youth and young adults. Here is what they said:

"The importance of ensuring health care access for justice-involved youth cannot be overstated. If our goal is to position youth to do well and to keep communities safe, we must ensure that youth's health needs are met. The recent changes to the Medicaid policy present a remarkable opportunity to do just that."
—Michael Umpierre, Center for Youth Justice

"The Juvenile Justice and Delinquency Prevention Act (JJDPA) requires individualized reentry case planning pre- and post-release for incarcerated youth; state implementation of the CAA health provisions can really complement and provide additional resources to strengthen implementation of the written reentry plans that states participating in the JJDPA already have to complete. States are already striving to have strong reentry systems in place and the system actors and implementation partners on the justice side are already invested in improving reentry outcomes, so their participation and investment in the CAA implementation can be a win-win as they collaborate with healthcare and other service partners."
—Melissa Milchman, Coalition for Juvenile Justice

To describe how these policies can help achieve better outcomes for youth and communities, and to inform their successful implementation, this paper:

- Identifies the role that access to health care and continuity of care can play in improving outcomes for youth;
- Discusses the health needs of young people involved with the justice system, based on a review of available research;
- Describes the youth continuity of care policies, and how implementing them can help connect youth and young adults to needed services; and
- Identifies early implementation practices and lessons from three states, Massachusetts, New Mexico, and North Carolina, with a focus on implementation in the juvenile justice system.

The appendices identify evidence-based approaches to screening, assessment, and post-release service interventions that, when implemented, have potential for improving the health of youth and young adults who are leaving the justice system and supporting public safety goals.

HEALTH CARE AND COVERAGE'S IMPACT ON YOUNG PEOPLE'S HEALTH, JUSTICE SYSTEM INVOLVEMENT, AND PUBLIC SAFETY

On a single day, approximately 29,314 youth are incarcerated in juvenile facilities, and another roughly 166,000 young people under age 25 are incarcerated in adult jails or prisons in the United States.[1] Incarceration in youth facilities has declined significantly over the past three decades, but since 2021 numbers have been increasing[2] and disparities for Black and tribal youth have increased.[3] Young people aged 12-17 involved in the justice system are more likely to be enrolled in Medicaid or CHIP or to be uninsured, compared to youth without recent justice system involvement.[4] In a national survey, more than 60% of youth aged 12-17 who had been incarcerated were covered by Medicaid or CHIP.[5] Research suggests that healthcare services, and possessing the necessary coverage to access to those services, can help prevent initial or repeated justice system involvement for youth and young adults, including incarceration. For example, a 2022 study[6] of young men in South Carolina found a higher likelihood of criminal activity and incarceration within two years for those who lost eligibility for Medicaid when they turned 19 than those who maintained Medicaid coverage.[7] Other studies have linked access to health insurance after release from incarceration with lower re-arrest rates[8] and suggested that community-based care coordination can prevent or delay justice system involvement and recidivism.[9]

> **"By their 20th birthdays, men with mental health histories who lost access to [Medicaid-supported] services are [22%] more likely to have ever been incarcerated relative to men in the comparison group."**
> —*Elisa Jácome* in *Mental Health and Criminal Involvement: Evidence from Losing Medicaid Eligibility*

Among youth who had already experienced juvenile detention, a 2023 California retrospective study of youth ages 12-18 found that young people who accessed primary care after release were less likely to return to detention.[10] The researchers also noted that while youth face multiple competing priorities after incarceration, such as reentering school or securing employment, a delay in accessing medical care could lead to more acute and ultimately more expensive health needs.[11] A 2020 systematic research review also found a lack of health insurance to be a significant barrier for youth transitioning from incarceration who are in need of services.[12] Given the potential for access to health care to improve outcomes for youth, and the high rates of Medicaid eligibility among young people who experience incarceration, the Consolidated Appropriations Act of 2023 (CAA) provisions hold great promise for significantly benefiting youth in the justice system, and for advancing public safety goals.

HEALTH AND DEVELOPMENTAL NEEDS OF YOUNG PEOPLE INVOLVED IN THE JUSTICE SYSTEM

Young people who come into contact with the justice system often have greater physical and behavioral health needs than their peers, and their experiences with the justice system–particularly incarceration–can compound existing issues and create new challenges. Research also suggests that, compared with their peers, youth involved in the justice system receive less preventative care, experience more emergency room visits, and have less continuity of health care coverage.[13]

Youth impacted by the justice system have significant physical and behavioral health needs

Research indicates that youth involved with the justice system have higher rates of physical health issues including asthma and hypertension, traumatic brain injury, oral health issues, missing vaccinations, sexually transmitted infections, and being overweight or obese than other youth.[14] [15] [16] Youth also may have experiences during incarceration that negatively affect their health.[17] Research has also linked experiencing incarceration in adolescence with worse health in adulthood, including general health issues as well as limitations on daily functions, such as climbing stairs, after underlying health and other potential contributing factors were adjusted for.[18]

Up to 70% of youth involved in the juvenile justice system may have a diagnosable behavioral health condition, including substance use disorders (SUD),[19] and up to one-third of youth involved in the justice system may have post-traumatic stress disorder (PTSD) related to experiences before or during incarceration.[20] As with physical health, the impacts of incarceration continue into adulthood. Individuals who experienced incarceration as youth or young adults are more likely to have depressive symptoms and suicidal thoughts later in life.[21] A 2017 study tracking youth who experienced juvenile detention found that in the 12 years after incarceration, more than 81% experienced SUD during that period.[22]

Incarceration can also interfere with the healthy development of adolescents and young adults in other ways. Being disconnected from family and community during adolescence–a pivotal period for brain development, skill-building, and building social networks–can inhibit young peoples' ability to live healthy lives, including completing school, building careers, and securing stable housing.[23]

> **"The importance of ensuring health care access for justice-involved youth cannot be overstated. If our goal is to position youth to do well and to keep communities safe, we must ensure that youth's health needs are met. The recent changes to the Medicaid policy present a remarkable opportunity to do just that."**
> *—Michael Umpierre, Center for Youth Justice*

Youth who have been involved in the justice system have often also been impacted by other harmful experiences

Youth, particularly Black youth, who are more likely to experience incarceration than their peers as youth and throughout adulthood,[24] often enter the juvenile justice system while living (or having previously lived) in foster care or having other child welfare system involvement.[25] Experiences of homelessness,[26] learning disabilities, and negative school experiences (including grade retention, school dropout/disconnection, suspensions, and expulsions)[27] are also common before and after youth justice system involvement. These experiences can interfere with the safety, connectedness, and opportunities for growth and skill-building that are essential to adolescent development.[28] Collaborative action between the health, juvenile justice, child welfare, homelessness, disability services, and education sectors can help make justice system involvement less likely and achieve healthier outcomes.[29]

MEDICAID REENTRY POLICIES HOLD PROMISE TO POSITIVELY IMPACT YOUTH AND YOUNG ADULTS

Nationwide Medicaid reentry policies create an opportunity to address the needs of youth and young adults by strengthening continuity of care as they are returning to communities. Under

Section 5121 of the Consolidated Appropriations Act (CAA) of 2023, states will use Medicaid and the Children's Health Insurance Program (CHIP) to cover certain services provided to eligible youth and young adults in correctional facilities.

These policies are significant because historically, a federal "inmate exclusion" policy has prevented Medicaid from covering any services for a person who is an "inmate of a public institution," including but not limited to jails, prisons, and youth correctional facilities.[30] The CAA policies are the first statutory changes to the inmate exclusion since it was established by Congress in 1965. In addition, some states are going further than these new policies are by revising the inmate exclusion using Medicaid section 1115 waivers, which can apply to both adults and youth and cover a slightly broader set of services than do the youth continuity of care policies.

The law applies to youth under the age of 21 or former foster care youth under the age of 26 who are eligible for or enrolled in Medicaid or CHIP and are incarcerated post-adjudication in state prisons, local jails, tribal jails, juvenile detention, or youth correctional facilities.[31] These young people may represent a relatively small share of the population in adult correctional facility, but given their disproportionately high health needs and past adverse experiences, reaching this population with expanded services represents an outsized opportunity for impact and improved outcomes for youth, their families, and communities. Facilities will work with their state Medicaid agencies to identify eligible youth and support their enrollment in Medicaid or CHIP, if they are not already enrolled.

The specific services covered by this policy are designed to facilitate safe transitions back to the community.[32] They include:

- **Screening and diagnostic services** to identify physical, dental, and behavioral health needs. Each state Medicaid agency will define the specific screening and diagnostic services that are covered, in line with the state's existing standards for the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program, which is Medicaid's comprehensive pediatric benefit. States must provide these screening and diagnostic services within 30 days prior to release, no later than one week after release, or as soon as practicable after release.

- **Targeted case management** to identify and address physical health, behavioral health, and health related social needs. Targeted case management must be provided within 30 days of release and for at least 30 days in the community. Specific case management activities include:
  - A comprehensive assessment to identify needs for medical, educational, and other intervention or support.
  - Development of a person-centered care plan that reflects how the needs identified in the assessment will be addressed and by whom.
  - Referrals to appropriate services, including making outpatient appointments or finding inpatient services, facilitating warm handoffs to providers, and other support for ensuring that an individual is able to successfully connect with community-based providers.

- Conducting monitoring and follow-up activities to ensure that the care plan is implemented, which may include ongoing contact with the individual, their social supports, and their service providers.

Federal guidance emphasizes that states should ensure that the implementation of these services do not lead to increased incarceration or longer stays/delayed release from incarceration.[33]

These policies will enable youth to connect to health and social services that meet their needs as they return to communities, potentially reducing the likelihood of future justice system involvement.[34] Most or all of the physical and behavioral health services needed by youth are covered by Medicaid in their communities. Leveraging Medicaid can expand access to quality care by ensuring coverage and connections to services during reentry. These connections start with ensuring that screenings and assessments are offered consistently. A discussion of opportunities to offer evidence-based approaches to screenings and assessments is in **Appendix A**.

> **"The transition from adolescence to adulthood is a critical period of intervention. Intervention programs for JIY [justice involved youth] during reentry, including both mental health and substance use treatment programs, have been shown to reduce the risk of reoffending and provide long-term cost benefits. Strengthening continuity of Medicaid coverage for JIY would help ensure access to these evidence-based interventions so that youth have the best chance to thrive."**
> *—Christopher Scannell, et al in Reducing Medicaid Coverage Gaps for Youth During Reentry (internal citations omitted)*

More fundamentally, the continuity of care policies are an opportunity to connect youth and young adults to evidence-based programming that has the potential to improve their and their families' health and well-being and improve public safety by making future justice system interactions less likely. Appendix B summarizes some of this programming. Currently, these services may not be offered in all communities, but in implementing the continuity of care policies, state and local governments and community partners can work to increase the availability of community resources with Medicaid's support.

IMPLEMENTING NEW POLICY TO BETTER SUPPORT YOUNG PEOPLE WHO ARE INVOLVED IN THE JUSTICE SYSTEM

The CAA of 2023 called for implementation of the Medicaid provisions starting in January 2025. **New Mexico**, **Massachusetts**, and **North Carolina** are among the jurisdictions that have implementation work well underway, and represent a range of geographic locations, system

sizes, stakeholder priorities and challenges, approaches and stages of implementation; they also are each implementing Medicaid Section 1115 re entry waivers. Although their efforts are unique to their local contexts, several themes emerged that can inform implementation efforts across the country.[35] At this early stage, these states' efforts have prioritized implementing the Medicaid policies in their juvenile justice systems; the states will then use these initial efforts to inform subsequent implementation in adult facilities. All information in this section of the paper, unless identified otherwise, comes from public agency staff in the state discussed. The authors are grateful for their time and generosity in sharing their work.

STATE MEDICAID AND JUVENILE JUSTICE SNAPSHOTS: NEW MEXICO, MASSACHUSETTS, AND NORTH CAROLINA

New Mexico had 222 youth in juvenile justice system placements during the 2023 National Census of Juveniles in Residential Placement (CJRP), which is a one day point-in-time count that includes youth pre- and post-adjudication under age 21 in juvenile facilities. New Mexico's Children, Youth & Families Department estimates that 97% of incarcerated youth in their system are eligible for Medicaid, and the agency expects to serve about 120 youth in juvenile facilities each year through the CAA. New Mexico's juvenile justice system is already implementing CAA services.

North Carolina had 573 youth in residential placement during the CJRP count, and they estimate their annual potentially CAA-eligible population in youth facilities to be approximately 177 (based on 2023 figures). North Carolina is currently fully implementing the CAA services in its JJ system, and will transition to implementing in its adult system (using their 1115 waiver).

Massachusetts had 285 youth in residential placement during the CJRP count. They estimate they will serve up to 600 young people per year through the CAA provisions highlighted in this report across youth and adult facilities. Massachusetts is currently implementing the CAA provisions in their youth justice system and is working towards full implementation in adult prisons and jails.

Previous sections of this paper explained how health care and continuity of care can improve outcomes for youth, outlined the available research on the health needs of young people involved in the justice system, and described changes in health care policies that can help connect young people who experience incarceration to needed services. This final section shares three sets of strategies for successful implementation of the new policies, as illustrated by the early implementation examples of three states:

- **Strategy 1:** Collaborate across agencies and sectors, including partnering with community providers
- **Strategy 2:** Promptly enroll all eligible incarcerated youth in Medicaid and ensure all appropriate services can be covered and paid for by Medicaid
- **Strategy 3:** Start release planning early and partner with community providers to ensure continuous service provision at reentry

Additional reflections from the states on their implementation efforts are shared below.

STRATEGY 1: COLLABORATE ACROSS AGENCIES AND SECTORS, INCLUDING PARTNERING WITH COMMUNITY PROVIDERS

The state adult corrections, juvenile justice, and health care agencies are essential partners in implementation. When they collaborate closely with each other, while also learning from other relevant systems and stakeholders, they can make implementation smoother. Collaboration is essential to addressing substantive issues, such as identifying who can provide which services, as well as administrative issues, such as capturing the information needed to ensure services can be funded appropriately.

In North Carolina, the agencies collaborating with the state Medicaid agency on implementation in the juvenile justice system included the Department of Public Safety, Division of Juvenile Justice and Delinquency Prevention (DJJDP), the Department of Adult Correction (DAC), Federally Qualified Health Centers (FQHCs), North Carolina Community Health Center Association (NCCHCA), and county-based managed care.

- To plan for implementation, there were recurring meetings and workgroups involving a cross section of these groups.
- The relevant agencies also engaged with the state's Department of Health and Human Services' Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) to discuss existing programs supporting the justice-involved population with reentry.

In New Mexico, the primary partners on implementation have been the New Mexico Healthcare Authority (HCA), the Children, Youth & Families Department (CYFD), and the Corrections Department (NMCD). The agencies have also partnered with counties to serve youth in county detention facilities. HCA and CYFD have a long history of working together.

- Early in their implementation planning, stakeholders including staff from HCA, CYFD, and NMCD attended a multi-day kickoff meeting facilitated by the Health and Reentry Project and National Academy of State Health Policy in 2024. The meeting included opportunities for the state team to learn together and with their peer states about how to advance implementation and address key challenges.

- A CYFD stakeholder explained that the meeting helped create team cohesion and helped him to be "bought in" and able to communicate the importance of these services to his leadership. New Mexico also had numerous workgroups that included additional stakeholders who contributed their insights and expertise during the planning phase. (Stakeholders who participated included a Medical Health Services Administrator, a Medical Transition Coordinator, Re-Entry Transition Coordinators, and a Detention Standards Administrator.)

- NM CYFD also hired a Medicaid billing specialist to help develop the billing program for both the CAA and their 1115 waiver implementation. A CYFD representative explained "We hired someone with not only years of Medicaid experience, but we chose someone who was a builder, so we could design the right solution from the beginning, rather than create workarounds that wouldn't hold up over time."

In Massachusetts, the Department of Youth Services (DYS) is an agency within the Executive Office of Health and Human Services Secretariat, along with the state's MassHealth agency, which manages Medicaid for the state.

- This proximity ensures close collaboration and has facilitated a strong partnership between DYS and MassHealth to comprehensively plan for CAA implementation.

Massachusetts had been offering incarcerated youth EPSDT services for many years and generally found that the available services in their DYS facilities were already meeting federal youth requirements. Their work was focused on enhancing their current processes to align with CAA requirements, specifically service delivery timelines. This included collaboration within agencies (e.g., DYS Central Office staff worked closely with DYS health and clinical leadership and staff) to identify gaps in the targeted case management, screening, and diagnostic services the state already offers in facilities and through community providers, to ensure process enhancements were aligned with CAA requirements.

- DYS and MassHealth also worked together to create documents and tools to help facilitate the delivery of services and to train staff on the CAA guidance.

DYS shares that "DYS and MassHealth, along with other agencies as appropriate, continue to meet regularly to update status, review questions or concerns, and modify courses of action as needed while these systems are better understood and aligned." DYS has also shared their work to date and lessons learned with key partners from the adult corrections system to help them fully implement the screening and diagnostic and targeted case management services, with MassHealth acting as a convenor of several conferences that brought the systems together.

STRATEGY 2: PROMPTLY ENROLL ALL ELIGIBLE INCARCERATED YOUTH IN MEDICAID TO ENSURE THAT ALL ELIGIBLE SERVICES ARE COVERED

Implementing the CAA policies can be an opportunity to connect more youth in a state to Medicaid coverage, which can continue after incarceration ends, and leverage Medicaid financing for eligible services.

In Massachusetts, all youth who are detained by the courts pre-adjudication or committed to the Department of Youth Services' custody post-adjudication are entered into the DYS electronic records system within 2 hours; MassHealth regularly accesses those records and uses them to determine eligibility for Medicaid coverage.[36] (Overnight youth, who are youth detained overnight pending court reopening during normal business hours, are an exception.) DYS conducts basic screenings on youth within 24 hours (e.g., to identify medical and behavioral health needs, including suicide risk) and based on issues identified, youth may have medical appointments or clinical follow ups within 48 hours. DYS and MassHealth are actively discussing potential enhancements to the DYS information management system to support billing.

In North Carolina, representatives from the youth and adult justice agencies (DJJDP and DAC respectively) can now determine an individual's enrollment status by accessing some information in the state Medicaid agency's information systems. (Social workers from each agency are able to log into the Medicaid Management Information System and search in real time to see if an individual in their facility is enrolled in Medicaid.) The adult system already has a process that supports eligible individuals in facilities in enrolling in Medicaid, and the youth system is currently working towards implementing a similar process at intake.

- All youth who enter DJJDP facilities receive a health screening as part of intake, and once admitted, facility social workers or case managers administer more comprehensive clinical assessments and develop individualized care plans for each young person.

Prior to CAA implementation, New Mexico's CYFD checked Medicaid eligibility for all youth entering custody and completed applications for eligible youth as needed. Additionally, CYFD is working with its state partners to ensure that all eligible youth receive Targeted Case Management and that it (and other CAA-related services) is delivered in ways that ensure Medicaid can cover them, including credentialing and enrolling service providers.

STRATEGY 3: START RELEASE PLANNING EARLY AND PARTNER WITH COMMUNITY PROVIDERS TO ENSURE CONTINUOUS SERVICE PROVISION AT REENTRY

Implementation of the CAA provisions can be an opportunity for states to expand or improve transition planning for youth prior to release from incarceration. It also creates opportunities to create or deepen partnerships between correctional and community providers to facilitate smoother reentry transitions.

In Massachusetts, DYS' reentry process, which was in operation prior to the implementation of the CAA policies, begins as soon as youth are committed to DYS' custody post adjudication, and includes identifying youth's strengths and needs and connecting them to appropriate health and other services. Transition planning for committed youth includes specific steps taken at 90, 60, and 30 days before release, including developing plans for community-based case management and needed services.

- The agency has found that this graduated planning process and starting service identification when youth enter their system helps prevent release delays.

As the state has started planning for and implementing CAA policies, their health services staff has become more involved and connected to transition planning (within 30 days prior to release), including working to identify service providers in the community, which has improved the health services transitions for youth. (In Massachusetts community providers can serve youth in facilities but it is a more common practice for youth, including in secure settings, to be given a "pass" and transported to see providers in the community as they near release.)

DYS is also working on implementing transitional services for its detained population who may be held anywhere from hours to months awaiting resolution of pending matters. (This service planning may look different than for committed youth, however, since the length of stay and release location, which is decided by the courts, may not have been determined yet.)[37] DYS also oversees diversion programming and a voluntary program to provide services for youth post-discharge through age 22.

- Even for youth who may not be covered by the CAA (e.g., diversion-only youth), agency staff's expanded knowledge and processes around Medicaid can lead to a broader consideration of services youth may benefit from and be eligible for without deeper justice system contact.

North Carolina youth have care plans, as discussed earlier, and warm hand-offs are used for services that will be delivered after release (meaning that the youth are connected to any new post-release service providers, rather than just being given a list of services they should access).

- As part of the changes North Carolina is implementing tied to the CAA, the state plans to take youth to local Federally Qualified Health Centers (FQHCs) to receive screening and diagnostic services (within 30 days of release).

Local Management Entity/Managed Care Organizations (LME/MCOs, organizations that manage care for North Carolina Medicaid beneficiaries who receive behavioral health services) will deliver in-facility and post-release care management, with each youth ideally having the same care manager before and after release. Specifically, a DHHS representative explains that "During the pre-release period, the youth will be connected with an LME/MCO who serves the youth's post-release county. The LME/MCO will assign a care manager to 'follow' the youth in the pre- and post-release period, whenever possible. If the county of release changes, a warm hand-off to the new care manager will occur."

- The state is also working towards these care management services being delivered by individuals with relevant lived experience and emphasizing in-person engagement.

In New Mexico, facilities can choose if they want to have services provided by staff or by community providers; this flexibility is important given the many rural communities served by

CYFD and the resource disparities between rural and urban communities, as well as the range of facilities youth are placed in.

- A CYFD representative explained that he is hopeful that the resources the state can now access through Medicaid will lead to greater services in rural and tribal communities, including through virtual services, and an expansion of services to young people in adult facilities similar to what is already offered in the state's juvenile facility.

REFLECTING ON THE ROAD TO IMPLEMENTATION

In New Mexico, implementation in the adult system is still getting underway, but has already begun in the juvenile justice system. A youth system stakeholder shared that "Under the new CAA protocols, we are hoping to implement a seamless re-entry program with better multi-system integration and support for our youth returning to the community." They also shared that going through the process of implementing the CAA policies also provided affirmation of their work and investment in juvenile justice reform and national best practices. In terms of work still to be done, they said "Our primary challenge [to achieving our goals] will be to build a Medicaid billing infrastructure that does not impede our capacity to provide high-quality re-entry services to young people leaving incarceration. We are working to develop a Medicaid billing process that will naturally integrate with our existing workflows without undue administrative encumbrance to our staff who are providing these necessary services."

Massachusetts reflected on their experience with CAA implementation so far, sharing that the development of a cross-functional working group inclusive of key stakeholders from MassHealth, DYS, and adult correctional facilities has been instrumental, DYS reflected that working to identify and fill gaps in current services to meet the new CAA policy, and to ensure the state can receive Medicaid reimbursement for all appropriate services, has been a critical lynchpin to strengthen connections between health care and transition planning for youth. DYS staff shared that part of what has made them successful—and can be helpful in other states—is having a strong team that meets regularly to talk through issues as they arise and staying in close contact with MassHealth to ensure that services are appropriately delivered. A DYS representative reflected on their experience with implementation, sharing that they view the new CAA policies as an opportunity to "ensure we are providing the best possible care for youth."

For North Carolina, having a consistent care manager before and after release was cited as a benefit of their new policies and practices, with an HHS representative sharing that one of the biggest opportunities presented by the CAA policies is "connections to care and establishing provider relationships in the pre-release period that will continue into the post-release period." They also suggest that two keys to their success which may be helpful to other states were developing relationships with key stakeholders early on, and learning about current state justice facility capabilities and services (through surveys and deeper follow-up conversations) before determining how services would be provided.

CONCLUSION

Changes to Medicaid policy outlined above are an opportunity for states to ensure that youth and young adults involved in the justice system receive the care that they need while incarcerated and are prepared and supported to receive appropriate care as they return to their communities. High quality implementation, including strong partnerships with both community partners and other relevant state and local agencies, ensuring that all eligible youth are enrolled in Medicaid and receive services promptly, and thoughtful and comprehensive case management as part of timely reentry planning can help better meet the needs of youth and families, improve their health and well-being, and help to strengthen communities. Through cross-sector partnerships and thoughtful planning and implementation, states can better leverage existing resources, identify and fill gaps, and ensure that young people can be healthy and avoid initial or repeat system involvement, improving public safety.

APPENDIX A: SCREENING AND ASSESSMENT IN THE YOUTH JUSTICE SYSTEM

The Medicaid reentry policies discussed in this paper require states to provide screening and diagnostic services (such as screening for and providing needed immunizations), along with targeted case management (TCM) focused on addressing identified health-related needs for youth and young adults who experience incarceration. States have flexibility to choose which screening and diagnostic tools they use, as long as they "meet reasonable standards of medical or dental practice" and are in accordance with the state's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. They also have flexibility on which services youth are connected with as part of TCM. These provisions offer states an opportunity to expand the use of high-quality screenings, assessments, and other services for youth who experience incarceration, which could lead to better overall outcomes for these youth.

"The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. EPSDT is designed to promote the health and development of children and adolescents by ensuring that children and adolescents receive appropriate preventative, dental, mental health, and specialty services. It includes periodic screenings to identify health and behavioral health conditions and follow-up services to correct or ameliorate a condition identified during a screening."
—Health and Reentry Project and Bureau of Justice Assistance in "Section 5121 of the Consolidated Appropriations Act: Frequently Asked Questions for State Departments of Corrections"

SCREENING AND ASSESSMENT FOR YOUTH WHO ARE IN THE JUSTICE SYSTEM

Almost all juvenile incarceration facilities evaluate a youth's needs, including health, substance use, and education, within one week of admission.[38] Adult jails and prisons may screen for communicable diseases or health issues requiring emergency treatment but may be less comprehensive than are juvenile incarceration facilities in assessing the longer-term needs of youth and young adults. Although many juvenile justice facilities use research-supported tools (such as the widely used Massachusetts Youth Screening Instrument–Second Version (MAYSI-2) screening tool, which includes both mental health and substance use), others use "in-house" tools that may not be evidence-supported.[39]

Some experts have called for more focus on assessing youth's strengths,[40] and have called attention to some widely available assessments that can be used for this purpose (e.g., the

Youth Assessment and Screening Instrument (YASI), Youth Level of Service/Case Management Inventory (YLS-CMI)).[41] The Council of State Governments has also called for the youth justice system to use specialized, evidence-supported, screening and assessment tools to identify mental health and substance use needs, noting that general risk/needs assessments commonly used in these settings will not necessarily uncover these issues.[42]

- **Screening tools** are usually brief questionnaires, checklists, or similar documents that can be quickly filled out and scored by anyone who has *been trained to do so*.
- **Assessment tools** are more in depth and typically require clinical expertise to administer and score. Screening tools may be used to determine which youth should receive an assessment, and both screening and assessment tools may indicate that a young person should receive clinical intervention and services.

The expansion of EPSDT services included in the CAA also provides an opportunity for wider use of appropriate screening and assessment tools. Having assessment findings that show the youth/family strengths, needs, and any specific health conditions may provide case managers opportunities to connect youth and families to more appropriate and impactful services during the transition back to communities.

APPENDIX B: EVIDENCE-SUPPORTED SERVICES FOR YOUTH WHO EXPERIENCE INCARCERATION

The Medicaid provisions discussed in this paper present an opportunity for the youth justice system, in partnership with health systems and providers, to ensure that they are not only screening all youth for health-related needs but also connecting youth to evidence-supported services that can improve health and lives. Through these provisions, there is an ability to not only connect youth to service providers during reentry, but to begin relationship-building, and provide some services pre-release while planning for the reentry transition.

Services for youth who are transitioning out of the justice system fall into several categories, many of which overlap, and services come in varying levels of intensity. Many of the types of programs and practices discussed below are considered “effective” or “promising” for preventing justice system contact, incarceration, and/or recidivism in youth, or for reducing risk factors associated with justice system contact.[43] The interventions identified are not exhaustive and range from local programs to highly standardized, widely replicated interventions. Some of these programs and practices have research support, according to the National Institute of Justice’s CrimeSolutions.Gov and the Office of Juvenile Justice and Delinquency Prevention’s Model Programs Guide, but others have not been evaluated in ways

that qualify them for inclusion in databases of "evidence-rated" interventions (i.e., they may not have had randomized or peer review studies conducted on them).[44]

The following list categorizes services by their defining topic or population served:

- **Specific health services** for youth with medical needs, such as community health worker support, interdisciplinary medical care for complex medical needs, and disease-specific interventions like diabetes education programs for teens who are insulin-dependent or nurse family partnerships that provide home visiting services for first-time parents, including teen parents.

- **Behavioral health services** include services for substance use and mental health needs.
  - *Substance use services* can range from office-based talk therapies like motivational interviewing to inpatient adolescent substance use treatment, services ordered by drug courts, and specific forms of medication-assisted treatment (for individuals 18 and older).
  - *Mental health services*[45] can range from lower-intensity interventions like outpatient therapies, youth peer supports, or medication management to medium or higher-intensity services like crisis response services, inpatient psychiatric stays, or residential treatment.

- **Specialized services for youth with serious mental health or intellectual developmental disorders**, such as those supporting employment and/or housing as well as independent living skills development. These services may include dedicated case management to connect youth with workforce, housing, and other agencies to make sure these needs are met, including accessing appropriate programming (e.g., Individual Placement and Support (IPS)).[46]

- **Family-focused interventions** delivered in the youth's home and community and designed to support both the youth and their support systems. These services have a range of intensity, including interventions like Functional Family Therapy as well as those that involve multiple systems such as Multisystemic Therapy or Intensive Care Coordination Using High Fidelity Wraparound services.[47] These higher intensity, "wraparound services" are often used to serve youth involved in the behavioral health, child welfare, and juvenile justice systems, particularly those at risk of out-of-home placements or for youth transitioning from out-of-home placement to caregiver homes or independent living. Other types of intensive family-focused interventions may include programs with out-of-home components in non-secure settings, such as Treatment Foster Care Oregon.[48]

- **Educational and vocational programs** that prepare youth for successful adulthood by supporting their ability to complete their education and obtain jobs. Many of these programs are experienced working with youth involved in the justice system (e.g.,

UTEC, Roca, YouthBuild).[49] Programs like these may help young people build interview skills, navigate issues such as gaps in their educational or work records due to incarceration, and secure housing; some also provide or connect youth to clinical services. For youth who've spent time in foster care, there are additional benefits and programs they may be entitled to, including tuition waivers in many states and federal Education and Training Vouchers.[50]

- **Mentoring and advocacy programs** that provide support—to youth or parents—from individuals who have similar experiences and/or are from the same neighborhoods or backgrounds as their clients, such as Youth Advocate Programs.[51] Peer support has been recognized as "an evidence-based mental health model of care" by the Centers for Medicare & Medicaid Services (CMS) and almost all states include peer support in their Medicaid-covered services.[52] CMS has noted that it can increase engagement in services and has pointed to research showing that this approach can "help reduce use of emergency departments, re-hospitalization, and involvement with the criminal justice system."[53] For young people at risk of justice involvement, there has been increasing interest in a form of peer support called Credible Messenger Mentoring. This approach, which involves hiring individuals with past justice system involvement "to engage young people on their own terms in structured and intentional relationships,"[54] has been identified as having "great promise" for preventing incarceration and recidivism.[55]

> **"CMS encourages states to expand availability and utilization of peer support services after release from incarceration to support youth reentering the community."**
> *—CMS Letter to State Health Officials Re: Provision of Medicaid and CHIP Services to Incarcerated Youth, July 2024*

The specific interventions and types of programming shared above are being deployed throughout the United States, in many cases supported by Medicaid, though experts have stated that their availability is not sufficient to meet the demand.[56] Changes to Medicaid policy offer an opportunity to invest in growing these services and connect young people who experience incarceration to programming that can support their health and well-being as they return to their communities.

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