Medicaid Access for Incarcerated Youth

by

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Dedication

This thesis is dedicated to all the youth that are involved in the juvenile justice system that I have worked with throughout the last several years. Thank you for all the lessons you have taught me and for helping me find my passion.

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Abstract

Those in the juvenile justice system tend to be minorities, have more health concerns than their peers, have the potential for long-term health issues and face many barriers in their homes and communities. In addition, there are complications for those in the juvenile justice system who are enrolled in Medicaid. By law, when youth are detained, they cannot have access to their Medicaid benefits. This causes difficulties once youth leave detention and are left without health insurance. This study found that there are significant areas that are lacking in the juvenile justice system including data tracking and consistent data tracking methods. In Michigan, there are no statewide standards governing the collection and reporting of data on youth involved with the juvenile justice system. In order to create public health interventions to best suit this population, there needs to be a sure way to collect and maintain data on this population.

Aim

The aim of this study is to determine if incarcerated youth are able to maintain their federal assistance (Medicaid) once they are released from detention in the state of Michigan. The lack of health insurance is a major barrier for youth to receive the proper health care they need once they are back in the community. Many incarcerated youths have several health conditions that are only addressed once they are in detention and the lack of follow up care can cause detrimental effects later in life. Not having access to insurance can cause further consequences, and potentially lead to incarceration later in life. The output of this project can be used as a policy analysis of the State of Michigan's juvenile justice system and their role in suspending versus terminating youth's medical assistance such as Medicaid.

Background

In 2019, Michigan detained 43 youth per 100,000 in the state (OJJDP, 2021). Many of these youth are a minority, have predisposing factors, have poor overall health and face the potential to have long-term health complications (Braverman & Murray, 2011; Gupta, et al., 2005).

In Michigan, black youth represent a significantly higher proportion of youth in placement than any other race. In 2015, 1,140 black youth were in placement, compared to 25 white youth and 61 Hispanic youth (Puzzanchera, 2018). They also typically have not interfaced with medical professionals until they are detained at a juvenile facility (Golzari & Anoshiravani, 2006; Braverman & Murray, 2011).

Youth in the juvenile justice system face specific risk factors that predict juvenile delinquency, making them predisposed to interact with the juvenile justice system. First, is mental health. Research has shown that hyperactivity, concentration or attention problems, impulsivity and risk taking, and violent behaviors are all risk factors for juvenile delinquency (Shader, 2001). Similarly, a low level of intelligence and delayed language development can also be linked to delinquency (Shader, 2001). Family structure also plays a role in predicting delinquency. Families that have a hostile home environment, mistreat children, lack parenting skills, and have antisocial parents are more likely to have children that will have juvenile delinquency (Shader, 2001). In addition to dysfunctional family structures, antisocial peers can be linked to delinquency (Shader, 2001). Peers play a significant role in the influence of delinquency and can influence their fellow peers to act in an antisocial manner. School policies

can be another risk factor for juvenile justice involvement. Schools that have policies that have a disproportionately negative impact on minorities, including grade retention, suspension and expulsion and the school's tracking of delinquency can have a negative impact on at-risk youth (Shader, 2001). Finally, the neighborhood can be a risk factor for delinquency. Neighborhoods that tend to have higher crime rates and poverty increases the risk for youth to be involved in crime (Shader, 2001). When these risk factors are combined, youth that face these risk factors are at a higher risk of juvenile delinquency. In addition, there are continual risks for delinquency as many of these risk factors need continual health care and intervention in order to maintain or treat.

Many of the youths that are detained each year receive basic health care while they are in a juvenile facility. Basic health care such as oral health, trauma-related injuries, infectious illnesses, and reproductive health are all essential services that detained youth require and receive in a detention facility (Barnert, et al., 2016; Braverman & Murray, 2011). Once they are released from detention, however, they do not receive continued health care. A study has found that when youth are returned to their families after detention, fewer than half show interest in care that was deemed important by detention medical staff, and a large portion of families were not successfully contacted after release (Braverman & Murray, 2011). Transition out of a detention facility can also be difficult because youth have limited external resources. Transition to a community medical facility can be difficult if the youth does not have an established provider or if their medical history from detention cannot be passed along to a community provider (Braverman & Murray, 2011).

Furthermore, youths that are in the criminal justice system tend to have more long-term and significant health needs than their nonincarcerated counterparts (Barnert, et al., 2016; Gupta, et al., 2005). Some of these health conditions include substance abuse, acute illnesses, sexually transmitted diseases, and psychiatric disorders (Barnett, et al., 2016; Braverman & Murray, 2011; Gupta, et al., 2005). These health conditions are linked to several social determinants of health. First is this population's involvement in high-risk behaviors such as violence, substance abuse and sexual activity (Braverman & Murray, 2011). Living in impoverished and abusive environments can also develop these health conditions. Exposure to traumatic brain injuries, lead exposure, tuberculosis and poor dental care can all result from these conditions (Braverman & Murray, 2011). These exposures can be due to the environment in which they grow up, as previously mentioned. In addition, these youth may have acquired health conditions that have been neglected or undiagnosed (Braverman & Murray, 2011). Poor health can also be caused by the underlying condition of low socioeconomic status. Lower socioeconomic status (SES) is correlated with teen births, being overweight and mental health problems. These are more likely in minority populations who statistically are more likely to live in lower SES environments (Braverman & Murray, 2011).

Studies have found that there is a strong causal association between youth incarceration and adult health outcomes such as worse overall health and functional limitations (Barnert, et al., 2016). One study concluded that adults that were incarcerated during their youth have worse health outcomes than individuals that do not have a history of incarceration. The four adult health outcomes that were statistically significant in the study were adult general health, adult functional limitations (i.e., health problems create limitations with climbing flights of stairs),

adult depressive symptoms and adult suicidal thoughts (Barnett, et al., 2017). These conditions can potentially come from an increased exposure to infectious diseases, trauma in juvenile detention facilities and social barriers present after detention (Barnert, et al., 2016).

In 2013, over 28 million children in the United States were enrolled in Medicaid. Another 5.7 million were enrolled in the Children's Health Insurance Program (CHIP) (Acoca, et al., 2014). Unfortunately, this does not include all children that are eligible for these insurance programs. There are still approximately seven million children that are uninsured (Acoca, et al., 2014). Many of the youth involved in the criminal justice system are eligible for government assistance. However, federal law states that any person that is in the care of a detention facility is not eligible for federal assistance (Acoca, et al., 2014; Barnert, et al., 2016). When a youth is detained, states have to suspend Medicaid, if they currently have these benefits, during their stay in the detention facility. However, youth's benefits are terminated, instead of suspended (Barnert, et al., 2016). This causes a challenge for youth that are released post-detention to access health care.

Objectives

This research will focus on addressing the gaps in research regarding youth and their federal assistance such as Medicaid. The research will first look at the demographics of youth incarcerated in Michigan and will help determine if Michigan's incarcerated youth follow similar trends to other research on the makeup of the incarcerated youth population. This will also help to identify the need for policies and programs to help youth retain Medicaid. The first question will address if juvenile detention facilities in Michigan suspend or terminate incarcerated youth's Medicaid. The second question will address if there are policies in Michigan that are implemented to help youth get their Medicaid back once they are released from detention. This research will help youth involved in the juvenile justice system with Medicaid benefits as not having readily available insurance can be a barrier to receiving basic health care services.

Methods

Data will be collected from several sources. General data about youth in the juvenile justice system will be collected from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the State of Michigan. In addition, data will be collected from five Michigan counties to learn about the demographics of youth that are involved in the juvenile justice system at a more local level. These counties include Genesee County, Livingston County, Oakland County, Lapeer County, and Ingham County as the University of Michigan - Flint is in Genesee County and the latter counties surround it. Data about youth that are enrolled in Medicaid will be taken from peer reviewed literature. In addition, peer reviewed literature will be reviewed to analyze policies regarding Medicaid access for youth when they are released from detention, social determinants of health, risk factors and potential long-term health concerns regarding this population.

Data Analysis

There is a large gap in data collection for juveniles in the juvenile justice system. In Michigan, there is not a central, statewide database that holds basic information regarding detained youth. This allows individual counties and juvenile court systems to collect the quality and quantity of data at their own standards. In one county, they do not have a digital system with all their data about juveniles in their youth detention facility and data can only be accessed by going through information by hand to pick out specific demographics. This is a major issue because it limits the ability to provide accurate and adequate research on this population. There is very little research on incarcerated youth post-release, nor is there research on how successfully youth get their Medicaid back once they are released. This leads to several questions that are left unanswered.

Results

Data were collected from several sources, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP), regarding youth demographics and social determinants of health in detention. In addition, several studies were reviewed to collect information regarding youth that are detained, risk factors, social determinants of health and potential long-term health concerns.

Local data regarding youth in Michigan was to be collected from five counties surrounding and including Genesee County. The court administrators from Genesee County, Livingston County, Oakland County, Lapeer County, and Ingham County were all contacted via email several times to find information regarding youth detained in their facilities. Genesee and Livingston Counties were the only ones that responded to the emails sent.

In Genesee County, there is no concise data that is easily accessible regarding youth that are detained at their facility, Genesee County Juvenile Justice Center. The court administrator for this county stated that the data is only reported via name. No other identifiers or demographics are reported. In order to obtain this information, one would have to go case by case. In addition, they do not have any information about Medicaid status (January 2023).

The Livingston County court administrator asked for a phone interview to relay information about their county. The phone interview took place on March 13, 2023. During the phone interview, it was noted that Livingston County does not have their own detention center and most of the youth on probation in this county are not detained. If youth must be detained, they are outsourced to other counties such as Washtenaw and Ottawa. Last year, there were only

eight youths detained that were on probation in Livingston County. In addition, it was estimated that about half of the youth on probation in Livingston County have private insurance. If there is a youth who needs emergency medical services, they typically will use their private insurance and the court system will pay the remaining balance out of pocket. If a youth does have Medicaid and they are detained, it is left to the parents to complete the paperwork to inform the state about their child's detainment. It is also left to the parents to reinstate the youth's benefits once they leave detention. Livingston county does have a data tracking system for their youth on probation. The system is called Youth Center by Bizstream. This system can track all pertinent information about probationary youth. The court administrator stated that this is a fairly new system that is being pushed out for Michigan counties to use in order to track youth. However, there is not a funding source readily available for this, and counties are being told to find their own funding source. The Livingston County court administrator stated that they estimate that only about 20 Michigan counties are currently using this system.

A faculty member (a specialist in Criminal Justice Policy and has several years of experience in this field) in the University of Michigan - Flint's Master of Public Administration program was also contacted to see if data about detained youth is readily available. He reported that there is not a readily available nor a standardized system as most data is collected independently.

A literature review was also conducted to see what research was available regarding Michigan detained youth. A search of Google Scholar and the University of Michigan - Flint's library was conducted. No previous research or literature was found regarding youth detained in Michigan and their status on Medicaid including if they are eligible and if they are enrolled. The

State of Michigan website does not provide any information about youth in the juvenile justice system data tracking either.

Michigan does have some push to create legislation to help detained youth with their Medicaid status. In July 2022, the Michigan Task Force on Juvenile Justice Reform (Task Force) created a report regarding their recommendations to advance "proven practices and strategies for reform grounded in data, research and fundamental constitutional principles" (*Michigan Task Force*, 2022). There were several key findings and recommendations in the report regarding data and Medicaid.

In the Key Findings section of the Task Force report, the last of ten key findings is "Data are unavailable or unreliable to answer basic questions about the juvenile justice system's performance across decision points and to guide system decisions and improvements" (*Michigan Task Force*, 2022). This is a major finding as it proves that there is no statewide data that can be used by researchers to progress with juvenile justice reform and to ensure best practices are being used effectively.

In the Recommendations section of the report, the Task Force unanimously agreed that there should be an "administrative process and protocols and MDHHS [Michigan Department of Health & Human Services] staff to support the timely reinstatement of Medicaid for youth leaving detention or longer-term residential facilities" (*Michigan Task Force*, 2022). The recommendation also makes mention of exploring opportunities for Michigan Medicaid coverage to continue while youth are in detention for medical and prescription care (*Michigan Task Force*, 2022). There are also two recommendations in the report for developing standardized data

collection and sharing robust quality assurance procedures to address data quality issues statewide (*Michigan Task Force*, 2022).

There are a few states that have recently enacted legislation that helps youth with the Medicaid re-enrollment process before being released from detention so their benefits can be reinstated once they are in the community. In 2011, Oregon passed legislation that requires all detention facilities to suspend, rather than terminate medical assistance for all youth and adults who are incarcerated for up to twelve months (Zemel, 2013). Ohio also passed similar legislation in 2009 that requires youth's medical assistance to be suspended, not terminated if they are incarcerated for up to twelve months (Zemel, 2013). This is significant because it allows benefits to be reinstated once a person leaves detention, as opposed to the person who was incarcerated to reapply for their benefits. Thus, people who were incarcerated can return to their community and seek health care services without the delay of waiting for benefits to be reinstated. There is no current legislation in Michigan that enforces similar policies.

Overall, more than two months were spent trying to collect relevant data regarding youth detainment and Medicaid status of youth in Michigan with minimal success.

Discussion

In order to create health care policy change, substantial data is needed. Data that proves that there is a missing element in policy to improve the health status of a particular group. With the juvenile justice population, there is no data in Michigan that is standardized or regulated *(Michigan Task Force*, 2022). This makes it incredibly difficult to identify health care policy for this population. Before policy for health care can be implemented, it is crucial to push for policy that creates a statewide data system for the juvenile justice system.

Similarly, there is a lack of funding for data systems in the State of Michigan. As previously stated, there is a case manager and data collection system (Youth Center) that is being pushed for juvenile justice centers and courts across Michigan to be used. However, it is not currently funded and individual counties need to source funding in order to pay for the computer system. This can lead to a lack of consistency in data tracking and variation in data usage. Altogether, this can lead to poor health outcomes for this population as deregulated data may not track essential health information if it is not mandated.

At the federal level, data is collected by the National Institute of Justice (NIJ) who works with the OJJDP to do data collection at the national level regarding juvenile crime, victimization, and the juvenile justice system (Adams, 2021). Every year, the OJJDP is required to submit a report to Congress on juveniles in custody across the nation. This was a requirement set by the Juvenile Justice and Delinquency Prevention Act of 1974 (Adams, 2021). NIJ is responsible for the data collection through the Census of Juveniles in Residential Placement and the Juvenile Residential Facility Census. The censuses are administered in alternating years and collect information regarding youth that are detained or placed in a residential facility. The censuses, however, have had challenges including the maintaining and improving quality, completeness and utility of the data collected (Adams, 2021). The censuses also do not collect data from youth that are held in federal facilities, adult prisons or jails, facilities that are exclusively mental health or substance use treatment facilities, or facilities for abused or neglected children (Adams, 2021). Data collection for both censuses has remained the same since they began in 2000 (Adams, 2021). Since this data collection system misses several youths in the juvenile justice system and has not developed to change overtime, there could potentially be many questions that are left

unanswered. For example, there will be no information in the census regarding coronavirus or consequences of the coronavirus on this population as the censuses have not changed since the coronavirus pandemic has happened. In addition, there will be missing data regarding mental health and substance misuse as these populations are not included in the census collection.

The Youth and the Juvenile Justice System 2022 National Report by the NIJ shows many statistics regarding youth and the juvenile justice system by state. Some of those statistics include youth that are detained, placed in residential treatment and crimes committed. However, there is no data that discusses the breakdown of health needs by state. While the report does briefly mention mental health and teenage birth rates, it goes into significantly more detail regarding the types of crimes that youth have committed and youth victimization (Puzzanchera, et al., 2022). There is mention about impoverished youth and data regarding the percentage of youth that live in poverty and/or live in a one parent household, but there is no mention of Medicaid status (Puzzanchera, et al., 2022). The lack of data regarding health needs and Medicaid status of these youth shows how imperative it is to collect data regarding this information. Without knowing the health care needs or insurance status of incarcerated youth, policy cannot begin to reflect the needs of the population.

Recommendations

Overall, this study provided valuable information regarding the juvenile justice system in Michigan. This study provided insight into the issue of lacking data on the juvenile justice population. Missing data such as this is very crucial because it makes research regarding the population difficult to conduct; therefore, making it difficult for researchers to learn about ways to improve the overall health status of this vulnerable population. While there are some websites that can provide generic data such as the number of youths incarcerated, male versus female breakdown and white versus nonwhite breakdown, more important information such as health status, insurance status, social determinants of health and other such measures are not readily available for research purposes. Due to this, it can be challenging to create interventions and programming for this population if these major factors are left unknown.

There were several lessons learned through this project. The first being that some population data is significantly harder to find than others. As previously mentioned, there was no known current research about the youth population in the juvenile justice system in Michigan. The only study that could be found was titled *Juvenile justice and child welfare: Longitudinal research in the state of Michigan* and was published in 1994. The study was not accessible for this research. The second lesson learned was the amount of time needed to search for articles in less researched populations. As previously stated, it took over two months to find relevant articles and it took over three months to get in touch with court administrators to learn about the juvenile justice system in Michigan. This process was very time consuming, and if there was not

a time limit on this research, several more months could have been spent trying to get more information about this population. The final lesson learned was that there is not much being done to help the health of this vulnerable population. Currently, there are only two states that have legislation to help youth reinstate their Medicaid once they leave detention. This is a severely lacking priority that needs to be addressed to help these vulnerable youth regain control of their health care.

It is recommended that all counties in Michigan have a data collection system for their youth involved in the juvenile justice system. This is the first step in obtaining vital information about these youth. This data will allow public health professionals to create and implement interventions, programs, and regulations to increase and promote proper health care for this population.

It is also recommended that the State of Michigan takes into consideration the proposal of the Task Force and moves forward with legislation to help youth establish Medicaid before leaving detention and allow youth to maintain their Medicaid status while incarcerated. This would be a groundbreaking criminal justice reform, and Michigan would be only one of three states to have this important legislation. It is also imperative that the State of Michigan moves forward with the Task Force's recommendation of creating a universal data system and quality assurance system for this data to better track youth in the juvenile justice system.

Conclusion

Health is a human right (World Health Organization, 2022). Youth that are involved in the criminal justice system have major health concerns that need to be addressed (Barnett, et al., 2016; Braverman & Murray, 2011; Gupta, et al., 2005). In addition to having health concerns, they are also typically a minority and have a low socioeconomic status. This leads to more difficulties accessing proper health care, especially when their insurance could potentially be terminated. In addition, the data tracking for this population is not regulated in the State of Michigan, which makes it more difficult to meet the needs of this population *(Michigan Task Force*, 2022). In order to improve the lives of a very vulnerable population, data collection needs to be monitored and succinct. By standardizing data collection, information regarding incarcerated youth can be used to create and provide proper health care programs and policies. In addition, there needs to be a policy in place to help youth reestablish their Medicaid status once they leave detention or allow youth to maintain their status regardless of incarceration *(Michigan Task Force*, 2022). This will allow youth to be able to utilize health care in their community once they are released without the repercussions of insurance loss.

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