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RESEARCH ARTICLE

Reducing Medicaid Coverage Gaps for Youth During Reentry

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Abstract

Although many justice-involved youth (JIY) rely on Medicaid, due to the federal "inmate exclusion" Medicaid is often suspended or terminated upon youth's intake to detention, which can lead to coverage gaps at release. We interviewed 28 experts on Medicaid and the justice system and conducted thematic analysis to identify solutions for reducing Medicaid coverage gaps during reentry. Participants viewed coverage gaps during reentry as a significant public health problem to which JIY are especially vulnerable. Recommended solutions for reducing coverage gaps for JIY included (a) leave Medicaid activated, (b) reactivate Medicaid before or during reentry, (c) enhance interagency collaboration, and (d) address societal context to ensure health care access for Medicaid-eligible JIY. Doing so may improve health outcomes and reduce cycles of youth incarceration.

Keywords: justice-involved youth; Medicaid; reentry; coverage gaps

Introduction

Justice-involved youth (JIY), defined as youth who have been arrested (Aalsma *et al.*, 2017), have disproportionately high morbidity and mortality compared with the general adolescent population (Barnert *et al.*, 2016; Winkelman *et al.*, 2017). A high proportion of JIY come from low-income families and rely on Medicaid for access to health care when in the community (Albertson *et al.*, 2020). One study at an urban detention center found that 66% of youth had Medicaid at intake (Aalsma *et al.*, 2012). Likewise, a survey of state Medicaid agencies and juvenile correctional facilities found that most participating states reported greater than 50% JIY enrollment in Medicaid (Zemel & Kaye, 2009a).

When JIY with Medicaid coverage enter the justice system, however, coverage is disrupted due to the federal ''Medicaid inmate exclusion policy'' (Acoca *et al.*, 2014). The inmate exclusion prohibits states from using federal Medicaid funds to pay for health care services while an individual is incarcerated, except for inpatient care. Consequently, states have adopted a policy of either terminating or suspending Medicaid when JIY enter the justice system. Both Medicaid termination and suspension can result in gaps in coverage after release from detention or incarceration (Acoca *et al.*, 2014).

Termination requires reenrollment, whereas suspension requires reinstatement of Medicaid upon reentry into the community (Medicaid and CHIP Payment and Access Commission, 2018). Although the prevalence of Medicaid coverage gaps for JIY undergoing reentry is unknown, Medicaid coverage gaps have been shown to be more common and of longer duration for JIY than peers who are not involved in the justice system (Aalsma *et al.*, 2017).

The literature on youth's health needs during the crucial reentry period is sparse (Barnert *et al.*, 2016); however, studies of previously incarcerated adults have shown increased rates of hospitalization and death in the first few weeks after release (Binswanger *et al.*, 2007; Frank *et al.*, 2014; Wang *et al.*, 2013). A study in Washington found the risk of death was 12 times higher for adults

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in the first 2 weeks after release from incarceration than other state residents, with the leading cause of death being drug overdose (Binswanger *et al.*, 2007).

Like justice-involved adults, JIY have high rates of untreated mental health problems, including substance use disorders, which are known risk factors for recidivism that, if left untreated due to coverage gaps, may potentiate a cycle of incarceration and worsening health outcomes (Baglivio *et al.*, 2014; Barrett *et al.*, 2014; Constantine *et al.*, 2013; Hoeve *et al.*, 2013; McReynolds *et al.*, 2010; Schubert & Mulvey, 2014).

Although suspension and termination are defined mechanisms by which Medicaid is deactivated for JIY entering the justice system, little is documented in the peer-reviewed literature about mechanisms for reactivating Medicaid coverage during youth reentry. Several promising policies exist (Bandara *et al.*, 2015; Butler & Murphy, 2014; Jannetta *et al.*, 2018; Patel *et al.*, 2014; Ryan *et al.*, 2016; Zemel *et al.*, 2013), but comprehensive recommendations are lacking. We sought to identify solutions for reducing coverage gaps and promoting continuous Medicaid coverage for youth during reentry.

Method

We used a qualitative approach consisting of semistructured interviews with experts at the intersection of Medicaid and the justice system. We developed an initial sampling frame based on researcher knowledge of the field and used snowball sampling to identify additional participants (Johnson, 2014). Our intent was to interview experts on juvenile justice, but many interviewees recommended to us also had expertise on adults. Of 44 prospective participants, 28 (64%) accepted emailed invitations to participate.

The final sample consisted of nine health policy researchers or policymakers; eight frontline providers with expertise in pediatrics, medicine, or care coordination; three judges or probation officers; four representatives from juvenile justice advocacy organizations; and four Medicaid administrators (Table 1). Of these participants, 24 individuals had expertise related specifically to juvenile justice and 4 had expertise about the adult correctional system.

We conducted phone interviews, lasting from 30 to 60 min, from November 2018 through April 2019. The interview guide asked participants about their professional role, perceived problems associated with gaps in Medicaid coverage for JIY, and potential solutions (Supplementary Appendix SA1). We used six-step thematic analysis to identify themes (Braun & Clarke, 2006). Two team members coded each interview using Dedoose software 1.3.34 (SCRC, Manhattan Beach, CA, USA) and the team met weekly to reach consensus and identify themes that illuminated participant perspectives and recommendations for reducing Medicaid coverage gaps for JIY at reentry.

A second round of coding was performed to examine issues that were unique to youth in the juvenile justice system as compared with adults. Sampling continued until we reached and surpassed saturation of major themes. Findings were debriefed and validated with two experts outside of the study team. Our university's institutional review board approved study procedures.

Table 1. Participant Roles

Roles	N *(%)*
Health policy researcher or policymaker	9 (32)
Health care provider or care coordinator	8 (29)
Juvenile court judge or probation officer	3 (11)
Juvenile justice advocacy organization representative	4 (14)
Medicaid administrator	4 (14)
Total	28 (100)

Results

Participants described JIY as being uniquely impacted by Medicaid coverage gaps (Theme 1) compared with the justice-involved adult population and identified several opportunities for reducing Medicaid coverage gaps for JIY during reentry. Proposed solutions (Theme 2) included the following recommendations (i.e., subthemes): (a) leave Medicaid activated, (b) reactivate Medicaid before or during reentry, (c) enhance interagency collaboration and communication, and (d) address societal context to ensure health care access for Medicaid-eligible JIY. Table 2 gives recommended solutions. Overall, experts viewed pursuing reforms to reduce coverage gaps during reentry as necessary for protecting JIY's rights and reducing cycles of poor health outcomes and recidivism.

Theme 1: JIY Are Uniquely Impacted by Medicaid Coverage Gaps

Participants viewed Medicaid coverage gaps at reentry, which several described as commonly lasting from weeks to months, as detrimental to both JIY and justice-involved adults but described features of JIY that make them uniquely impacted by coverage gaps. In particular, they discussed youth's developmental immaturity and malleability. They highlighted the importance of access to health care during the vulnerable reentry period and the potential of positive interventions to improve health and justice outcomes and developmental trajectories.

Participants also described that youth, unlike adults, depend on their parents or guardians to ensure the youth have Medicaid coverage, which can create logistical challenges with reactivation as parents or guardians may not be available to carry out reactivation processes or provide household information. This contrasts with justice-involved adults who are present in custodial settings and able to participate in the reactivation processes. In

Table 2. Thematic Quotes From Interviews With Experts Involved in the Juvenile Justice System and Medicaid

Theme 1: JIY Are Uniquely Impacted by Medicaid Coverage Gaps	
• ''Obviously juveniles in some ways, should be, even a higher priority…For kids early on, their brains are not fully developed…So yeah. I think they should be, I think they should be a priority and I think these are practical steps.''	
• ''I think of children as still…they exist in a formative state meaning it's possibly easier to get a 16-year-old changed than it is a 46-year-old. In whatever, behavior, perceptions, that kind of stuff.''	
• ''We need to make sort of biological decisions about your care for children versus trying to fit a square peg in a round hole.''	
Theme 2: Proposed Solutions	
Solution—Leave Medicaid Activated	
End inmate exclusion	• ''Just removing the restriction. That doesn't cost anybody anything. It saves a lot of time in the back end with people if they know they have it…I think it's removing the restriction will let us work with the greatest impact.''
Suspension rather than termination	• ''I guess ideally, I do definitely think the suspension only [i.e., instead of termination] is a totally reasonable ask.''
Delayed suspension	• ''The second could be that people don't lose their Medicaid until they are adjudicated so that people that are in jail, adults that are in jail or juveniles that are in juvenile hall, would continue to have their Medicaid continue.''
End time-limited suspension	• ''And the fact that people are terminated after a year as opposed to allowing for renewal [i.e., by maintaining suspension rather than termination status] just seems … doesn't seem to make a lot of sense.''
Solution—Reactivate Medicaid Coverage Before or During Reentry	
Presumptive eligibility	• ''It would be great if there were presumptive eligibility if they didn't have insurance and then someone needs to figure out how they get insurance within that 30 days, basically.''
Medicaid enrollment or reinstatement assistance	• ''Once they're out…it would be nice if it wasn't just the families. If the juvenile justice system was proactively reaching out pre discharge. And helping make sure that they were put on [Medicaid] so that they get out and first thing they already have Medicaid back enrolled.''
Solution—Enhance Interagency Collaboration and Communication	
Promote a culture of collaboration among agency staff	*Breaking Down Agency Silos* • ''I think it definitely helps to have strong relationship with your sister agency when you're trying to do these types of projects, having buy-in is really, really invaluable. But also, state Medicaid programs have challenges but so do their sister agencies, so understanding the challenges that your sister agencies are facing, I think, is really helpful as well. It puts things into better context.'' *Forming a Task Force* • ''Do we need a task force? Yeah. I mean, clearly, we do if… I think they [JIY] should be a priority and I think these are practical steps, many of which are relatively low-cost.''
Improve information exchange systems to facilitate interagency communication	• ''But I think there is a need for some sort of integration or talking between those systems because especially for things like this the systems sort of need to talk efficiently and in a timely manner so that the enrollment and things like that just happen smoothly without anybody really having to think about it.''
Solution—Address Societal Context to Ensure Health Care Access for JIY Eligible for Medicaid	
	Participate in Affordable Care Act Medicaid Expansion • ''The other thing…is that with [state] being a Medicaid expansion state, it affords the opportunity for the first time to really think about strategies for enrolling individuals while they're still incarcerated into a Medicaid program.'' *Adopt Diversion Programs* • ''I mean, I guess the other thing…is really diversion and just reducing the number of kids and teenagers that are incarcerated at all. That would obviously reduce the number of kids who had their Medicaid suspended or turned off.'' *Provide Immediate Access to Health Services During Reentry* • ''I think that, number one, having them leave with a prescription that covers them for at least a month would be really important''

JIY = justice-involved youth.

addition, experts noted that the smaller size of the JIY population and the public's sympathetic attitude toward youth, compared with incarcerated adults, could be advantageous for implementing reforms to reduce gaps in Medicaid coverage at reentry that could later be extended to justice-involved adults.

Theme 2: Proposed Solutions

Solution—Leave Medicaid Activated. This theme refers to eliminating or modifying the Medicaid ''on switch''—in other words, a mechanism to allow JIY to maintain Medicaid benefits and/or eligibility while detained or incarcerated, thereby preventing coverage gaps at release. Participants described several policy solutions for achieving this goal: (a) end the inmate exclusion, (b) implement suspension rather than termination policies, (c) implement delayed suspension policies, and (d) end time-limited suspension.

End inmate exclusion. Participants viewed the inmate exclusion as the root cause of Medicaid coverage gaps for JIY transitioning in and out of juvenile justice facilities. One person described the inmate exclusion as ''archaic'' and a ''flawed means of cost-sharing'' from federal to local governments, asserting that Medicaid should cover costs while youth are incarcerated. Participants recommended ending the inmate exclusion as the most impactful solution to reduce coverage gaps for JIY at reentry; however, they voiced feasibility concerns due to the need for broad political support to change existing federal legislation.

Suspension rather than termination. Several participants reported that termination, compared with suspension, lengthens coverage gaps and recommended suspension over termination policies. One participant cited the recent passage of the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 (SUPPORT, 2018), which prohibits Medicaid termination practices at intake and prescribes that Medicaid *may be* suspended. Although participants agreed that enacting a suspension policy in states that continue to terminate Medicaid for JIY would be impactful, only a few participants were aware of the SUPPORT Act provision before the interview.

Delayed suspension. Participants stated that although most JIY are detained for short periods of time before release, their Medicaid coverage is often suspended regardless of their length of stay. This practice was viewed as unreasonable and inefficient as it creates disproportionate administrative burden on JIY and their families to get Medicaid coverage reinstated. As an alternative, participants recommended delaying suspension for a specific period of time, ranging from weeks to months after starting detention. They viewed delayed suspension policies as feasible and worthwhile to pursue.

End time-limited suspension. Several participants noted that in some states with suspension rather than termination policies, the suspension status is time limited, meaning that an individual's Medicaid coverage is terminated after a specified duration of time, often 1 year. They indicated this stipulation stems from the need for annual Medicaid eligibility redeterminations. Participants suggested that the annual need to redeterminine Medicaid eligibility should not be enforced during incarceration and that JIY's Medicaid coverage should remain in suspension status throughout the duration of incarceration.

Solution—Reactivate Medicaid Coverage Before or During Reentry. Participants emphasized the value of reactivating Medicaid before release and, if not, doing so during reentry. Recommendations for promoting reactivation included (a) presumptive eligibility and (b) Medicaid reactivation assistance.

Presumptive eligibility. Participants discussed ''presumptive eligibility'' policies, which allow an individual who meets basic eligibility criteria for Medicaid to receive temporary coverage for health care services after release until a final determination of eligibility can be made (Bandara *et al.*, 2015). Participants explained that these policies allow JIY to fill prescriptions and attend appointments in the immediate postrelease period and for Medicaid to be billed retroactively once coverage is officially turned back on. Although several participants raised implementation concerns due to a perceived administrative and logistical burden of presumed eligibility policies, the majority of participants who commented on presumptive eligibility viewed it favorably.

Medicaid enrollment or reinstatement assistance. Participants expressed that Medicaid reactivation procedures during reentry are difficult for JIY and their families to navigate and, at times, confusing for justice and health agency staff, as well. To increase the likelihood of Medicaid reactivation and simplify the process, participants recommended providing prerelease planning services to help JIY fill out Medicaid applications. They also recommended having more navigation support and resources for JIY and their families applying for Medicaid postrelease. Participants raised concerns regarding funding and staffing constraints as barriers but were overall broadly supportive of such programs.

Solution—Enhance Interagency Collaboration and Communication. To decrease Medicaid coverage gaps for JIY, participants recommended greater collaboration

among Medicaid agencies, juvenile detention facilities, and community health care organizations through (a) promoting a culture of collaboration among agency staff and (b) improving health information exchange systems.

Promote a culture of collaboration among agency staff. Participants indicated that Medicaid, juvenile detention facilities, and community health agencies often operate as ''silos,'' and that lack of collaboration among agencies delays Medicaid reactivation during reentry. Reported barriers to improving interagency collaboration included lack of funding, regional differences in Medicaid administration, lack of person-to-person communication between agencies, and lack of knowledge about how other agencies or jurisdictions function.

To promote a culture of collaboration among agencies, participants recommended increasing direct contact and interagency knowledge-sharing among corrections, health, and social service agency staff. Participants also recommended forming task forces to systematically strengthen interagency partnerships and share best practices across agencies regarding Medicaid coverage for JIY during reentry.

Improve information exchange systems to facilitate interagency communication. Participants described a need for better technological infrastructure to facilitate electronic information exchange among local and state Medicaid agencies, juvenile detention facilities, and community health care organizations so that gaps in Medicaid coverage at release could be avoided. Each agency type was described as having its own record system, which participants viewed as ''not very integrated'' or ''completely apples and oranges'' and designed to facilitate communication within agencies but not between agencies.

Perceived barriers to improving health information exchange systems across agencies included cost, privacy concerns regarding sharing health or criminal records, and feasibility concerns due to the need for multiple data use agreements from participating jurisdictions.

Solution—Address Societal Context to Ensure Health Care Access for JIY Eligible for Medicaid. Outside of addressing Medicaid coverage gaps, participants discussed several broader mechanisms for expanding or maintaining access to health care for JIY eligible for Medicaid. For example, to increase enrollment for low-income youth, experts noted that more states should participate in the Affordable Care Act's Medicaid expansion. Participants also discussed the importance of preventing youth incarceration, such as by expanding diversion programs, which would not only prevent Medicaid deactivation but also avoid negative health effects of incarceration.

Finally, experts supported efforts to provide immediate access to health care services for JIY during reentry, such as issuing a temporary Medicaid card, providing a short-term supply of medications at the time of release, and assisting with scheduling appointments with community providers. Participants noted that providing Medicaid for JIY was not sufficient to guarantee access to care and that other reforms needed to be put in place to strengthen the linkage between providing health care coverage and access to health care services.

Discussion

Overall, participants indicated that JIY are a vulnerable population that are negatively impacted by Medicaid coverage gaps during reentry, with a high potential for benefit if the problem is resolved. Most participants viewed Medicaid coverage gaps as a significant but solvable public health concern that warrants action at the federal, state, and local level. Participants indicated that promoting continuous Medicaid coverage for youth during reentry could improve youth's health outcomes, reduce recidivism, and, in doing so, improve youth's life course trajectories.

Priority Solutions

Study participants proposed four types of solutions to the problems catalyzed by the inmate exclusion: (a) implementing mechanisms that leave Medicaid active at entry into the justice system, (b) implementing mechanisms to ensure Medicaid is reactivated during reentry, (c) enhancing cross-sector collaboration and communication, and (d) addressing contextual factors that prevent JIY from accessing services. Given perceptions of the intractability of ending the inmate exclusion, participants prioritized more incremental solutions.

They favored suspension-based (rather than termination-based) policies, which aligns with the endorsement of suspension by the Centers for Medicare and Medicaid and the National Commission on Correctional Health Care (NCCHC, 2019; Schwalbe *et al.*, 2012) and with the recent passage of the federal SUPPORT Act, which prohibits termination of Medicaid for justice-involved individuals under the age of 21 years (SUPPORT, 2018).

Of note, the SUPPORT Act also mandates each state, ''prior to the individual's release from such a public institution, conduct a redetermination of eligibility'' for JIY. However, the legislation does not prescribe specific pathways for reactivation and lacks an enforcement mechanism (SUPPORT, 2018). Only a small number of participants in our study were aware of the SUPPORT Act, indicating that policymakers and health and juvenile justice leaders will need to work closely together to ensure effective implementation.

As participants noted, improving cross-sector collaboration may facilitate effective solutions that improve Medicaid coverage for JIY. Efforts to better integrate

corrections, Medicaid, and health systems in the adult setting provide successful examples of how juvenile justice facilities can enhance interagency collaboration and communication to decrease Medicaid coverage gaps at reentry.

For example, the New York City jail system uses an electronic medical record system to share patient records between jail and community providers, facilitating communication that can be used to identify and remedy coverage gaps (Martelle *et al.*, 2015). Agencies in Arizona, California, Maryland, and Washington states have also undertaken efforts to improve linkages between health care and criminal justice organizations (Mallik-Kane *et al.*, 2018; Wishner & Mallik-Kane, 2017).

Given the much smaller number of incarcerated youth compared with adults (Kaeble & Cowhig, 2016; OJJDP Statistical Briefing Book, 2020), successful reforms in the adult correctional setting can serve as templates for similar reforms for JIY and may, in fact, be easier and less costly to implement. Furthermore, participant insight that diversion programs could prevent Medicaid gaps by preventing entry into the justice system reflects prior research on the societal benefit of diversion interventions (Wilson & Hoge, 2013).

Impact of Policy Change

The solutions suggested by participants to strengthen Medicaid coverage for JIY during reentry could have short-term and long-term public health benefits for JIY and their families (Albertson *et al.*, 2020). Policies aimed at reducing the time and logistical requirements of Medicaid reactivation could reduce the immediate administrative burden on health, social service, and justice agencies, as well as decrease the burden on JIY and families. In addition, ensuring Medicaid coverage is reactivated at the time of release would make it more likely for JIY to have access to medical and mental health care services and prescribed medications, which may improve youth's health outcomes and reduce recidivism.

The transition from adolescence to adulthood is a critical period of intervention (Loeber *et al.*, 2013). Intervention programs for JIY during reentry, including both mental health and substance use treatment programs, have been shown to reduce the risk of reoffending and provide long-term cost benefits (Sabol & Listenbee, 2014). Strengthening continuity of Medicaid coverage for JIY would help ensure access to these evidence-based interventions so that youth have the best chance to thrive.

Research Priorities

Findings indicate a need for future research to better describe the baseline characteristics of the Medicaid-eligible JIY population and current coverage patterns, and to measure how coverage and health outcomes are affected with implementation of reform. Although JIY are presumed to be predominantly low income with most qualifying for Medicaid, few published studies have measured the percentage of JIY who are reliant on Medicaid coverage as their primary source of insurance (Aalsma *et al.*, 2012; Zemel & Kaye, 2009b).

In addition, studies describing the prevalence and duration of Medicaid coverage gaps for JIY at reentry are lacking, as are studies quantifying the resultant impact of health care utilization and related health or justice outcomes. Furthermore, developing metrics capturing decreased prevalence and length of Medicaid coverage gaps at reentry, improved health status, decreased recidivism, and cost savings due to implementation could be useful for determining which policies are most successful and lead to more widespread adoption.

Limitations

Several limitations warrant mention. The purposive sampling approach may have introduced biases. Although we continued interviews until we reached and surpassed thematic saturation, it was not possible to account for all the nuances of Medicaid policy and practices by state and local jurisdictions. Since these were telephone interviews, rather than in-person interviews, trust may have also been an issue. Also, because the inmate exclusion impacts justice-involved adults as well, at times it was unclear which facets of the data were unique to JIY versus both JIY and justice-involved adults. Nevertheless, clear themes and policy recommendations emerged that participants felt warranted immediate attention in policy and practice.

Conclusions

Findings from the study suggest that feasible and impactful solutions for reducing Medicaid gaps for JIY during reentry exist. Moreover, these solutions could improve youth's health, reduce the risk of recidivism, and positively influence the developmental trajectories of JIY. Ultimately, reducing Medicaid coverage gaps for JIY may lead to not only more efficient health care use but also a more just approach. Promoting continuous Medicaid coverage at reentry for JIY signifies an opportunity to alleviate the underlying health disparities that lead to cycles of repeat incarceration.

Authors' Note

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Supplementary Material

Supplementary Appendix SA1

References

Aalsma, M. C., Anderson, V. R., Schwartz, K., Ouyang, F., Tu, W., Rosenman, M. B., & Wiehe, S. E. (2017). Preventive care use among justice-involved and non-justice-involved youth. *Pediatrics, 140*(5), e20171107. https://doi.org/10.1542/peds.2017-1107

Aalsma, M. C., Blythe, M. J., Tong, Y., Harezlak, J., & Rosenman, M. B. (2012). Insurance status of urban detained adolescents. *Journal of Correctional Health Care, 18*(4), 274–284. https://doi.org/10.1177/1078345812455629

Acoca, L., Stephens, J., & Van Vleet, A. (2014, May). *Health coverage and care for youth in the juvenile justice system: The role of Medicaid and CHIP* [Issue brief]. https://www.kff.org/wp-content/uploads/2014/05/8591-health-coverage-and-care-for-youth-in-the-juvenile-justice-system.pdf

Albertson, E. M., Scannell, C., Ashtari, N., & Barnert, E. (2020). Eliminating gaps in Medicaid coverage during reentry after incarceration. *American Journal of Public Health, 110*(3), 317–321. https://doi.org/10.2105/AJPH.2019.305400

Baglivio, M. T., Jackowski, K., Greenwald, M. A., & Howell, J. C. (2014). Serious, violent, and chronic juvenile offenders. *Criminology & Public Policy, 13*(1), 83–116. https://doi.org/10.1111/1745-9133.12064

Bandara, S. N., Huskamp, H. A., Riedel, L. E., McGinty, E. E., Webster, D., Toone, R. E., & Barry, C. L. (2015). Leveraging the Affordable Care Act to enroll justice-involved populations in Medicaid: State and local efforts. *Health Affairs, 34*(12), 2044–2051. https://doi.org/10.1377/hlthaff.2015.0668

Barnert, E. S., Perry, R., & Morris, R. E. (2016). Juvenile incarceration and health. *Academic Pediatrics, 16*(2), 99–109. https://doi.org/10.1016/j.acap.2015.09.004

Barrett, D. E., Katsiyannis, A., Zhang, D., & Zhang, D. (2014). Delinquency and recidivism: A multicohort, matched-control study of the role of early adverse experiences, mental health problems, and disabilities. *Journal of Emotional and Behavioral Disorders, 22*(1), 3–15. https://doi.org/10.1177/1063426612470514

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—A high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157–165. https://doi.org/10.1056/NEJMsa064115

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Butler, B., & Murphy, J. (2014). The impact of policies promoting health information technology on health care delivery in jails and local communities. *Health Affairs, 33*(3), 487–492. https://doi.org/10.1377/hlthaff.2013.1125

Constantine, R. J., Andel, R., Robst, J., & Givens, E. M. (2013). The impact of emotional disturbances on the arrest trajectories of youth as they transition into young adulthood. *Journal of Youth and Adolescence, 42*(8), 1286–1298. https://doi.org/10.1007/s10964-013-9974-9

Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014). Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: Results of a national survey. *Journal of General Internal Medicine, 29*(9), 1226–1233. https://doi.org/10.1007/s11606-014-2877-y

Hoeve, M., McReynolds, L. S., Wasserman, G. A., & McMillan, C. (2013). The influence of mental health disorders on severity of reoffending in juveniles. *Criminal Justice and Behavior, 40*(3), 289–301. https://doi.org/10.1177/0093854812459639

Jannetta, J., Dorn, S., Kurs, E., Reginal, T., Marks, J., Serafi, K., Guyer, J., & Cantrell, C. (2018). *Strategies for connecting justice-involved populations to health coverage and care* [Policy guide]. Urban Institute. https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf

Johnson, T. P. (2014). *Snowball sampling: Introduction*. Wiley StatsRef: Statistics Reference Online. https://doi.org/10.1002/9781118445112.stat05720

Kaeble, D., & Cowhig, M. (2016). *Correctional populations in the United States, 2016* (NCJ 251211). Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/cpus16.pdf

Loeber, R., Farrington, D. P., & Petechuk, D. (2013). *Bulletin 1: From juvenile delinquency to young adult offending (Study group on the transitions between juvenile delinquency and adult crime)* [Final technical report (NCJ 242931)]. National Institute of Justice. https://www.ncjrs.gov/pdffiles1/nij/grants/242931.pdf

Mallik-Kane, K., Jannetta, J., Hatry, H. P., Marks, J., & Reginal, T. (2018). *Measuring progress in connecting criminal justice to health: A how-to guide to performance management for practitioners* [Research report]. Urban Institute. https://www.urban.org/research/publication/measuring-progress-connecting-criminal-justice-health

Martelle, M., Farber, B., Stazesky, R., Dickey, N., Parsons, A., & Venters, H. (2015). Meaningful use of an electronic health record in the New York City jail system. *American Journal of Public Health, 105*(9), 1752–1754. https://doi.org/10.2105/AJPH.2015.302796

McReynolds, L. S., Schwalbe, C. S., & Wasserman, G. A. (2010). The contribution of psychiatric disorder to juvenile recidivism. *Criminal Justice and Behavior, 37*(2), 204–216. https://doi.org/10.1177/0093854809354961

Medicaid and CHIP Payment and Access Commission. (2018, July). *Medicaid and the criminal justice system* [Issue brief]. https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf

National Commission on Correctional Health Care. (2019). *Health care funding for incarcerated youth* [Position statement]. https://www.ncchc.org/health-care-funding-for-incarcerated-youth

Office of Juvenile Justice and Delinquency Prevention Statistical Briefing Book. (2020). *Estimated number of juvenile arrests, 2017*. https://www.ojjdp.gov/ojstatbb/crime/qa05101.asp?qaDate=2017&text=yes

Patel, K., Boutwell, A., Brockmann, B. W., & Rich, J. D. (2014). Integrating correctional and community health care for formerly incarcerated people who are eligible for Medicaid. *Health Affairs, 33*(3), 468–473. https://doi.org/10.1377/hlthaff.2013.1164

Ryan, J., Pagel, L., Smali, K., Artiga, S., Rudowitz, R., & Gates, A. (2016, June). *Connecting the justice-involved population to Medicaid coverage and care: Findings from three states* [Issue brief]. Kaiser Commission on Medicaid and the Uninsured. https://www.kff.org/medicaid/issue-brief/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-findings-from-three-states/

Sabol, W. J., & Listenbee, R. L. (2014). *Changing lives: Prevention and intervention to reduce serious offending* (NCJ 243993). Office of Juvenile Justice and Delinquency Prevention. https://www.ncjrs.gov/pdffiles1/nij/243993.pdf

Schubert, C. A., & Mulvey, E. P. (2014). *Behavioral health problems, treatment, and outcomes in serious youthful offenders* (NCJ 242440). Office of Juvenile Justice and Delinquency Prevention. https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/242440.pdf

Schwalbe, C. S., Gearing, R. E., MacKenzie, M. J., Brewer, K. B., & Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review, 32*(1), 26–33. https://doi.org/10.1016/j.cpr.2011.10.002

SUPPORT for Patients and Communities Act of 2018, Pub. L. 115-271 (10/24/2018).

Wang, E. A., Wang, Y., & Krumholz, H. M. (2013). A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: A retrospective matched cohort study, 2002 to 2010. *JAMA Internal Medicine, 173*(17), 1621–1628. https://doi.org/10.1001/jamainternmed.2013.9008

Wilson, H. A., & Hoge, R. D. (2013). The effect of youth diversion programs on recidivism. *Criminal Justice and Behavior, 40*(5), 497–518. https://doi.org/10.1177/0093854812451089

Winkelman, T. N. A., Frank, J. W., Binswanger, I. A., & Pinals, D. A. (2017). Health conditions and racial differences among justice-involved adolescents, 2009 to 2014. *Academic Pediatrics, 17*(7), 723–731. https://doi.org/10.1016/j.acap.2017.03.003

Wishner, J. B., & Mallik-Kane, K. (2017, January). *Information sharing between Medicaid and corrections systems to enroll the justice-involved*

population: Arizona and Washington: Medicaid areas of flexibility to provide coverage and care to justice-involved populations [Brief]. Urban Institute. https://www.urban.org/sites/default/files/publication/88046/info_sharing_2.pdf

Zemel, S., & Kaye, N. (2009a). *Findings from a survey of juvenile justice and Medicaid policies affecting children in the juvenile justice system: Inter-agency collaboration*. National Academy for State Health Policy. https://www.nashp.org/wp-content/uploads/2009/09/JuvJust.pdf

Zemel, S., & Kaye, N. (2009b). *Medicaid eligibility, enrollment, and retention policies: Findings from a survey of juvenile justice and Medicaid policies affecting children in the juvenile justice system*. National Academy for State Health Policy. https://www.nashp.org/wp-content/uploads/2009/12/MacFound11-09.pdf

Zemel, S., Mooney, K., Justice, D., & Baudouin, K. (2013). *Facilitating access to health care coverage for juvenile justice-involved youth*. National Academy for State Health Policy. https://www.nashp.org/wp-content/uploads/2014/03/Facilitating_Access_to_Health_Care_Coverage.pdf