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Health Coverage and Care for Youth in the Juvenile Justice System: The Role of Medicaid and CHIP

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Introduction

Girls and boys in the juvenile justice system are a diverse group of young people with often complex health needs.[1] Many are from low-income families of color, have suffered abuse, were involved in the foster care system, and may require comprehensive and ongoing physical, reproductive, mental, and behavioral health services upon discharge from juvenile justice residential facilities. The provision of comprehensive, coordinated physical and mental health services for girls and boys while they are in the juvenile justice system and in their communities and after release is important to their rehabilitation and reintegration into society. Given the low incomes of many of these youth, Medicaid has the potential to play an important role in financing these services.

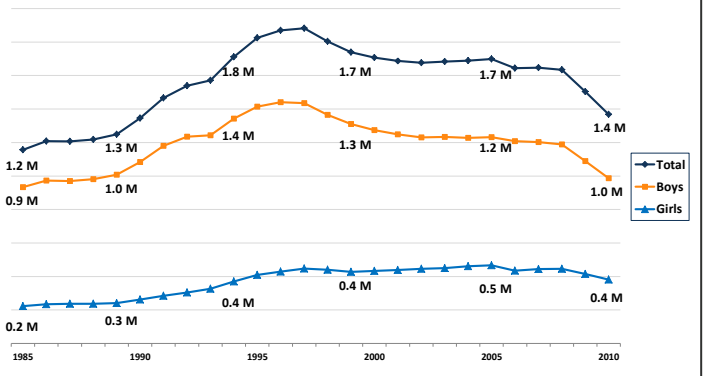
This brief provides an overview of the health and mental health needs of girls and boys in the juvenile justice system and the role of Medicaid in addressing those needs. It focuses on the circumstances of those girls and boys who are placed in juvenile justice residential facilities, the discontinuity of Medicaid coverage for those youth, and the options for improving coverage, continuity of care and access to needed services post-discharge, including new opportunities provided by the Affordable Care Act.

Profile of Youth in the Juvenile Justice System

As of September 2010, approximately 70,800 youth were held in juvenile justice residential placement facilities nationwide. [2] The number of juveniles in residential placements varies by state, and as of 2010, California had more than twice the number of juveniles in residential placements than any other state (see Appendix, Table 1). The majority of youth entering the juvenile justice system are placed on community probation, depending on the seriousness of their offenses and other factors such as the availability of community alternatives. Juveniles with more serious offenses, or who fail to respond to intermediate sanctions, may be detained or committed to a range of residential facilities for varying lengths of time. Over the course of 2010, about 1.4 million cases were handled by the juvenile

Figure 1

Annual Number of Cases Handled by Juvenile Courts, by Sex, 1985-2010



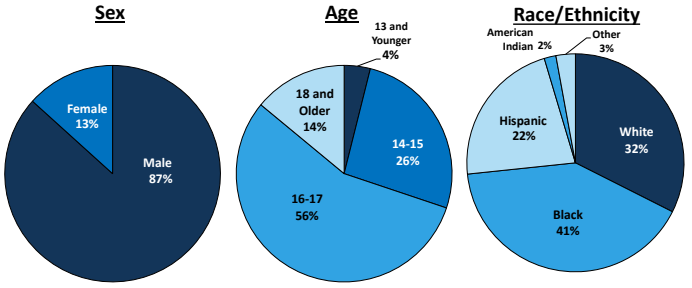
SOURCE: Sickmund, M., Sladky, A., and Kang, W. (2012). "Easy Access to Juvenile Court Statistics: 1985-2009." Online. Available: http://www.ojjdp.gov/ojstatbb/ezajcs/

court system in the United States.[3] This number has generally been declining since 1997; however, the decline has been greater for boys than girls (Figure 1). The proportion of juvenile arrests for girls has climbed steadily in recent decades, from 19% in 1985 to 28% in 2009.[4]

Youth in juvenile justice residential placements are a diverse group, varying in sex, age, and race/ethnicity (Figure 2). The majority (87%) of youth in juvenile justice residential placements are male, although girls make up a growing percentage of the juvenile justice population as a whole. In 2010, over half (56%) of youth in juvenile justice residential placements were between ages 16 and 17, and three in ten were under age 16. While the juvenile justice population held in residential placements is racially and ethnically diverse, youth of color are overrepresented in these facilities. Youth of color comprise about one-third of the U.S. juvenile population, but about two-thirds of the youth in residential placements.[5,6,7]

Figure 2

Selected Demographic Characteristics of Juveniles in Residential Placement, 2010



Total = 70,793 Juveniles in Residential Placement

SOURCE: SOURCE: Sickmund, M., Sladky, T.J., Kang, W., & Puzzanchera, C. (2013). "Easy Access to the Census of Juveniles in Residential Placement." Available: http://www.ojjdp.gov/ojstatbb/ezacjrp/

Although it is generally recognized that a majority of youth in juvenile justice facilities are from low-income families, there is a lack of national, comprehensive data on family income of youth offenders. Literature in the juvenile justice community generally recognizes a relationship between poverty and juvenile offending.[8,9,10] However, conditions of poverty are complex and contain multidimensional interactions between factors such as poor neighborhoods, families, schools, and peers.[11]

A portion of youth in the juvenile justice system is also involved in the child welfare system. These youth are often referred to as crossover youth. Limited data are available on this population since few jurisdictions track the number and outcomes of crossover youth, but it is estimated that 9-29% of youth involved in the child welfare system engage in delinquent behavior.[12] Crossover youth are more likely to be children of color than the general population or than either system individually. A majority of these youth are male. However, the proportion of crossover girls is greater than in the general delinquency population. Youth from the foster care system who enter the juvenile justice system also tend to be younger when committing their first offense than youth in the general delinquency population.[13]

Across the United States, there are over 2,500 juvenile justice residential settings holding youth under age 21.[14] While these settings generally offer correctional and/or therapeutic treatment, there is currently no Federal law or standard definition that defines residential treatment programs. Therefore, these facilities vary widely according to the offense levels of the girls and boys housed there, program goals, services provided, security features, such as locked rooms or cells, physical environment, facility size, length of stay, and targeted population. They include detention centers and long-term secure facilities, where youth are generally confined with limited access to the community, as well as shelters, group homes, and wilderness camps, where youth are more likely to have more regular contact with the community (Table 1). Juvenile residential facilities also vary in whether they are state, local, or privately-owned and operated.

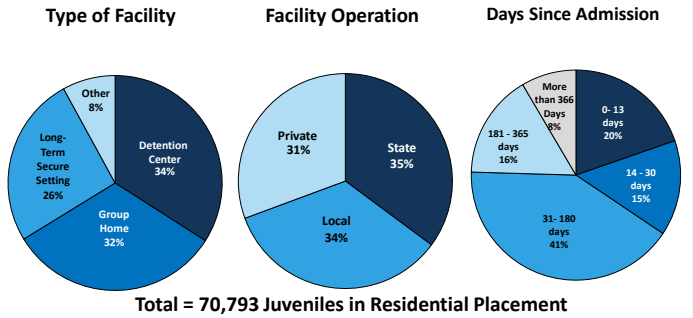
Table 1: Types of Juvenile Justice Residential Placements	
Type of Placement	**Definition**
Reception/Diagnostic Center	A short-term facility that screens persons committed by the courts and assigns them to appropriate correctional facilities.
Long-Term Secure Facility	A specialized type of facility that provides strict confinement for its residents. Includes training schools, reformatories, and juvenile correctional facilities.
Boot Camp	A secure facility that operates like military basic training. There is emphasis on physical activity, drills, and manual labor. Strict rules and drill instructor tactics are designed to break down youth's resistance. Length of stay is generally longer than detention but shorter than most long-term commitments.
Detention Center	A short-term facility that provides temporary care in a physically restricting environment for juveniles in custody pending court disposition and, often, for juveniles who are adjudicated delinquent and awaiting disposition or placement elsewhere, or are awaiting transfer to another jurisdiction.
Shelter	A short-term facility that provides temporary care similar to that of a detention center, but in a physically unrestricting environment. Includes runaway/homeless shelters and other types of shelters.
Ranch/Wilderness Camp	A long-term residential facility for persons whose behavior does not necessitate the strict confinement of a long-term secure facility, often allowing them greater contact with the community. Includes ranches, forestry camps, wilderness or marine programs, or farms.
Group Home	A long-term facility in which residents are allowed extensive contact with the community, such as attending school or holding a job. Includes halfway houses.

SOURCE: Sickmund, M., Sladky, T.J., Kang, W., and Puzzanchera, C. (2011) "Easy Access to the Census of Juveniles in Residential Placement." Online. Available: http://www.ojjdp.gov/ojstatbb/ezacjrp/ and Melissa Sickmund, OJJDP.

Youth in juvenile justice facilities reside in a variety of residential placement settings for various lengths of time (Figure 3). As of 2010, 60 percent of youth in juvenile justice residential placements were held in detention centers or long-term secure settings. About one-third (32%) of juveniles were residing in group homes, and eight percent were living in a variety of other settings including ranches or wilderness camps, boot camps and diagnostic centers. About an equal number of youth reside in private, local, and state residential facilities, although youth often switch placements over time. Girls and boys spend varied lengths of time in the juvenile justice system, from a few days to several years, depending on the severity of their offenses. As of 2010, one in five youth had resided in a residential placement facility for less than two weeks, while a quarter (24%) had resided in a facility for at least six months or more. Moreover, many juvenile offenders spend multiple stays in detention centers.[15] In some states, over a third (37%) of juvenile detainees are rearrested and returned to incarceration within three years after release.[16]

Figure 3

Youth in Residential Placement Settings, by Type of Facility, Facility Operation, and Length of Stay, 2010



Total = 70,793 Juveniles in Residential Placement

Length of stay measures the number of days since admission. Data represent point-in-time estimates of the juvenile population in residential placement in 2010.
SOURCE: Sickmund, M., Sladky, T.J., Kang, W., & Puzzanchera, C. (2013). "Easy Access to the Census of Juveniles in Residential Placement." Available: http://www.ojjdp.gov/ojstatbb/ezacjrp/

Health Needs of Girls and Boys in the Juvenile Justice System

A majority of juveniles that enter custody have unmet health needs. Over two-thirds of youth in one survey of juvenile justice residential facilities reported a health care need, including injury, problems with vision or hearing, or other illness.[17] A number of national and regional surveys of youth in detention have consistently found high rates of traumatic injury, tuberculosis, dental problems, and sexually transmitted

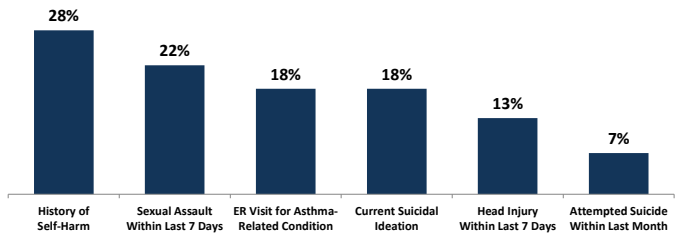
infections, including HIV, among youth in detention.[18] In addition, many youth also have multiple physical, mental, and behavioral health disorders. In particular, crossover youth from the foster care system who enter the juvenile justice system often have mental health and/or substance use disorders and special education needs.[19]

Many youth in juvenile justice have serious mental, emotional, and behavioral health needs. Some studies estimate that between 50 and 75 percent of youth detained in the criminal justice system have a mental health or substance use disorder, and a substantial portion have a serious mental health condition.[20] Medical assessments of juvenile justice-involved youth commonly identify previously undiagnosed conditions such as traumatic stress disorder, attention-deficit/hyperactivity disorder, and bipolar disorder.[21] In FY 2012, California estimated that 30 percent of youth housed in its division of juvenile justice required mental health treatment, and two-thirds had a substance use disorder.[22] Rates of depression and dysthymia among detained youth are higher than in the general population of adolescents and place them at significant risk, as these potentially life-threatening disorders are difficult to identify and treat in secure settings.[23]

Girls held in juvenile justice facilities are among the sickest and most medically underserved of all adolescent populations. Girls experience higher rates of mental health and substance use disorders and are less likely than boys to have their medical needs identified, treated, or followed inside the juvenile justice system or after their release to their communities. The 2009 Girls Health Screen Validation Study, conducted with girls entering detention centers in Philadelphia, Pennsylvania and San Diego and Santa Cruz Counties in California, revealed that many girls entered detention with previously unidentified and urgent physical, reproductive, and mental health needs and were also suffering from a range of chronic illnesses. [24] Girls in the study also reported having experienced high rates of chronic trauma and serious mental illness. Some 13% of girls entering detention experienced a head injury within the preceding week; nearly one in five had visited the emergency room for asthma-related conditions, and over one in five experienced sexual assault within the previous week (Figure 4).[25] Further, almost 28% of girls entering detention centers in the study reported a history of self-harm, including cutting and burning; and 18% reported current suicidal ideation. Nearly seven percent of girls had attempted suicide within the last month.[26, 27] (See Appendix 2 for more information on the Girls Health Screen).

Figure 4

Share of Girls Entering Juvenile Justice Reporting Specific Health Conditions, 2009



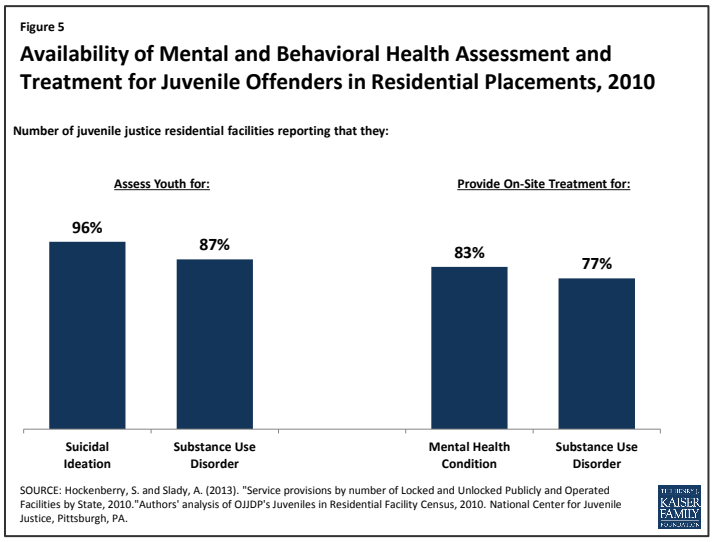
Based on data for the 2009 Girls Health Screen Validation Study conducted with girls entering detention centers in Philadelphia, PA, and San Diego and Santa Cruz, CA
SOURCE: Acoca and Golzari. Girls Health Screen Validation Study, 2013

Health Services for Youth in Juvenile Justice Residential Placements

Health care services for youth in residential facilities may be provided by states, counties, or private contractors. Many counties either pay for health, mental health and behavioral health services through their local public health services departments or they contract with private correctional health providers to deliver services. For example, in Los Angeles County, the Probation Department pays the County

Departments of Health and Mental Health to provide health and mental health services for detained youth. In San Diego County, the Department of Probation contracts with a private medical provider to provide health services for this population.

Due to a lack of national health and safety standards, there is wide variation in the array of health services provided to youth in residential placements. Most states and counties provide youth in these facilities with a comprehensive physical assessment and some basic mental health screening and treatment (Figure 5). However the information collected at admission and the kinds of services offered within residential facilities differs by facility.[28] In 2007, for example, only 53 of over 3,000 juvenile justice residential facilities were in compliance with National Commission on Correctional Health Care's voluntary Standards for Health Services in Juvenile Detention and Confinement Facilities, which were developed by leaders in health, law, and corrections to assess health service delivery.[29]



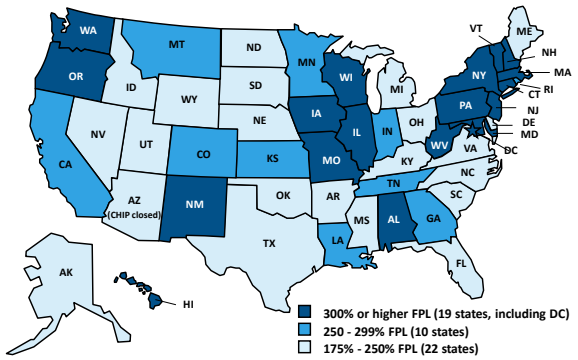
Recent studies highlight concerns about the quality of care provided to girls and boys in juvenile justice. In particular, research points to inadequate treatment of the mental and behavioral health needs for youth in juvenile justice and insufficient attention to the unique needs of girls. Despite their higher rates of substance use disorders, girls have fewer substance use disorder treatment programs available to them in juvenile facilities. Two studies of the needs of 1,000 girls in the California juvenile justice system and 960 girls in the Florida juvenile justice systems revealed that 88% of girls interviewed reported between one and three serious health issues that were not adequately addressed, including asthma, sexually transmitted infections, and traumatic head injuries.[30,31]

The Role of Medicaid and CHIP

Medicaid and the Children's Health Insurance Program (CHIP) play a particularly important role in providing health coverage for children, covering more than one in three (37%) children nationwide. In June 2013, over 28 million children were enrolled in Medicaid and another 5.7 million were enrolled in CHIP.[32] The programs serve as an important source of coverage for low-income children of all races and ethnicities who often do not have access to affordable private coverage through a parent's employer. Both Medicaid and CHIP are jointly financed by states and the federal government and administered by states within broad federal rules. Over time, states have achieved significant progress in expanding coverage for children through Medicaid and CHIP. As of 2014, more than half of the states (29, including DC) extend Medicaid or CHIP to children in families with incomes at or above 250% FPL ($49,475 for a family of three in 2014) and 19 states, including DC, cover children in families with incomes at or above 300% FPL ($59,370 for a family of three) (Figure 6). However, despite the success of Medicaid and CHIP, over 7 million children remain uninsured. It is estimated that most (5.2 million) uninsured children are already eligible for Medicaid or CHIP coverage but not enrolled.[33]

Figure 5

Children's Eligibility for Medicaid/CHIP by Income, January 2014



NOTE: Thresholds include the standard 5 percentage point of the FPL disregard.
SOURCE: Based on data from the Centers for Medicare and Medicaid Services, as of January 2014.

Medicaid covers a comprehensive set of physical, mental, dental, and vision services for children. Under Medicaid, all states must cover certain benefits for children, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, long-term care, services provided at Federally Qualified Health Centers (FQHCs) and many rehabilitative services. EPSDT guarantees children comprehensive coverage, including physical and mental health therapies, dental and vision care, personal care services and durable medical equipment, that may not be covered or may be limited in coverage for other populations.[34] States are generally prohibited from imposing premiums and cost-sharing for mandatory coverage of children in Medicaid. CHIP also offers comprehensive benefits to children, although EPSDT services are not required in separate CHIP programs and states have more flexibility to charge premiums and cost sharing in separate CHIP programs.

While a large number of youth entering juvenile justice residential facilities may be eligible for Medicaid or CHIP, federal law prohibits most from having their services paid for by Medicaid or CHIP, due to the "inmate exclusion." Given their low incomes, most children moving into and out of juvenile justice facilities are likely eligible for Medicaid and CHIP. Further, nearly all crossover youth in juvenile justice residential placements are automatically eligible for Medicaid on the basis of being a foster child.[35] However, the inmate exclusion policy limits Medicaid and CHIP coverage for most services for youth detained in juvenile justice facilities. Specifically, federal Medicaid law prohibits the payment of federal Medicaid matching funds for the cost of any services provided to an "inmate of a public institution," except when the individual is a "patient in a medical institution."[36] This policy, known as the inmate exclusion, applies to both adults in jails or prisons as well as to youth involuntarily detained in a state or local juvenile facility, although there are some distinctions in the law between Medicaid and CHIP. Youth may be enrolled in

Medicaid while detained in a juvenile justice facility; however, even if they are enrolled, Medicaid will not cover the cost of their care, except for care received an inpatient in a hospital or other medical institution. In contrast, children may not be enrolled in CHIP while involuntarily detained.[37]

The inmate exclusion makes it challenging to maintain continuous coverage for low-income youth moving into and out of juvenile justice facilities. Because youth involuntarily held in public institutions are ineligible for CHIP, children who are enrolled in the program lose their coverage upon entry into residential placements. Additionally, while states are not required to terminate Medicaid eligibility for youth when they enter residential facilities, many still do, or let the coverage lapse while they are in residential placement.[38] Moreover, there has historically been wide variation among juvenile justice facilities and Medicaid agencies in the scope of policies and procedures to connect youth to coverage as they prepare to re-enter the community.[39] As such, juvenile justice-involved youth may often be uninsured upon release from a facility, making it difficult to access continuous, comprehensive care as they renter the community. These gaps in coverage and access may have particularly important implications for juvenile justice-involved youth given their significant physical and mental health needs.

The ACA maintains and strengthens Medicaid and CHIP coverage for children. The ACA protects the gains already achieved in children's coverage by requiring states to maintain eligibility thresholds for children who are at least equal to those they had in place at the time the law was enacted through September 30, 2019. Moreover, the ACA establishes a minimum Medicaid eligibility level of 138% FPL for all children up to age 19. Prior to the ACA, the federal minimum eligibility levels for children varied by age, and the federal minimum for older children ages 6 to 18 was 100% FPL. As a result of the law, 21 states transitioned children from CHIP to Medicaid in 2014; states still receive the enhanced CHIP federal matching rate for coverage of these children. The ACA also requires that states provide Medicaid coverage to children aging off of foster care up to age 26 as of 2014. In addition, the ACA establishes new streamlined and coordinated enrollment processes for all states, which aim to make it easier for eligible individuals to enroll and renew in Medicaid, CHIP, and private health insurance obtained through new Health Insurance Marketplaces. The law also emphasized the importance of outreach to uninsured populations, including vulnerable groups, by providing states with new funding opportunities to reach and enroll these individuals.

The ACA does not make any changes to the Medicaid and CHIP inmate exclusion.[40] While the ACA expansion in Medicaid eligibility and simplified enrollment policies have the potential to facilitate enrollment into coverage for youth leaving incarceration, many youth will continue to be ineligible for Medicaid and CHIP-funded services while in residential placements.

Key Issues Looking Forward

Improving health care for youth in juvenile justice facilities is important given their complex and significant health needs. While the overall number of youth involved in the juvenile justice system has declined, they continue to be a sizeable and vulnerable population with significant physical and mental health needs. In particular, youth in juvenile justice include large number of foster care youth and a growing share of girls, who are often younger than other youth in the system and many have additional mental and behavioral health needs. Given that incarcerated youth spend varying lengths of time in detention, frequently enter with a multitude of undiagnosed or untreated conditions, and often cycle in and out of correctional facilities, continued attention to their physical and mental health care needs while in residential placements is important to their rehabilitation and reintegration into the community. While most residential juvenile justice facilities provide youth with basic health care services, the lack of standards for assessment and treatment of mental and physical needs results in inconsistent and often inadequate care to address their complex health needs. Applying more uniform standards for health assessments and treatment could help improve care for youth while they are detained and better prepare them for reentry back into the community upon release.

Increased efforts to support continuous Medicaid and CHIP coverage for juvenile justice-involved youth are key for maintaining their access to ongoing, comprehensive care. Given their significant health needs, a majority of youth who leave residential placement require ongoing care as they return to the community. Many juvenile justice-involved youth are eligible for Medicaid and CHIP, which provide coverage for the broad range of health care services they need. However, the inmate exclusion for Medicaid and CHIP often contributes to gaps in coverage, particularly as children are released from juvenile justice facilities, making it challenging for them to maintain continuous access to care within the community. States and juvenile justice facilities can support more continuous coverage and care by adopting policies that suspend rather than terminate Medicaid coverage for youth once they enter detention facilities. In addition, initiatives to enroll eligible youth in Medicaid and CHIP coverage upon release from a facility can facilitate continuity of coverage and care. The ACA eligibility expansions and enrollment simplifications provide increased opportunities to connect youth to coverage in Medicaid and CHIP. In particular, expanded eligibility for foster care youth and the new streamlined enrollment policies may make it easier to connect youth to coverage as they transition from juvenile justice facilities back into the community, and a number of states have placed increased focus on connecting individuals to health coverage upon release from detention.

Connecting youth to community providers will also be important to ensure continuity of care. Given that many youth enter juvenile justice residential facilities without regular health care services, many are released without an established medical home. Even with health coverage, many will likely need support and guidance to find community providers that can provide care for their complex physical and mental health needs, and many would likely benefit from efforts to care coordination and case management services. Some states and localities have established programs within individual jurisdictions that seek to ensure that youth are immediately connected to primary care and medical homes once they leave detention. However, continued work to ensure youth are connected to providers as they reenter the community will be important for maintaining their access to necessary care.

Finally, more data are needed on youth in juvenile justice and their coverage and care. Data and information gaps, inconsistencies, and lack of coordination across agencies and jurisdictions pose major barriers to the systematic identification of the health and mental health needs of girls and boys while they are in the juvenile justice system, as well as efforts to improve their access to health coverage and care upon their release. The limited data and information on the socio-economic circumstances of youth entering the juvenile justice system also make it difficult to assess their eligibility for benefits. As such, increased data collection efforts could help support identification of health needs among the population, development of efforts to address their needs, and the ability to track progress and impacts over time.

This issue brief was prepared by Leslie Acoca of the National Girls Health Justice Institute and Jessica Stephens and Amanda Van Vleet of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU).

The authors express their appreciation to Andy Schneider, former consultant with the Kaiser Commission on Medicaid and the Uninsured, for his invaluable contributions to this project.

Appendix 1 Girls and Boys in Juvenile Justice by State, 2010

State of Offense	Total	Male	Female
United States	**70,793**	**61,359**	**9,434**
Alabama	1,101	951	150
Alaska	282	240	42
Arizona	1,092	897	195
Arkansas	729	627	102
California	11,532	10,203	1,329
Colorado	1,530	1,308	222
Connecticut	315	264	51
Delaware	252	228	24
District of Columbia	180	168	12
Florida	4,815	4,155	660
Georgia	2,133	1,884	249
Hawaii	120	87	33
Idaho	480	408	72
Illinois	2,217	1,959	258
Indiana	2,010	1,623	384
Iowa	738	618	120
Kansas	843	750	93
Kentucky	852	717	138
Louisiana	1,035	924	111
Maine	186	159	27
Maryland	888	825	63
Massachusetts	663	564	99
Michigan	1,998	1,614	384
Minnesota	912	789	123
Mississippi	357	297	57
Missouri	1,197	1,011	186
Montana	192	156	36
Nebraska	750	489	261
Nevada	717	609	108
New Hampshire	117	99	18
New Jersey	1,179	1,095	84
New Mexico	576	495	81
New York	2,637	2,100	540
North Carolina	849	732	117
North Dakota	168	126	42
Not Reported	2,568	2,295	273
Ohio	2,865	2,550	315
Oklahoma	639	558	81
Oregon	1,251	1,110	144
Pennsylvania	4,134	3,798	336
Rhode Island	249	240	9
South Carolina	984	870	114
South Dakota	504	372	129
Tennessee	789	699	90
Texas	5,352	4,671	684
Utah	684	594	90
Vermont	33	30	3
Virginia	1,860	1,662	201
Washington	1,305	1,143	162
West Virginia	561	492	69
Wisconsin	1,110	936	174
Wyoming	255	165	90

Note: To preserve the privacy of the juvenile residents, state level cell counts were rounded to the nearest multiple of three. "State of Offense" refers to where the juvenile committed the offense for which they were being held.
SOURCE: Sickmund, M., Sladky, T.J., Kang, W., and Puzzanchera, C. (2013) "Easy Access to the Census of Juveniles in Residential Placement." Online. Available: http://www.ojjdp.gov/ojstatbb/ezacjrp/

Appendix 2: Girls Health Screen (GHS)

The Girls Health Screen (GHS) and Girls Health Passport (GHP) are projects of the National Girls Health and Justice Institute (NGHJI), located in Los Angeles, California. The NGHJI is dedicated to improving the health and mental health of girls in the juvenile justice system and to decreasing the risk that girls will recidivate, or re-enter, the juvenile justice system, or enter the criminal justice system as adult women in the future. Ultimately, the NGHJI expects to apply the tools and lessons learned from serving girls in the juvenile justice system to the needs of girls in the child welfare and education systems. [41]

The Girls Health Screen (GHS) is the only evidence-based and gender-responsive medical screen developed exclusively for the approximately 500,000 girls 11-17 years old who enter the juvenile justice system and locked detention facilities across the United States each year. The GHS is a triage model, self-report questionnaire including Urgent, Care, and Advocacy (community care) items addressing multiple dimensions of girls' lives. The girls' answers to GHS questions are scored according to the urgency of the medical response required and the timeframe within which care should occur. Two of the innovations of the GHS are its comprehensiveness and its integration of physical and mental health questions, leading to greater coordination of services within facilities for the benefit of girls. For example, if a girl is experiencing an acute medical problem, such as a miscarriage, and is also feeling hopeless and suicidal, both problems will be identified and responded to simultaneously. The GHS complies with all statutory requirements for medical intake for detained juveniles.

The GHS includes 117 questions, written in fourth grade language, that appear in a simple Yes/No format that most girls comprehend and complete in 11-13 minutes. The GHS has been converted into an iPad application connected to an electronic health database that records and scores girls' answers, triggers immediate responses from health and mental health professionals in facilities, and enters the girls' health data into their permanent medical record. The GHS iPad application will soon have an audio option so girls who cannot read will be able to hear the questions as well as read them on the screen. The GHS iPad application is attractive, simple to use (large Yes/No buttons for each question), and is more portable than the larger computers used by most probation and health services agencies. The GHS will be translated into Spanish and multiple other languages as required by the region it is serving.

The GHS is designed to improve the health of girls in the juvenile justice system by assisting juvenile correctional facilities to identify, prioritize, treat and follow the physical and mental health needs of girls entering their care earlier and more effectively than would occur using previous instruments not validated for use with high-risk girls. Since the GHS identifies whether or not girls have medical benefits upon entry into the system, the results also prompt juvenile probation and social services agencies to proactively enroll girls in care, or reinstate their medical benefits as a standard part of their pre-release process.

The GHS was created in response to previous research revealing that detained girls tend to have different and more serious health (including reproductive), and mental health needs than their male counterparts; and are less likely to have their health needs identified or met within a system designed for the larger population of boys. Studies also indicated there were no gender-responsive medical standards for girls entering juvenile justice residential facilities nationally and no standardized medical screening and assessment tools designed specifically for girls other than the GHS, which was, at that point, being developed.[42]

A further rationale for the development of the GHS came from a study of the health and other needs of nearly 1,000 girls in the Florida Juvenile Justice System, revealing that access to physical health care could reduce girls re-offending or committing a violent offense in the future by 72%.[43]

After validation of the screen with girls entering three detention sites nationally, the Girls Health Screen was piloted in the Bernalillo County Detention Center in Albuquerque, New Mexico, and findings from a report on the screen found that, by

asking medical questions that should be asked of this population of girls, in language that girls understand, can identify serious health problems that might otherwise be overlooked during standard medical intake. [44] The report revealed that many girls entering that facility had acute medical needs, such as severe burns and suicidality, which had been missed by nurses during routine medical intake.

Between 2012 and 2014, the Girls Health Screen was piloted in a locked Los Angeles County Probation Camp where it has served approximately 180 girls and is now part of the standard medical intake for every girl entering that facility. In 2014, the Girls Health Screen will be expanded to become the standard medical intake for the approximately 2,000 girls who enter all three detention facilities in Los Angeles County annually. Los Angeles County arrests and detains more youth than any other United States jurisdiction and is committed to a coordinated effort between County Health Services, Mental Health and Probation Departments and the NGHJI to improve medical intake for girls in its care[45].

The GHS will be installed in iPad form at detention intake and its database will interface with the existing County electronic health record. Also in 2014, the GHS will become the standard medical intake for all girls entering detention in San Joaquin County, California, as part of a California statewide juvenile justice reform effort. It is hoped that once fully implemented in two Counties, the GHS will enter juvenile justice and other facilities holding girls across California and nationwide.

The Girls Health Screen is the first entry in an iPad-based Girls Health Passport (GHP). The GHP will provide secure, web-based, portable health records for detained girls, and contribute to the development of a seamless continuum of medical screening, assessment, treatment and follow-up linking the health information gained in institutions with medical homes and providers in their communities.

Appendix 3: Origins of Medicaid's Inmate Exclusion

When Medicaid was enacted in 1965, Congress prohibited states from using federal Medicaid matching funds to pay for care or services for any "inmate of a public institution" or for any individual under 65 who is "a patient in an institution for mental diseases." An exception was made if an "inmate of a public institution" was a "patient in a medical institution:" in this circumstance, the Federal government would match the cost of care for the "inmate."

The origins of this statutory language can be traced back through the Kerr-Mills legislation of Medical Assistance for the Aged, which was enacted in 1960, to the program of Grants to States for Old Age Assistance that was enacted in Title I of the original Social Security Act of 1935. Under the Old Age Assistance program, the Federal government made payments to states for half of the costs of cash assistance to the elderly poor. In order to qualify for assistance, an individual had to be 65 or older, needy, and not "an inmate of a public institution."[46]

The genesis of this policy may have been state old age assistance laws in effect at the time. The 1935 Old Age Security Staff Report, which provided specifications and cost estimates for a federal program of public assistance for the aged poor, included the findings of a survey of these state laws.[47] The Staff Report concluded that the laws "make sure that the recipients of relief are 'deserving' citizens. People who have deserted their husbands or wives, have failed to support their families, have been convicted of a crime, have been tramps or beggars, or have failed to work according to their ability, are ineligible to receive assistance in most of the states. Inmates of jails, prisons, infirmaries, and insane asylums are also barred from receiving pensions."[48] The inmate exclusion may ultimately be rooted in notions of the "deserving" poor.

The Kerr-Mills legislation, enacted as part of the Social Security Amendments of 1960, was the immediate predecessor to Medicaid. It amended the Old Age Assistance Program of 1935 to add Grants to States for Medical Assistance for the Aged. This was an important milestone in Federal policy toward the elderly poor: making Federal matching funds available to states to share in the costs of purchasing medical care on behalf of this population directly from providers as well as for cash assistance to the elderly themselves.

Kerr-Mills barred the use of Federal matching funds to pay for services for "any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases."[49] The Medicaid law, enacted five years later, adopted this policy but dropped the prohibition on institutions for tuberculosis.

Whatever the rationale for the "inmate of a public institution" in 1935, it is clear that by 1965 considerations beyond who is "deserving" were in play. In particular, Congress did not want the new federal Medicaid funds to replace funds that states and counties were already spending on individuals in prisons or jails and on individuals with mental illness or mental retardation residing in hospitals or other institutions. As explained by Rosemary and Robert Stevens in their study of the origins of the Medicaid program, "Since the program was intended to provide additional services, the law sought to prevent the states from using the new Federal medical care dollars to replace their existing medical assistance expenditures....Medicaid was not to be regarded (at least, not according to the legislation) as a welcome windfall that would release dollars for other purposes in the states."[50]

Since 1965, the Medicaid statute has been amended to make some changes in this policy. Federal funds are now available to match the costs of services provided by intermediate care facilities for individuals with intellectual disabilities (ICFs/ID), as well as inpatient services provided by psychiatric hospitals to individuals under 21. In both cases, inpatients in state and county facilities are not subject to the "inmate of a public institution" exclusion. In addition, the definition of "institution for mental disease" has been modified to allow Federal funds to match the costs of services to Medicaid beneficiaries residing in facilities with 16 or fewer beds. The "inmate of a public institution" exception does, however, continue to apply to inmates of state and local prisons, jails, and juvenile detention facilities.

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