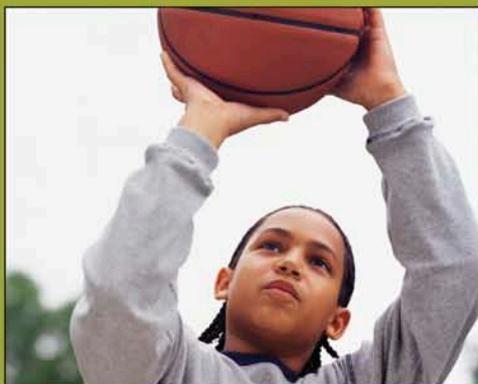


Juvenile Justice Resource Series

New Directions for Behavioral Health Funding and Implications for Youth Involved in the Juvenile Justice System



***New Directions for Behavioral Health Funding and
Implications for Youth Involved in the Juvenile
Justice System***

**Alison Evans Cuellar, Ph.D.
George Mason University**

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About the Technical Assistance Partnership for Child and Family Mental Health

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is "helping communities build systems of care to meet the mental health needs of children, youth, and families."

This technical assistance center operates under contract from the Federal Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- The American Institutes for Research—committed to improving the lives of families and communities through the translation of research into best practice and policy, and
- The National Federation of Families for Children's Mental Health—dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families.

The TA Partnership includes family members and professionals with extensive practice experience employed by either the American Institutes for Research or the National Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

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Forward

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) recognizes the many challenges system of care communities face in working to better meet the needs of all of the children, youth, and young adults they serve. In an effort to help these communities meet the unique needs of young people involved or at risk of involvement with the juvenile justice system, the TA Partnership is releasing a resource series focused on this population. The TA Partnership has contracted with the National Center for Mental Health and Juvenile Justice (NCMHJJ) and other experts in the field to produce this resource series. Each brief examines a unique aspect of serving this population, from policy to practice, within system of care communities.

We hope that this resource series will support the planning and implementation of effective services, policies, and practices that improve outcomes for children, youth, and young adults involved or at risk of involvement with the juvenile justice system as well as their families.

New Directions for Behavioral Health Funding and Implications for Youth Involved in the Juvenile Justice System

Overview

Epidemiological studies have found that youth involved with the juvenile justice system have notably higher than average rates of behavioral health disorders¹ and higher than average rates of selected medical conditions,² which partly reflects their risk-taking behavior. This brief focuses primarily on funding and delivery of care for behavioral health problems. When referring to youth in the justice system, we include youth anywhere in the justice continuum, from the point of contact with law enforcement to detention, probation, potential incarceration, and/or reentry into the community.

Several major financing streams exist to support mental health services for youth involved in the juvenile justice system. These include Federal funds, various Federal–State partnerships, State programs, and private financing mechanisms. This brief first describes the historical funding base for mental health services for youth and how it has changed over time. It then discusses recent changes that could significantly impact the funding and service landscape going forward and highlights opportunities for input from stakeholders.

Federal Grants Over the Past Decade

There are two major Federal sources of grant funding for behavioral health services to youth involved with the justice system. The first source, which is focused on delinquency, is a set of programs administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) that are specific to justice-involved populations not residing in facilities. These funds, including the juvenile justice formula grants and the Juvenile Accountability Block Grants, have been declining (nearly 70 percent from 2000 to 2010).³ The other source, which supports direct delivery of mental health services, is administered by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). It supports State mental health services for children through programs such as the Comprehensive Community Mental Health Services for Children and Families program (or systems of care). Consistent with Federal efforts to promote systems of care, funding for this program has not declined, but rather increased modestly since 2000. However, over the past 10 years, funding for SAMHSA's block grant program for community mental health services to children and adults fell almost 10 percent (after adjusting for inflation). SAMHSA also administers the Federal Substance Abuse Prevention and Treatment Block Grant program, which serves adults and children. Funded at only \$1.7 billion in 2010, this program also has not kept up with inflation.⁴

A smaller Federal program, the Mentally Ill Offender Treatment and Crime Reduction (MIOTCR) Act was designed to help States and counties design and implement collaborative efforts between criminal justice and mental health systems. MIOTCR funds are modest, rising from \$5 million in 2005 to \$12 million in 2010. Overall, despite

increased efforts by juvenile justice agencies to collaborate with local mental health departments for youth involved in the justice system, the general picture has been one of a shrinking funding base for behavioral health services.

One area where there have been more intensive efforts toward interagency collaboration is reentry. The Second Chance Act provides support to State and local authorities to develop programs for reintegrating into the community adults and juveniles who have been incarcerated. There is considerable joint sponsorship among Federal agencies of Second Chance programs, including the U.S. Departments of Justice, Education, Health and Human Services, Housing and Human Development, and Labor. The goal is to fund projects for both adults and juveniles that promote planning prior to release, comprehensive educational, employment, and mental health/substance abuse services just after release, and long-term mentoring and support.

Another area of expansion receiving attention by both justice and behavioral health officials is drug courts. Drug courts promote treatment approaches rather than traditional incarceration for those who are involved in the justice system because of substance use/abuse-related problems. The U.S. Department of Justice's Office of Justice Programs' Bureau of Justice Assistance, OJJDP, and SAMHSA together awarded approximately \$10 million in 2010 toward expanding the substance abuse treatment capacity of juvenile treatment drug courts.⁵ Another effort includes a partnership with the Robert Wood Johnson Foundation to integrate a community model called "Reclaiming Futures," which is designed to detect substance abuse and to provide services and support to youth, with the drug courts model.

Private Health Insurance

Private health insurance is a significant source of funding for behavioral health services and covers 45 million children (or 60 percent of the child population).⁶ However, people with private health insurance who seek care for behavioral health conditions generally face higher copayments and more limits to coverage—such as caps on the number of outpatient visits and inpatient days—than do those who seek care for other health conditions.⁷ These restrictions often reduce the use of behavioral health services and increase the financial burden on individuals who have severe behavioral health problems seeking necessary treatment.

Recent State and Federal mental health parity laws have improved coverage of mental health benefits by removing arbitrary limits on coverage, such as outpatient visits or inpatient days, and differences in insurance copayments and deductibles. However, these laws do not address the fact that some services are perhaps not covered at all. Among such services are several that are important for youth in the justice system, including provider interactions with schools and other agencies, family education, and behavioral health screening and assessment provided by primary care providers.

Medicaid and the Children’s Health Insurance Program

Significant increases in funding for youth mental health services have occurred through expansions in public health insurance coverage, primarily through expansions of Medicaid and the introduction of the Children’s Health Insurance Program (CHIP) in 1997. Medicaid and CHIP are a shared Federal–State responsibility. In 2009, 28 million children (or 37 percent) were covered by public health insurance at some time during the year.⁸ More recently, as a result of the recession, many children lost private insurance coverage when their parents lost employment and employment-based insurance. However, increases in Medicaid and CHIP coverage more than offset these drops, leaving the net number of children with any type of insurance essentially unchanged.⁹

Medicaid

Medicaid covers a broad set of services, broader than most private insurance. Many of these services are offered at State option and several are used to target mental health. For example, 37 States cover targeted case management for mental health through Medicaid; 49 States include the rehabilitation services option (or “rehab option”¹⁰) for behavioral health; and 32 States include the prescription drug option for mental health.¹¹ Unlike private insurance, Medicaid in some States covers mental health services to youth in schools.¹² It also reimburses providers who are not necessarily physicians or in office-based settings. Additionally, two important evidence-based treatments for high-need youth involved with the justice system are covered by some Medicaid programs: multi-systemic therapy (MST) for youth with serious conduct disorder and functional family therapy (FFT). A survey of justice agencies found that 11 of 21 respondents (52 percent) used Medicaid funds to deliver MST services to youth in the juvenile justice system.¹³ Furthermore, 9 of the 21 agencies (43 percent) said they delivered FFT services to youth using Medicaid funds. It is important to note that both FFT and MST are intensive, multicomponent interventions, and Medicaid does not cover all portions of these interventions.¹⁴

Medicaid does *not* pay for services for “inmates of public institutions,” meaning Medicaid does not cover youth who are incarcerated in particular settings.¹⁵ Medicaid will, however, cover services for youth who remain in the community. These youth might be in the community before adjudication or even after adjudication if they are, for example, at home, under electronic monitoring, or providing community service. Furthermore, among those youth who are incarcerated, as long as they are incarcerated in a private rather than public detention or correctional facility, services to them continue to be covered by Medicaid.

Children’s Health Insurance Program (CHIP)

Through CHIP, States can cover children beyond their Medicaid eligibility levels. In some States, CHIP and Medicaid are indistinguishable. However, in other States, the broad set of services covered by Medicaid does not extend to CHIP. In these States, CHIP looks more like private insurance. CHIP eligibility varies across States. As of 2011, 25 States (including the District of Columbia) cover children in families with income up

to 250 percent of the Federal poverty level; 22 States had eligibility thresholds between 200 and 250 percent of the Federal poverty level; and 4 States covered children at lower income levels.¹⁶ Nationally, 7.7 million children are covered through CHIP, compared with 24.4 million covered by Medicaid.¹⁷ For children with mental health needs, this proportion is higher as many are in low-income families.

Uninsured Children

Expanded eligibility for insurance notwithstanding, 10 percent of children remained uninsured in 2009.¹⁸ For teenagers, the rate was 12 percent. For many children and youth, the issue was not that they were ineligible for health insurance but that they were not enrolled.¹⁹ More than half of children are not enrolled in Medicaid or CHIP programs for which they are eligible. Getting them enrolled so that their care can be paid for is a high priority—so much so that the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included Medicaid bonus payments for States to adopt certain outreach, enrollment, and retention/renewal procedures, including collaborations with community-based organizations, health departments, school districts, and others.

The Changing Landscape

The 2010 Patient Protection and Affordable Care Act (PPACA) will not significantly change the insurance coverage of children in the near term. While this health care reform measure includes a large expansion of Medicaid eligibility, the expansion covers primarily adults, not children, because low-income children are already eligible for Medicaid or CHIP. There are, however, other changes that will build on ongoing trends. Discussed below, these changes have shaped and will continue to shape behavioral health services for youth in juvenile justice.

Health Insurance Enrollment

Enrollment in health insurance for families who have private health insurance through the work place is generally not affected. However, insurers are prohibited from excluding from coverage children with pre-existing health conditions. For others, there is a strong emphasis on having a “no wrong door” approach to health plan enrollment, whether coverage is sought from Medicaid, CHIP, or a private health insurance plan offered through a new “health exchange.”²⁰ The Federal government has proposed additional funding for States that streamline and upgrade their Medicaid eligibility systems. And, the Federal government is actively assisting States in the design and implementation of the necessary information technology (IT) systems needed to accomplish this. In addition to helping youth and their families enroll in health coverage generally, these programs have the potential to help them enroll in a variety of benefits including food stamps, assisted housing, and other important low-income assistance programs. Such enrollment increases overall well-being and stabilizes family situations.

A recent survey of State juvenile justice agencies found that 5 of 21 respondents had the system capability to access the Medicaid agency’s database.²¹ This access is important to

help ensure enrollment and to help youth access health care immediately upon release. More attention is being paid to enrollment and boosting IT systems' capabilities around enrollment and retention. This means greater IT system access might be given to juvenile justice agencies to ensure that they can identify Medicaid eligible and Medicaid enrolled youth.

The same survey identified that some Medicaid IT systems do not allow or make it difficult for States to "suspend" Medicaid enrollment rather than terminate it. The distinction between "suspension" and "termination" is important. Medicaid will not cover individuals who are "inmates of public institutions."²² But States are permitted to put the youth's enrollment effectively on hold by "suspending" enrollment rather than canceling it entirely. This makes it easier for youth to rejoin Medicaid upon release. Locally, advocates for youth in the justice system can provide input on key benefits and features to include in the upgraded enrollment procedures and IT systems, such as where and how families can enroll and whether they are suspended. Federal funding to support the upgraded enrollment systems is available, as noted previously.

Declining Discretionary Support for Behavioral Health

There is an expectation that as Medicaid expands to include more eligible populations and efforts expand to enroll more eligible people, there will be less need for block grants to States for services such as behavioral health treatment. This shift from block grants to health insurance means that more funding will be driven by insurance coverage and payment rules.

Mental Health Parity

The Federal Mental Health Parity and Addiction Equity Act of 2008 mandated that private health insurance plans have the same financial requirement (such as copayments and deductibles) and treatment limits for mental health and substance abuse benefits as for other medical benefits. This includes Medicaid managed care plans. Called "parity," this provision was extended to all State CHIP plans in 2009. Prior to the Federal parity law, nearly two-thirds of State CHIP programs used limits on the number of inpatient days or the number of outpatient visits for some or all behavioral health services.²³ In addition, half of States had copayments for such services of up to \$30 for outpatient care and \$40 for prescription drugs. Such limits were more common for substance abuse services than mental health services. Service limits and copayments, even amounts as low as \$5, can deter low-income families from seeking care.²⁴

Federal parity laws will extend not only to Medicaid and CHIP but also to private plans offered through the new health exchanges created as a result of the PPACA. This means funding through insurance mechanisms will continue to be important. It does not, however, mean that certain services, such as care coordination, must be covered—only that any medical and behavioral health benefits be covered on an equivalent basis.

Primary Care

In the past decade, as funding for services shifted from targeted, specialized mental health funding to broad-based insurance, a major shift in delivery occurred. Today, a significant amount of mental health care occurs in primary care settings.^{25–26} This trend is likely to accelerate as Medicaid pays greater attention to primary care in general. Recent Federal Medicaid policy increased payment rates to primary care doctors (family medicine, general internal medicine, and pediatric medicine) and provided Federal support to finance the payment increase for 2 years.²⁷

Emphasizing primary care also means rethinking collaborative delivery models between primary care and mental health care. One example is the Massachusetts Child Psychiatry Access Project (MCPAP), a program that provides timely telephone psychiatric and clinical guidance to primary care providers (PCPs) treating children with mental health problems.²⁸ PCPs receive assistance from MCPAP regardless of the child's insurance coverage. The program is currently funded by State mental health dollars, not private insurance or Medicaid, because many of the services are not provided face-to-face with patients and are not billable through insurance claims.

One noteworthy feature of MCPAP is that the primary connections within this program are between PCPs and local medical centers. Although MCPAP case managers may facilitate referrals to specialty clinics, the emphasis is not on developing the specialty mental health component of the delivery system. This is somewhat in contrast to historical efforts of juvenile justice agencies to forge closer ties with local mental health departments and community mental health centers to provide services to youth in the system. It is important for juvenile justice systems to consider designs such as MCPAP or similar models, which are designed to support primary care, given the emphasis and funding that is being given to bolster the primary care sector.^{29, 30}

Medical Homes

The term “medical home” was coined in pediatrics several decades ago and has become frequent in recent health policy discussions. There is no one definition of a medical home, but the definition provided by the American Academy of Family Practice (AAFP) gives a general sense of a medical home's key features. According to AAFP,

A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute, and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes.³¹

Moving from a standard primary care practice to a medical home model means providers function in interdisciplinary teams and engage in care coordination. It also means incorporating health technology, such as electronic medical records, that can improve care coordination and communication. Currently 17 State Medicaid programs pay higher fees to providers who are certified as medical homes.³²

An important policy step is to define what a primary care practice must do in order to qualify as a medical home and, therefore, to qualify for additional payment. Many medical home models exist, such as the National Committee on Quality Assurance (NCQA), the Center for Medical Home Improvement, and The Joint Commission,³³ and each is still in flux. A medical home for youth involved in the justice system would need to address certain unique challenges such as frequent disenrollment from Medicaid, as well as the need to obtain input from a variety of community agencies about care. Without close collaboration, care provided to youth in the primary care community may be disrupted through frequent changes in justice system placement and unexpected transitions, leaving families and providers unprepared.

While medical home models have increased in popularity, several challenges exist, including obtaining meaningful youth and family input and measuring ongoing care. For example, researchers have found several weaknesses in the existing surveys used to evaluate medical homes.³⁴ This early stage of development means there is an opportunity for juvenile justice stakeholders to describe the unique care coordination challenges of youth involved in the system. Consumers, families, providers, and justice stakeholders should be involved in defining medical homes, in the development of the criteria to measure the effectiveness of medical homes, and in the evaluation of medical homes' performance. As criteria for medical homes are further developed, they could be tailored to subpopulations, for example, by incorporating multi-tier standards. Expertise from juvenile justice stakeholders could also contribute to the technical assistance material provided to practices seeking recognition as medical homes.³⁵

Medicaid Health Homes

Since passage of the PPACA, State Medicaid programs can choose to develop and pay for "health homes." These health homes are a special type of medical home defined within the Medicaid program specifically designed for adult or child populations with complex chronic conditions.³⁶ Health homes became possible, as a State Medicaid plan amendment, in 2011. To qualify as a health home program, the targeted Medicaid beneficiaries must have (1) at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, or substance abuse disorder; (2) one chronic condition and be at risk for another; or (3) one serious and persistent mental health condition. States can target their health home program to only those individuals with particular chronic conditions or to those with higher numbers or greater severity of chronic or mental health conditions. In addition, the services offered to the health home target group do not need to be comparable (in amount, duration, and scope) to services normally provided to beneficiaries in the State Medicaid program.

In terms of services, health homes are designed to cover comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings and follow-up; individual and family support; and referral to community and social support services. Health IT is another important component of health homes as it can facilitate care coordination and communication.

To encourage States to adopt a health home option within Medicaid, the Federal match rate is 90 percent for the first 2 years of the program. Furthermore, States interested in the health home option may receive up to \$500,000 of Medicaid funding for planning activities related to the development of a health homes State plan amendment.³⁷

Both medical homes and health homes represent a unique opportunity for juvenile justice. Most State initiatives focused on Medicaid medical homes are less than 2 years old and grew out of extensive planning group activities.³⁸ The opportunity that currently exists is to shape the characteristics of medical homes, how they are evaluated, and how they are rewarded to fit the needs of youth in the justice system.

Implications and Conclusion

The trends outlined above point to several important steps that could be taken on behalf of youth involved with the juvenile justice system in order to improve their access to quality behavioral health care:

- Use Medicaid options to cover important behavioral health services, such as MST, FFT, and other therapies
- Consider a Medicaid health home option for youth with severe behavioral health disorders
- Ensure that all children are enrolled in health insurance programs for which they are eligible, including Medicaid and CHIP
- Establish Medicaid policies that ensure that youth in secure facilities are suspended from the program, rather than terminating their benefits entirely
- Pay attention to the primary care delivery system and make appropriate linkages
- Become involved in defining medical homes for youth in the justice system

A challenge for those seeking to take advantage of these unique opportunities and reengineer care for youth in the justice system is simply to be heard. States are likely to be consumed with organizing and operating the new health insurance exchanges, implementing Medicaid expansions for adults, designing enrollment systems for Medicaid, and promoting electronic health records. At the same time, tight State budgets have led to cuts in State staff. Consequently, juvenile justice agencies must articulate their priorities and unique needs clearly and persistently.

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