ModelsforChange
Systems Reform in Juvenile Justice

Knowledge Brief

Mental Health Services in Juvenile Justice: Who pays? What gets paid for? And who gets to decide?

Providing effective mental health services for youths in the juvenile justice system raises complex policy questions, including: Who pays? What services get paid for? And who gets to decide? The answers to these questions are changing rapidly, as financing shifts from specialized programs to broad-based insurance such as Medicaid. This brief provides an overview of the changing financing streams and federal health care reform, and explores the opportunities and challenges facing mental health and social service providers, juvenile justice practitioners, and others who want to have a seat at the policy table.

Background

Youths in the juvenile justice system are four to six times as likely as other youths to suffer from mental health disorders. About 7 to 12 percent of youths in the general population suffer from serious psychiatric problems; for youths in detention, those figures are 60 to 70 percent for males and 60 to 80 percent for females. The services they require are provided through several different delivery systems, including primary care, specialty medical care, and social services, and in multiple settings, such as schools, private offices, and community clinics.

The policy challenge is complex: How can we best fund services for this relatively small group of youths while creating incentives for the services to be delivered effectively? Mental health and social service providers, juvenile justice practitioners, and others who deal with troubled youths can play a critical role in that effort. But to do so they need to understand the changes taking place in the financing and delivery of mental health care. This brief offers an overview of these changes and a summary of the opportunities and challenges they present.

Financing is shifting from specialized programs to broad-based insurance.

The question of who pays is closely tied to what is being paid for and who gets to decide. In general, financing has

been moving from targeted, specialized mental health funding to broad-based insurance.

Three government funding streams historically have shaped mental health services for justice-involved youths: federal grant programs that target delinquent youths, federal grant programs that fund direct delivery of mental health services, and insurance programs such as Medicaid. They differ not only in their relative size—Medicaid is by far the largest—but also in leadership and supervision. The first two programs are administered by experts in their respective areas, justice and mental health, while the latter, a broader-based insurance program, plays a substantial and growing role.

Juvenile justice grants. The Office of Juvenile Justice and Delinquency Prevention administers two major types of grants—block grants and state juvenile justice formula grants—for services targeted to justice-involved youths outside of detention facilities. These funds address 30 specific areas, one of which is mental health services. While the overall grant amounts are set at the federal level, they are distributed within states by state advisory groups that include justice experts and experts on problem youths. Combined, these grants declined by 69 percent over the past decade.

Federal Juvenile Justice Funding 2000 vs. 2010

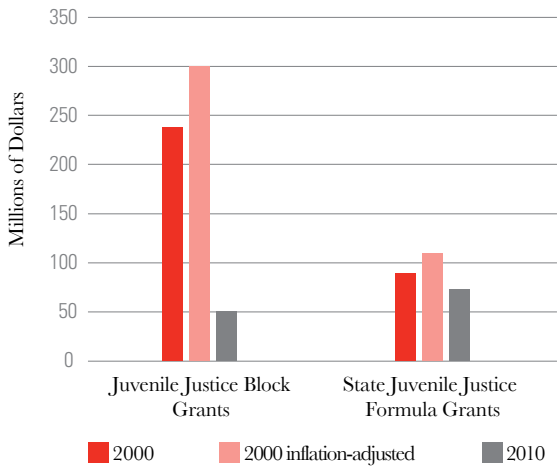

figure 1

Mental health grants. The largest federal grant program that directly supports mental health services for youths—Comprehensive Community Mental Health Services for Children and Families—supports project grants to develop community-based systems of care. This federal funding source, $121 million in 2010, has been relatively flat in real terms. States also receive federal formula grants to support community mental health services more broadly, primarily for direct services for adults. In 2010, $421 million was appropriated to states through mental health formula grants, a 7 percent decline in real terms since 2000.

Federal Mental Health Funding 2000 vs. 2010

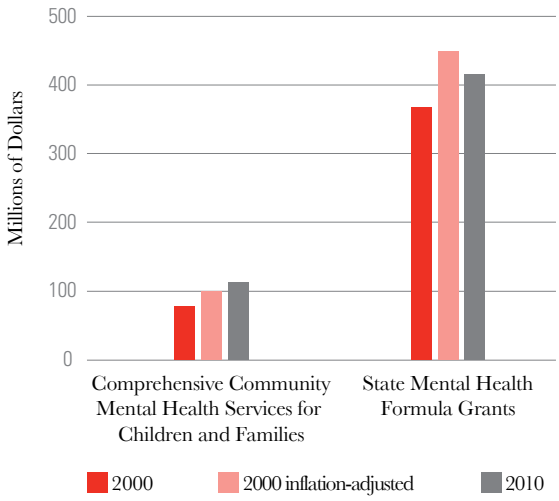

figure 2

Medicaid and CHIP. The largest increase in funding for youth mental health services has come from increased insurance coverage, primarily through the expansion of Medicaid and the introduction of the Children's Health Insurance Program (CHIP) in 1997. These programs cover a larger percentage of children in poor mental health than of those in good mental health (see figure 3).

It's important to note that overall health expenditures are higher for children in poor mental health. In 2008, the average child in poor mental health spent $5,586 on health care, compared to $1,467 on average for other

children. Medicaid is a major payer of these expenses, covering 37 percent of health expenses for children with fair or poor mental health (see figure 4).

Note that with Medicaid, which covers more than 30 million children, the researchers speak broadly of "health expenditures." Medicaid can cover diverse services, many at state option. For example, it covers targeted case management for mental health in 37 states, rehabilitation for mental health in 49 states, and prescription drugs for mental health in 32 states. Medicaid can also cover portions of intensive, multi-component interventions, such as multi-systemic therapy for youths with serious conduct disorders; mental health services in schools and other non-medical settings; and providers who are not physicians.

Through CHIP, states can cover children beyond their Medicaid income-eligibility levels, though eligibility varies: in 24 states, including the District of Columbia, CHIP extends to children above 250 percent of poverty; in four states eligibility remains below 200 percent of poverty. In some states benefits are also more restrictive and services less broad than with Medicaid, and states need not use CHIP funds to target beneficiaries with special needs. Furthermore, states can charge premiums and cost-sharing on a sliding fee scale. In total, six million children are covered through CHIP.

Health Insurance for Children Under Age 19, by Mental Health Status

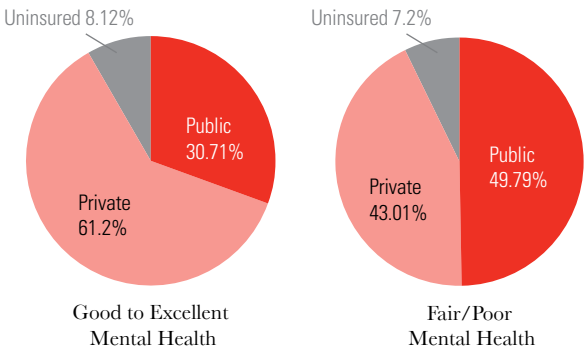

figure 3

Total Health Expenditures Paid by Payer Type, Children Under Age 19

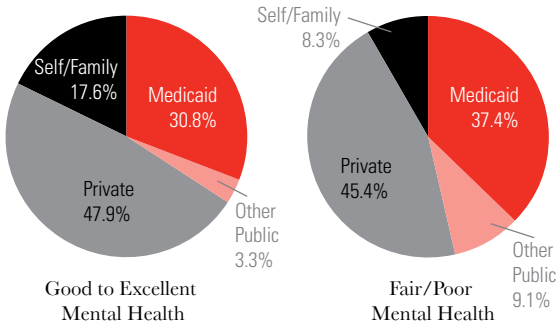

figure 4

Private insurance and out-of-pocket. Many youths with mental health conditions still pay for significant portions of care through private insurance, which covers health expenditures for 58 percent of all children. For children with fair or poor mental health, however, private insurance plays a smaller role than Medicaid (figure 3).

And even with public and private coverage, families pay for a significant portion of care from their own funds. For children in poor mental health, families paid 8 percent of health care expenditures themselves, compared to 18 percent for families of children in better mental health (figure 4).

Recent state and federal mental health parity laws have improved private coverage of mental health benefits by removing arbitrary limits on benefits and differences in co-payments and deductibles. However, the laws don't require coverage of some important services, such as provider interactions with schools and other agencies, family education, or mental health screening and assessment provided by primary care providers.

Many children lost private insurance coverage when their parents lost employment during the recent recession. Increases in children covered by Medicaid and CHIP, bolstered by federal stimulus funds, more than offset these drops, but that may not hold: under

continuing fiscal pressure, many states are considering cuts in Medicaid benefits and in payments to providers.

The uninsured. Despite the various public and private insurance programs, 11 percent of children were uninsured for some part of the year and 8 percent were uninsured the entire year; for teens, the latter proportion is almost half again as high: 11 percent were uninsured the entire year. More than half of uninsured children are eligible for Medicaid or CHIP, but simply are not enrolled. Getting them enrolled so their care can be paid is a high priority.

Changes in mental health care call for more collaboration.

Mental health in primary care. Along with the changes in funding have come two large changes in mental health care for all populations: more of that care involves psychotropic prescription drugs, and—facilitated by that change—more of it is taking place in primary care settings. The move to primary care requires a major shift in focus for justice agencies, which have long collaborated with public mental health systems; they now must establish relationships with the primary care community as well.

The primary care approach has potential advantages for justice-involved youths, who have many medical needs beyond mental health. Primary care providers can often manage both medical and psychiatric conditions, with specialist input when needed or with additional assistance from care managers and other social services. But there are cautions as well. Justice-involved youths present challenges such as frequent changes in placement, unexpected transitions between detention and the community, and abrupt disenrollment from Medicaid, all of which can disrupt both their care and the funding of that care. These challenges call for the close collaboration of primary care providers, specialists, schools, family members, and social service agencies.

Collaborating with Medicaid. As noted earlier, juvenile justice and state mental health agencies have long collaborated in the delivery of care, and even in the administration of programs; yet in only 22 states have they attempted to combine or coordinate funding streams. With the growing role of Medicaid in funding mental health care for youths, justice and mental health will need to collaborate with this large insurance program as well—on both financing and delivery of services—to ensure that programs remain sustainable. As the major funder, the Medicaid agency in each state makes key decisions about coverage, reimbursement, and contracting; these decisions in turn drive mental health care delivery for justice-involved youths, poor children, foster care youths, and SSI recipients. Federal law already requires that state child welfare agencies work with Medicaid to examine and improve the delivery of health care services to children in foster care. Similar efforts, while not federally required, could benefit youths in juvenile justice.

Federal health care reform is reshaping health care delivery.

The recently enacted Patient Protection and Affordable Care Act (ACA) of 2010, the health reform law, will not significantly change the insurance coverage of children in the near term. While the law includes a large expansion of Medicaid eligibility, this will affect primarily adults, since low-income children are already eligible for Medicaid or CHIP. Other provisions of the law, however, could lead to significant changes in the delivery of care to youths in juvenile justice.

Primary care. The health care reform law places a strong emphasis on primary care. The ACA increases payment rates to primary care doctors (family medicine, general internal medicine, and pediatric medicine), with federal support to finance the payment increase for two years. This is likely to further increase the role of primary care in the delivery of mental health services to youths and to enhance Medicaid attention to primary care in general.

Medical homes. In Medicaid and elsewhere, the law promotes the development of medical homes, a

multidisciplinary, team-based model aimed at enhancing the delivery of continuous, coordinated care. The law particularly targets patients with complex, chronic conditions, and there is not yet any mention of youths in the juvenile justice system as a special population. Still, these medical homes represent a unique opportunity for the juvenile justice community, which could help define the payment model to include services that fall outside the usual reimbursement framework—for example, social services addressing the youth's family and school. The National Committee for Quality Assurance (NCQA) recently issued new standards for medical homes, making specific mention of common mental health conditions among children, such as ADHD, ADD, and depression, and affirming that mental health needs are part of the whole range of conditions that must be addressed by the medical home team. NCQA refers practitioners to resources that include publications on mental health care for children and youths, including one on children in foster care.

Accountable care organizations. The ACA also promotes accountable care organizations (ACOs), a type of reform that ties provider reimbursements to quality measurements and cost control. ACOs are encouraged to monitor care transitions and ensure coordination of care for beneficiaries, to reach out to patients with reminders and advice, and to collect and evaluate data on outcomes. For the justice-involved population this is potentially a tremendous opportunity, though not without risks. Here again it will be important to build new channels of communication, share data, and develop population-based outcome measures that can lead to improved care for justice-involved youths.

Meeting the challenge. A challenge for those seeking to improve care for justice-involved youths is that reform places many new demands on states. They have to organize and operate the new health information exchanges, implement the Medicaid expansions, design income eligibility systems that coordinate Medicaid and the exchanges, and implement electronic health records. These activities are likely to consume a significant amount of state attention and staff time. And despite new federal funding, the recession has made it more difficult to add employees, and elections have brought a turnover in leadership and staff. While states struggle to meet their new challenges, juvenile justice agencies must find a seat at the table and clearly articulate their priorities and the unique needs of justice-involved youths.

Opportunities

Some changes in the funding and service-delivery scene are either positive in themselves or can be put to positive use. They include:

- Improvement in mental health parity laws
- Access to providers of care for multiple conditions in youths
- Access to multi-component interventions
- Access to state mental health services for youths
- New treatment models, such as medical homes
- New funding models, such as accountable care organizations
- Reimbursement beyond traditional fee-for-service

Challenges

The juvenile justice community has work to do in order to take advantage of the opportunities.

- Shift focus from siloed populations (juvenile justice, mental health) to general health delivery systems
- Find ways to work with restricted funding, especially less funding targeted to mental health or juvenile justice
- Raise awareness among primary care providers of juvenile justice population needs
- Articulate priorities and needs to state personnel
- Help develop models that reimburse non-face-to-face visits and enhanced care coordination to this population
- Help develop targeted outcome measures
- Develop working relationships with new multidisciplinary teams
- Assist youths in community re-entry and other care transitions

The research described in this brief was supported by the MacArthur Foundation's Models for Change Research Initiative, and was carried out by Alison Evans Cuellar and Sidney Johnson, George Mason University.

This brief is one in a series describing new knowledge and innovations emerging from Models for Change, a multi-state juvenile justice initiative. Models for Change is accelerating movement toward a more effective, fair, and developmentally sound juvenile justice system by creating replicable models that protect community safety, use resources wisely, and improve outcomes for youths. The briefs are intended to inform professionals in juvenile justice and related fields, and to contribute to a new national wave of juvenile justice reform.