Chapter 3:

Medicaid for Justice-Involved Youth Transitions to the Community

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Key Points

- The Medicaid program has historically played a limited role in the care of justice-involved individuals during incarceration. However, recent changes in federal Medicaid policy have provided opportunities to improve health care transitions for adults and youth returning to the community.
- Young people involved in the juvenile justice system, also referred to as justice-involved youth (JIY), are predominantly age 15 years or older and male. Youth of color; lesbian, gay, bisexual, transgender, and queer youth; and youth with disabilities are overrepresented in the juvenile justice system. JIY have high rates of unmet physical and behavioral health needs and frequently have complex and comorbid health conditions. They also experience considerable trauma, adverse childhood experiences, and chronic stress, which correlate with poor health outcomes into adulthood.
- States may use Section 1115 demonstration authority to provide limited prerelease services to incarcerated youth. The Consolidated Appropriations Act, 2023 requires states to provide certain screenings and diagnostic services to eligible youth 30 days before release and targeted case management services 30 days before release and for at least 30 days thereafter, beginning January 1, 2025.
- Examples of state challenges to providing prerelease services include enrolling correctional providers as Medicaid providers and establishing needed billing processes. In response, some states are developing guidance for new correctional providers and have engaged a third-party administrator for billing and technical assistance.
- Coordination between Medicaid and correctional agencies and facilities is key to implementing the new requirements. Such coordination has not historically been the norm, and states are working to improve interagency connections. Ongoing coordination challenges include engaging some local correctional facilities and data sharing between Medicaid and corrections.
- Despite challenges to service implementation and the complexities of serving JIY, several stakeholders that we interviewed expressed optimism about the opportunities that evolving federal Medicaid policies provide to better serve these youth and support transitions to the community.

CHAPTER 3: Medicaid for Justice-Involved Youth Transitions to the Community

This chapter describes findings from MACPAC's examination of access to pre- and post-release services for Medicaid-eligible juveniles or "youth" involved in the juvenile justice system.[1] MACPAC completed this work as a follow-up to the analysis on Medicaid for justice-involved adults that appeared in MACPAC's June 2023 report to Congress. That chapter examined adults' ability to access Medicaid coverage upon release from incarceration and state efforts to provide timely coverage, care continuity, and access to services upon reentry into the community. In that chapter, we identified key considerations for implementing prerelease Medicaid services under Section 1115 demonstrations such as cross-agency collaboration, availability of prerelease services in jails, data sharing and infrastructure, provider continuity during the pre- and post-release period, and monitoring and evaluation of the 1115 demonstration. We noted that instituting prerelease Medicaid services requires substantial investment of time and resources to improve outcomes for individuals involved in the criminal justice system (MACPAC 2023). This finding, as well as the coverage and access challenges for adults that we highlighted, provides important context for understanding the issues and health care needs of similarly situated youth.

Justice-involved youth (JIY) share some characteristics with adults in correctional settings, but the circumstances of youth differ from adults in meaningful ways that have implications for their coverage and access to services. JIY also have distinct clinical needs and considerations when compared to justice-involved adults partly due to their ongoing physical, cognitive, and emotional development. Youth who are involved in the juvenile justice system have high rates of unmet physical and behavioral health needs—including mental health conditions and substance use disorder (SUD)—compared to their non-incarcerated peers and frequently have complex and comorbid health conditions. These poor health outcomes are compounded for youth of racial and ethnic minority groups; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth; youth with disabilities; and youth with child welfare system involvement, all of whom are overrepresented in the juvenile justice system (Barnert et al. 2016).

States and the federal government have taken measures to improve health care transitions for JIY as they leave correctional settings and return to the community, a critical period that can have implications for future justice system involvement. Research indicates that connecting youth with services upon release can reduce youth recidivism, thus highlighting the importance of a successful transition for both youth and the community (Aggarwal and Will 2023). Although Medicaid has historically played a limited role in the care of justice-involved individuals during incarceration, recent federal policy has allowed states more flexibility to provide Medicaid services to JIY. For example, Section 5121 of the Consolidated Appropriations Act, 2023 (CAA 2023, P.L. 117-328) requires states to provide certain Medicaid-eligible incarcerated youth with screening and diagnostic services before release and targeted case management services before and after release (CMS 2024).[2] These new requirements went into effect in 2025. In this evolving policy space, federal and state stakeholders have made considerable progress implementing new requirements while navigating numerous challenges related to changed processes, technical systems issues, and coordination across agencies that serve JIY. State implementation of these requirements is in the early stages, and resulting data and outcomes that address access to care and supports during the transition to community have yet to emerge.

To understand federal statutes, regulations, and guidance pertaining to the provision of health care for incarcerated youth, including those reentering the community, MACPAC contracted with RTI International to conduct a policy scan of the relevant provisions. RTI also assisted MACPAC by conducting a literature review to understand the physical and behavioral health care needs as well as access to and utilization of health services among JIY. To gather

stakeholder perspectives on Medicaid coverage and health care needs of JIY, RTI conducted interviews with Medicaid and juvenile justice officials from five selected states (Maryland, Nebraska, New Mexico, North Carolina, and Washington), federal officials, policy and research experts, advocates and service providers, and individuals with lived experience in the juvenile justice system.

This chapter provides background on juvenile justice settings, detention rates, and lengths of stay, then summarizes the demographic characteristics and health needs of youth who are incarcerated or transitioning from incarceration. Next, the chapter describes federal Medicaid policy for JIY, including recent changes to smooth health care transitions for youth leaving correctional settings. The chapter then explores how state Medicaid agencies are approaching transition periods and describes state-reported efforts to implement new federal Medicaid policy as well as whether any access barriers to health services are unique to JIY.

Youth in the Juvenile Justice System

Juvenile justice settings for JIY can be broadly categorized into facility-based and community-based settings, with some overlap between the types of settings. In both categories, a range of programs and interventions focus on rehabilitating JIY and reintegrating them into the community.[3] Common judicial interventions for JIY include secure confinement (placement in a long-term secure facility or residential program), secure detention (short-term confinement while awaiting adjudication or other court decisions), probation (a court-imposed intervention during which youth remain at home under system supervision), or diversion (programs to redirect youth away from formal criminal prosecution and toward rehabilitative programs) (OJJDP 2024; AECF 2022, 2021a, 2021b). Despite declines in arrests and incarceration over the last two decades, disparities among youth in the justice system persist (Rovner 2025a, 2025b).

Facility-based settings

Juvenile correctional facilities are common placement settings for JIY; however, alternatives to secure confinement have been a key area of focus in recent years (OJJDP 2024, NASEM 2022). Examples of alternatives include group homes or halfway houses that offer a structured environment for smaller groups of youth by focusing on building life skills and education in a less restrictive setting than correctional facilities. Other residential facility options include boot camps, wilderness programs, and juvenile halls, which vary widely in duration and intensity (OJJDP 2024, Barnert et al. 2016).

More restrictive settings include juvenile detention centers, residential treatment centers (RTCs), and long-term secure facilities. Juvenile detention centers most commonly serve as short-term holding facilities for youth while they await processing or disposition of charges. However, some states also use detention centers to hold youth who have been found delinquent as they await long-term placement. RTCs are facilities that focus on providing services to youth with substantial behavioral health needs. However, RTCs have considerable variability in staffing, treatment modalities offered, and security, and are more likely to be operated by a private entity (OJJDP 2011). Long-term facilities, which can be hardware secure or staff secure, are settings where youth are typically confined for several months or more after adjudication, which is the court process that determines if the juvenile committed the act for which he or she is charged (OJJDP 2025a).[4] Both detention centers and long-term facilities are typically operated by state or local juvenile justice agencies or private providers.

Community-based settings

Community-based programs include probation and diversion programs that aim to divert youth from the juvenile justice system before formal adjudication. Probation is court-ordered supervision of JIY in the community and is often used as an alternative to incarceration; it is the most common outcome for youth referred to juvenile and criminal courts. Youth

on probation must comply with certain court-mandated conditions, such as school attendance, counseling, or community service. Aftercare, or post-release supervision, involves the supervised release of youth from a detention facility, typically after they have served a portion of their sentence. Diversion programs, such as pretrial or restorative justice programs, often involve community service or therapy.

Other community-based programs include mentorship programs, peer support groups, counseling, and vocational training (Goldner and Ben-Eliyahu 2021). These programs are designed to help JIY address behavioral health needs. They also provide structured, educational, and vocational training to improve youth's academic skills and strengthen job readiness (Cramer et al. 2019). Family-based interventions such as multisystemic therapy and functional family therapy are evidence-based interventions that aim to improve family functioning and address mental, emotional, and behavioral needs through face-to-face therapy, typically in a home setting (Gottfredson et al. 2018, Robst 2015). Numerous community-based programs have been shown to reduce juvenile justice recidivism (OJJDP 2024).

Detention rates and lengths of stay

National rates of youth incarceration have decreased in the past two decades. Between 2000 and 2023, the number of youth in juvenile justice facilities dropped from 108,800 to 29,300, which represents a 73 percent decline (Rovner 2025b). Additionally, the number of youth in adult facilities declined from 10,420 in 2008 to 2,250 in 2021 (Zeng et al. 2023). These declines are attributed to a number of factors, such as reduced juvenile arrests and sentence lengths, reform legislation that set priorities for diversion and community-based rehabilitation options over detention, and reduced arrests and use of incarceration during the COVID-19 pandemic in an effort to reduce transmission of the disease in facilities (Rovner 2025b, Harvell et al. 2022, NASEM 2022, Puzzanchera et al. 2022). However, a limited monthly survey conducted of approximately 150 jurisdictions in 30 states suggests that the number of youth in detention is rising to pre-pandemic levels (AECF 2022).

Lengths of stay in correctional settings vary. In detention centers, which are used for transitional confinement, a 2022 analysis of youth held in 32 states showed that the average length of stay in a detention center was 40 days. Male youth stayed longer at 44 days than female youth at 25 days. According to this research, the length of stay in detention ranged from less than 24 hours to 21 months. This analysis also found that the average length of stay for youth in correctional facilities (after adjudication) was 259 days, or about 8.5 months (PbS 2022). Similar to detention lengths of stay, male youth were confined to correctional facilities about 1.5 months longer at 262 days compared to female youth who were confined for 219 days. Data from this analysis also showed that the length of stay in correctional facilities ranged from 1 day to 2,406 days, or more than 6.5 years (PbS 2022).

JIY population characteristics

JIY are predominantly male, which is reflected across different stages of the juvenile justice system. For example, of 29,314 youth in residential placement in 2023, male youth accounted for 85 percent of the placements, with female youth accounting for the remaining 15 percent (Puzzanchera et al. 2025, OJJDP 2023a). Compared to their male counterparts, female youth were also less likely to be petitioned, adjudicated, detained, or committed into out-of-home placement after arrest for most categories of delinquent offenses (Ehrmann et al. 2019). Despite representing half of the overall youth population, male youth were also involved in 72 percent of delinquency cases handled by juvenile courts in 2022 (Hockenberry and Puzzanchera 2024a). JIY also tended to be older, with those age 15 and older accounting for 85 percent of youth in residential placement in October 2023 (OJJDP 2023b).

Despite recent declines in rates of incarceration nationally, disparities among youth in the justice system persist. Black youth, in particular, continue to be overrepresented in correctional placements (Figure 3-1) as well as other stages of the juvenile justice system.

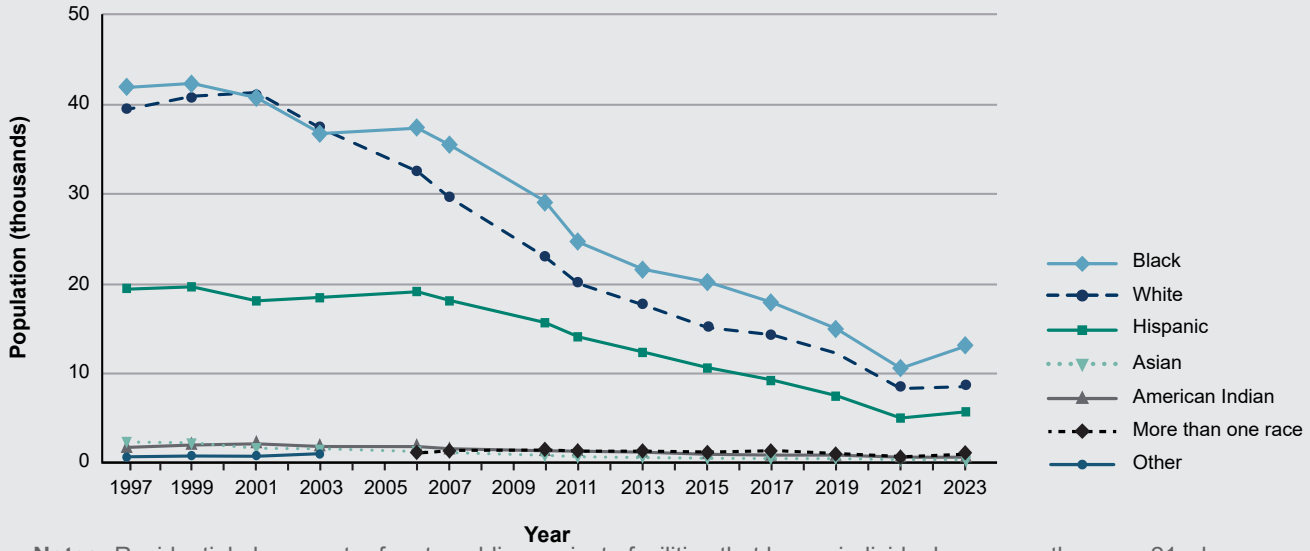
In 2023, Black youth were 5.6 times as likely to be placed in juvenile facilities as their white peers (Puzzanchera et al. 2025, Rovner 2025a). Additionally, based on 2023 data of placement in juvenile facilities, 46 percent of youth in these facilities were Black, despite Black youth comprising 15 percent of all youth across the United States. Black youth were also placed in juvenile facilities at a rate of 293 per 100,000 youth, compared to a white youth rate of 52 per 100,000 (Puzzanchera et al. 2025, Rovner 2025a).

Similar disparities played out in detention rates for Black youth as well as other groups, such as American Indian or Alaska Native youth. Although the detention rates for all racial and ethnic minority groups have declined since 2010, the detention rate for Black youth was almost eight times higher than the rate for white youth, and the rate for American Indian or Alaska Native youth was almost six times that of white youth in 2023 (Table 3-1) (OJJDP 2023c).

Additionally, research shows that youth of color are more likely to be formally prosecuted, referred to juvenile court, detained, petitioned, and charged as adults than white youth (Rovner 2025b, Ramos et al. 2022). This disparity also plays out in commitment rates for youth of color, which show that Black youth were 4.5 times as likely to be committed after adjudication than their white peers in 2023 (Table 3A-1) (OJJDP 2023d).

LGBTQ+ youth are also overrepresented in detention and other correctional settings (OJJDP 2014). Such youth are more likely to have contact with law enforcement than their heterosexual and cisgender peers and more likely to face arrest, including for minor offenses such as loitering (Ramos et al. 2022). Additionally, studies indicate that youth with disabilities are overrepresented in the juvenile justice system (OJJDP 2025b, 2017a). For example, one study estimates that 65 to 70 percent of JIY meet the criteria for a disability, which is more than three times higher than the general population (The Arc 2015). The disabilities among these youth include physical, learning, social-emotional, mental health, and intellectual and developmental disabilities (The Arc 2015).

FIGURE 3-1. Youth in Residential Placement by Race and Ethnicity, All Offenses, 1997–2023



Notes: Residential placement refers to public or private facilities that house individuals younger than age 21 who were charged with an offense or adjudicated for an offense. American Indian includes Alaska Native; Asian includes Pacific Islander.

Source: Puzzanchera et al. 2025.

Health Needs of Youth Involved with the Juvenile Justice System

Youth who are involved in the juvenile justice system have high rates of unmet physical and behavioral health needs compared to their non-incarcerated peers and frequently have complex and comorbid health conditions (Barnert et al. 2016). JIY also experience much more trauma, adverse childhood experiences, and chronic stress than other youth, which correlate with poor health outcomes, such as hypertension and cognitive difficulties, and future justice system involvement (NASEM 2022). Additionally, research finds that poor health outcomes among JIY persist into adulthood (Barnert, Abrams, and Dudovitz 2019; Barnert, Dudovitz, and Nelson 2017).

TABLE 3-1. Detention Rates by Race and Ethnicity, 1997–2023

Year	Detention rate (per 100,000 youth)						Ratio of detention rates relative to white youth				
	White	Black	Hispanic	AI/AN	API	More than one race	Black	Hispanic	AI/AN	API	More than one race
1997	54	264	122	125	48	–	4.9	2.3	2.3	0.9	–
1999	54	258	116	113	41	–	4.8	2.1	2.1	0.8	–
2001	52	223	109	112	37	–	4.3	2.1	2.2	0.7	–
2003	47	210	102	110	36	–	4.5	2.2	2.3	0.8	–
2006	43	221	97	116	26	–	5.1	2.3	2.7	0.6	–
2007	40	215	90	93	21	–	5.4	2.3	2.3	0.5	–
2010	34	192	78	103	17	22	5.6	2.3	3.0	0.5	0.6
2011	32	183	68	104	14	23	5.7	2.1	3.3	0.4	0.7
2013	30	179	60	87	11	27	6.0	2.0	2.9	0.4	0.9
2015	26	166	50	86	8	28	6.4	1.9	3.3	0.3	1.1
2017	27	165	44	96	9	24	6.1	1.6	3.6	0.3	0.9
2019	23	152	41	105	9	20	6.6	1.8	4.6	0.4	0.9
2021	18	116	24	87	5	15	6.4	1.3	4.8	0.3	0.8
2023	19	149	29	108	6	19	7.8	1.5	5.7	0.3	1.0

Notes: AI/AN is American Indian or Alaska Native. API is Asian or Pacific Islander. White, Black, and API racial groups exclude persons of Hispanic ethnicity. Until 2006, the Census of Juveniles in Residential Placement (CJRP) collected six detailed race and ethnicity categories (white, Black, Hispanic, American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander) and an "other" category. In 2006, the other category was replaced with "two or more races" (labeled here as "more than one race"). Rates for the more than one race category are displayed only for 2010 to the present.

Detained youth include youth being held as they wait for a court hearing, adjudication, disposition, or placement elsewhere. The detention rate is the number of youth in residential placement on the CJRP reference date per 100,000 youth age 10 through the upper age of original juvenile court jurisdiction.

The ratio of detention rates was created by dividing the rates for each racial or ethnic minority group by the white rate. A ratio of 1.0 indicates the rates for the comparison group are equal. For example, if white and Black youth were detained at the same rate, the ratio would be 1.0. A ratio greater than 1.0 means that the rate for the racial or ethnic minority group is greater than the rate for white youth. A ratio less than 1.0 means that the rate for the racial and ethnic minority group is less than the rate for white youth.

– Dash indicates omitted data.

Source: OJJDP 2023c.

Physical health conditions

Incarcerated youth have high rates of unmet physical health needs and higher mortality rates compared to the general youth population (Barnert et al. 2016). Youth with Medicaid coverage who enter the juvenile justice system often do so behind schedule on basic services such as well-child visits. As a result, many JIY are not up to date on recommended screenings (and subsequent assessments and treatment, as needed) for physical, developmental, social, behavioral, and mental health; hearing and vision; lead exposure; and speech and language. They are also more likely than other children to not have received needed routine childhood immunizations, preventive and restorative dental care, and eye care, including corrective lenses. JIY also need reproductive health services, which are not consistently provided in correctional settings (Barnert et al. 2016). Despite such needs, individuals with lived juvenile justice experience whom we interviewed cited difficulty obtaining medical care in the correctional facilities where they were held. For example, one individual noted that youth seeking health care were not believed that the service was needed, were punished for seeking care, or were not seen quickly unless it was an emergency.

In addition to an unmet need for routine care, some youth enter the juvenile justice system with chronic conditions such as asthma, diabetes, seizure disorders, and sickle cell disease as well as infectious diseases. These conditions are often undermanaged or undiagnosed in the JIY population, which can lead to serious consequences (Barnert et al. 2016). Researchers, state officials, and an individual with lived juvenile justice experience indicated that JIY also have emergency care needs, often arising from violence-related injuries. Beyond the need for health services, JIY need supports that address health-related social needs such as affordable and nutritious food, safe housing, employment assistance, and education to prepare them for reentry into the community.

Behavioral health conditions

Most youth in correctional settings have behavioral health needs. Studies estimate that 70 percent of JIY have a mental health condition, and more than 50 percent meet the criteria for an SUD (Cronin-Furman et al. 2023, Field et al. 2023). Other research notes that about two-thirds of youth in correctional settings have at least one diagnosable mental health issue, compared to an estimated 9 to 22 percent of the general population (OJJDP 2017b, Schubert 2014). Common diagnoses include depression, attention deficit hyperactivity disorder, posttraumatic stress disorder, anxiety disorder, conduct disorder, and SUD (Barnet et al. 2016, Shufelt and Cocozza 2006).

Despite the needs of this population, efforts to screen for appropriate services are mixed across correctional facilities.[5] For example, in a 2020 survey of residential placement facilities that held youth charged with or adjudicated for law violations, 76 percent of the facilities that reported information about substance use said that they evaluated all youth for SUD, 9 percent said they evaluated some youth, and 15 percent said they did not evaluate any youth. Seventy-four percent of facilities that responded to mental health evaluation questions reported that a mental health practitioner working in the facility evaluated all youth for mental health needs. However, detention centers reported much lower rates; only 55 percent of these responding facilities reported screening all youth for mental health needs. Nearly all facilities (96 percent of respondents who reported information on suicide screening) said that they evaluated all youth for suicide risk (Hockenberry and Sladky 2024b). Although federal data show high levels of behavioral health screening, a 2019 meta-analysis found that only 32.6 percent of detained or incarcerated youth obtained SUD or mental health services while incarcerated (White et al. 2019).

Other considerations for JIY

Although JIY share similarities with justice-involved adults in terms of unmet health needs, they have unique considerations that have implications for the nature of the care needed as well as access to services.

Child development needs. Youth have distinct clinical needs when compared to adults, partly because they are still physically, cognitively, and emotionally developing. These needs range from basic childhood care, such as routine child screenings and immunizations, to complex, trauma-informed mental health care. Trauma-informed care is particularly important to address adverse childhood experiences, such as growing up in a household with substance

use and mental health challenges, as well as the trauma that can be caused by justice system involvement. For example, an individual with lived juvenile justice involvement whom we interviewed noted that the experience of being incarcerated and the conditions in correctional settings create additional trauma at a formative time in the youth's life.

Educational needs. Youth have educational needs that must continue to be met while they are detained. If the JIY has been identified as needing special education and has an individualized education program (IEP), it must be sent to the correctional facility where the youth is held, and services under the IEP must be provided.[6] Although the educational services received in a correctional facility must be comparable to the services that the youth received in their school, an advocate we interviewed indicated that correctional facilities are not always equipped to carry out special education requirements (OSERS 2014).

Child welfare system involvement. Youth involved in the justice system may be simultaneously involved with the child welfare system. According to research, these dually involved youth make up as much as 55 percent of the juvenile justice system population, and an estimated 9 to 29 percent of youth involved in the child welfare system also become involved with the juvenile justice system (Puzzanchera et al. 2022, Herz 2010). The health needs of these youth may be exacerbated by stress or trauma related to family disruption.

Parental consent. Legal requirements for medical consent shape care for JIY. Youth depend on their parents or guardians for access to health care and require their consent to care in many circumstances. The laws for health care consent for JIY can differ across states and even within a state. For example, a state juvenile justice official whom we interviewed explained that the corrections system in their state may be able to provide consent for the youth to obtain basic health services, but parental consent is required for psychiatric medications if youth are younger than age 16.

Federal Medicaid Policy for Justice-Involved Youth

Most JIY are likely eligible for Medicaid; however, federal policies have historically limited Medicaid's role in providing coverage and paying for health services for youth in juvenile facilities (Barnert et al. 2016, Acoca et al. 2014). Section 1905(a)(32)(A) of the Social Security Act prohibits the use of federal Medicaid funds for health care services for Medicaid enrollees when they are inmates of public institutions, except in cases of inpatient care lasting 24 hours or more.[7] This payment prohibition is commonly referred to as the "inmate payment exclusion," and it applies to youth as well as adults. As such, Medicaid generally covers health care services for eligible and enrolled youth when they are on parole and probation, while correctional authorities (e.g., counties and state departments of corrections) typically pay for health care costs during confinement in juvenile detention facilities.[8] Even with Medicaid's limited role during incarceration, it is an important source of coverage for eligible youth released into the community. Additionally, there have been several federal policy changes in recent years in an effort to address the unmet need of this population and improve health care transitions for incarcerated youth.

Suspending Medicaid coverage

Section 1001 of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) prohibits states from terminating Medicaid eligibility for an eligible juvenile who becomes an inmate of a public institution and instead requires states to suspend the youth's Medicaid coverage for the duration of their incarceration (CMS 2023b, 2021).[9] Suspended coverage requires reactivation or reinstatement, while terminated coverage requires submission of a new application. In providing guidance to states on this provision, the Centers for Medicare & Medicaid Services (CMS) indicated that suspending Medicaid eligibility for eligible youth assists with timelier and streamlined reinstatement of coverage for them upon release from incarceration (CMS 2021).[10] Suspension

can reduce administrative burden for both states and eligible youth while also ensuring access to essential health services more quickly in the days after release. The SUPPORT Act also requires states to process Medicaid applications submitted by or on behalf of JIY while they are incarcerated and redetermine eligibility (without requiring a new application) of certain eligible juveniles before their release (CMS 2021).[11]

Section 1115 reentry demonstrations

Section 5032 of the SUPPORT Act directed the Secretary of the U.S. Department of Health and Human Services (HHS) to convene stakeholders to develop best practices for states to ease health care–related transitions for incarcerated individuals to the community and to develop a report to Congress. This report, which the HHS Office of the Assistant Secretary for Planning and Evaluation submitted in January 2023, identified a number of health coverage challenges for individuals reentering the community as well as best practices to assist with coverage and care upon reentry (ASPE 2023).[12] The SUPPORT Act also directed HHS, through CMS, to issue guidance on Section 1115 demonstration opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration and to base this guidance on the best practices identified in the report to Congress. In April 2023, CMS issued this guidance, which describes how states can receive federal financial participation (FFP) for certain prerelease services for up to 90 days before the incarcerated individual's expected date of release through a Section 1115 demonstration (CMS 2023a). Under such a demonstration, states must provide case management, medication-assisted treatment services, and a 30-day supply of prescription medications upon release, at a minimum. However, states can elect to cover additional prerelease services in their demonstrations. CMS's guidance further provides that states with approved demonstrations will be expected to conduct interim and summative evaluations. In designing the evaluation, states may include how they will test whether the demonstration improved care transitions for individuals released from incarceration, including whether and how the demonstration improved coverage and quality of care.[13] States are required to submit an interim evaluation report one year before expiration of the demonstration or when the state submits a request to extend the demonstration. The state is also required to submit the summative evaluation report within 18 months after the demonstration period ends (CMS 2023a).

As of January 2026, 19 states have approved reentry demonstrations; of these, 14 states include JIY in their demonstration covered populations.[14] An additional eight states and the District of Columbia—six of which include JIY—have pending reentry demonstrations.[15] Table 3-2 describes key characteristics of the approved and pending reentry demonstrations that include youth populations.

Mandatory pre- and post-release services for youth

Section 5121 of the CAA 2023 requires state Medicaid programs, beginning January 1, 2025, to provide certain screenings and diagnostic services to eligible youth (i.e., post-adjudicated youth younger than age 21 or youth formerly in foster care younger than age 26) in public institutions in the 30 days before release.[16] If the state is not able to provide these screenings before release, the statute specifies that the state must provide them not later than one week or as soon as practicable after release.[17] Section 5121 of the CAA 2023 also requires states to provide Medicaid-eligible youth targeted case management services in the 30 days before release and for at least 30 days thereafter. States must submit a state plan amendment to CMS for approval before implementing these required services. The requirements for pre- and post-release services also generally apply to JIY eligible for the State Children's Health Insurance Program (CHIP). Additionally, the CAA 2023 provisions align CHIP rules with existing Medicaid rules regarding suspension rather than termination of coverage while the youth is an inmate of a public institution.

TABLE 3-2. Characteristics of Approved and Pending State Section 1115 Reentry Demonstrations that Include Youth Populations as of January 2026

Characteristic	Approved states	Pending states
Eligibility		
All youth	AZ, CA, CO, HI, IL, KY, MA, MI, NC, NM, OR, UT, VT, WA	AR, CT, DC, ME, NV
Youth with certain medical diagnoses		NJ[1]
Duration of prerelease coverage		
60 days	KY	NJ
90 days	AZ, CA, CO, HI, IL, MA, MI, NC, NM, OR, UT, VT, WA	AR, CT, DC, ME, NV
Benefits		
Mandatory benefits only	CO, KY	NJ
Additional covered services	AZ[2], CA, HI[2], IL, MA, MI[2], NC[2], NM, OR, UT, VT[3], WA	AR[4], CT[5], DC[6], ME[7], NV[8]
Additional covered services offered		
Lab and radiology	CA, HI, IL, MA, MI, NC, NM, OR, UT, WA	CT, NV
Durable medical equipment	CA, HI, IL, MA, MI, NC, NM, UT, WA	CT
Community health worker services	CA, IL, NM, OR, UT, WA	CT, ME, NV
Family planning	NM, OR, UT	CT, ME
Treatment for hepatitis C	NM, UT, VT	CT, ME
Medications and medication administration	CA, IL, MA, MI, NC, NM, OR, UT, VT, WA	CT, NV
Tobacco cessation	NC	
Peer support services	AZ, HI, NM, OR, UT, VT	DC, ME, NV
Clinical consultation services	CA, MA, NM, OR, UT, WA	CT, ME, NV

Notes:

[1] New Jersey's Section 1115 demonstration proposal requests authority to provide limited Medicaid services for incarcerated individuals who meet the criteria of having a behavioral health diagnosis.

[2] The Section 1115 demonstrations in Arizona, Hawaii, Michigan, and North Carolina specify that the states also offer practitioner office visits (e.g., physical exam, wellness exam, evaluation and management visit, mental health or substance use disorder treatment, therapy, or counseling).

[3] Vermont's Section 1115 demonstration specifies that the state also offers screening for common health conditions.

[4] Arkansas's pending Section 1115 demonstration specifies that the state plans to provide all state plan services, including medication-assisted treatment and counseling, 30-day supply of prescription drugs upon release, and case management.

[5] Connecticut's pending Section 1115 demonstration waiver specifies that the state will also offer screening for common health conditions, such as high blood pressure, diabetes, hepatitis C, and HIV, within the incarcerated population.

[6] The District of Columbia's pending Section 1115 demonstration specifies that it will also offer comprehensive behavioral and physical health screenings; counseling and therapy; and intensive, family-based services for youth.

[7] Maine's pending Section 1115 demonstration specifies that the state will also offer HIV care.

[8] Nevada's pending Section 1115 demonstration waiver specifies that the state will also offer treatment for HIV.

Sources: MACPAC analysis of state Medicaid Section 1115 reentry demonstration documents as of January 2026; KFF and The Health and Reentry Project.

Optional pre-adjudication services for youth

Section 5122 of the CAA 2023 provides states the option, beginning January 1, 2025, to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth held in public institutions before adjudication. CMS's July 2024 guidance notes that a state electing this optional coverage would be required to provide Medicaid and CHIP services that an eligible juvenile would otherwise be entitled to if not for incarceration, for the duration of the prerelease period pending disposition of charges, regardless of the type of correctional facility in which they are confined. CMS encourages states covering the optional prerelease services to collaborate closely with the juvenile and adult justice systems to ensure that coverage of such services "does not effectuate a delay of an individual's release or lead to increased involvement in the justice systems" (CMS 2024).

State planning grants

Section 206 of the Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42) authorized CMS to make planning grants available to states for activities and expenses related to complying with the prerelease screening, diagnostic, and case management services requirements under the CAA 2023.[18] In particular, state Medicaid and CHIP agencies can use the planning grants to develop operational capabilities to promote continuity of care for eligible justice-involved individuals, including youth after incarceration in state-operated prisons; local, tribal, and county jails; and youth correctional or detention facilities. These grants can also be used to identify and address operational gaps to comply with the statutory requirements. CMS provided specific examples of uses for the funds, such as establishing standardized processes and automated systems for determining Medicaid and CHIP enrollment status of inmates and investing in information technology (IT) to enable bidirectional information sharing between relevant entities to support care transitions among other permissible uses (CMCS 2024, CMS 2025).[19] In two rounds in 2025, CMS awarded these grants, ranging from $1.2 million to $5 million, to 27 states, the District of Columbia, and Puerto Rico.[20]

State Implementation of Federal Medicaid Policy

In light of evolving federal Medicaid policy for JIY in recent years, the states that we spoke with reported efforts to implement the changes and navigate challenges to serve these youth. Such efforts include suspending Medicaid eligibility for incarcerated youth and implementing required pre- and post-release services for JIY per the CAA 2023. Such officials also noted challenges to these efforts, such as establishing Medicaid billing for correctional facilities, but are identifying approaches to support the facilities in this role.

Suspending Medicaid coverage

States' past experiences suspending Medicaid for incarcerated individuals informed their ability to implement suspensions for youth. States reported using automated or manual approaches to suspend Medicaid and experienced challenges with the complexity of implementing suspension processes and engaging local correctional facilities in suspension efforts.

Past state experience with suspension. In some states, past experience implementing Medicaid suspension for incarcerated populations is informing their current juvenile justice efforts. For example, Maryland Medicaid officials noted that the state has had a suspension process in place for adults for many years that they have refined and recently applied to the JIY population. New Mexico Medicaid officials reported that the state has been suspending Medicaid coverage for incarcerated individuals as part of a health program for inmates that the state developed in 2014.[21] Since then, New Mexico's systems suspend coverage for Medicaid-eligible individuals after 30 consecutive days of incarceration, while also ensuring that the state does not provide coverage or pay claims during those 30 days. Similarly, Washington state has been suspending Medicaid coverage for adults and youth who enter a correctional facility since 2017, per state legislation enacted in 2016.[22]

Automated versus manual suspension processing. The states we contacted also varied in the extent to which their suspension processes were automated or manual or involved both approaches. For example, officials from one state indicated that the Medicaid program receives an automated file from the state's juvenile services department to suspend coverage and another file from that department to indicate who is being released from state custody to have their coverage reinstated.

Some states indicated that they use both automated and manual processes for suspending youth Medicaid coverage. Medicaid officials in one state said that although processes for suspension and reinstatement of coverage for JIY are largely automated, the state continues to support processes for manual workarounds, in case they become necessary. For example, if the automated process misses that the youth is being transferred to a different type of facility, rather than returning to the community, the state uses manual processes to ensure that the coverage remains suspended.

In some states, manual suspension processing is necessary due to the lack of an automated file exchange between the state Medicaid agency and some juvenile justice agencies or facilities or adult correctional facilities that hold youth. For example, Medicaid officials in one state reported that using an automated or manual suspension process depends on whether the Medicaid agency has an electronic file exchange arranged with the correctional facility. These officials noted that this automated file exchange is in place with the state agency administering the juvenile justice system and some, but not all, facilities. Since the file exchange is not in place across all facilities, the juvenile justice agency provides the state Medicaid agency a weekly population report that identifies all juveniles who are incarcerated in the county detention centers as well as in the state's long-term correctional facilities. Medicaid staff must manually enter this information into the eligibility system, which processes the suspension automatically. In two of the states that we interviewed, Medicaid officials indicated that although they have automated suspension processes in place for adults, the process for suspending Medicaid coverage for youth remains manual. In one of these states, individual facilities notify the Medicaid agency to suspend coverage for youth entering their facilities. In the other state, the Medicaid agency tracks post-adjudicated youth to manually process suspensions as well as other activities associated with the youth, such as coverage renewals and reinstatements.

Complexity with suspending coverage. State officials described some of the complexities they face with implementing suspension processes. For example, one state indicated that because different authorities in the state administer adult and juvenile corrections, the Medicaid program must navigate different eligibility rules for adults and youth to enable new suspension processes. Several state officials also noted that reinstatement of Medicaid coverage for JIY is further complicated by unpredictable release dates, especially in settings such as jails, where stays are shorter and variable.

Engaging facilities in suspension efforts. Engaging local correctional facilities has had implications for implementing suspension processes. For example, Medicaid officials in one state explained that they receive little information about incarcerated youth from the local jails in the state because each jail is run at the county level, and there is not a central agency that collects their data. As such, the Medicaid program must reach out to each jail to collect information on youth incarcerations. Officials in this state added that it has been difficult to persuade jails to provide what is needed to serve these youth and implement suspension processes.[23] Another Medicaid official noted that there are no efforts to suspend Medicaid coverage for youth at the local and county levels in their state. In the local and county facilities, youth tend to have shorter stays of less than 30 days and are pre-adjudicated. Thus, this state's Medicaid program does not suspend the youth's coverage, but it opted to implement Section 5122 of the CAA 2023 to maintain the full Medicaid benefit for these pre-adjudicated youth.[24]

Implementing pre- and post-release services

Although it is still early in the implementation of Section 5121 of the CAA 2023, states are working with CMS to implement the required pre- and post-release services under different approaches, often using managed care, to serve JIY. States reported that they are implementing services incrementally (or among a subset of facilities), providing services but not billing Medicaid, or providing services as part of their Section 1115 reentry demonstration waiver. In their implementation efforts, states also reported challenges related to enrolling correctional providers as Medicaid providers and establishing processes for them to bill Medicaid in accordance with program requirements.

State approaches. States' implementation efforts to support JIY are as unique as the states in which they operate. For example, Washington state Medicaid officials reported that the state received approval from CMS to implement Section 5121 pre- and post-release services incrementally as part of the state's Section 1115 reentry demonstration.[25] Washington launched services in juvenile detention facilities in July and November 2025 and January 2026 and will add more facilities in March and July 2026, according to officials.[26] New Mexico Medicaid officials also reported their plans to cover Section 5121 services for youth through the state's Section 1115 reentry demonstration once all facilities are incorporated in the demonstration.[27]

Maryland's efforts to implement pre-release services reflect the state's practice of providing screening and diagnostic services for JIY when they first arrive at a juvenile facility, as opposed to 30 days before release as required by the CAA 2023. State officials noted that these services are not billed to Medicaid, and CMS guidance recognizes situations in which an eligible youth may be screened upon entry to the correctional facility and be considered in compliance with the CAA 2023.[28] Similarly, New Mexico Medicaid officials reported that the state's juvenile correctional facilities provided pre- and post-release services to JIY but were not permitted to bill Medicaid until the state received CMS approval in December 2025. Officials added that the state's juvenile justice agency and correctional facility staff were already providing many of these services to JIY. The only difference since CMS's approval is that the correctional facilities are now permitted to bill Medicaid.

Managed care. States leverage managed care to provide targeted case management, which the CAA 2023 requires as pre- and post-release services. For example, Washington opted to provide pre- and post-release services through their managed care organizations (MCOs) to help with continuity of care for JIY because many of them transition into the correctional system for short periods of time. New Mexico Medicaid officials reported that their MCOs include a position called a "justice liaison" that helps youth, as well as adults, make connections with care coordinators before release. The justice liaison helps both the youth and care coordinator prepare for discharge by entering the juvenile facility to start a transition of care assessment and plan before release. As a result, officials noted that when the JIY leaves the facility, they have their plan and any prescription medications so that they can continue to receive the services in the community.

Provider enrollment and billing challenges. State officials described challenges enrolling correctional providers as Medicaid providers and establishing billing processes in light of technical limitations. In some cases, these challenges arise due to unfamiliarity with how to bill for Medicaid with the required documentation. For example, although one state's Medicaid officials reported that they have been successful in creating a correctional provider type for providers who can bill Medicaid, it has been a challenge because the providers were unfamiliar with how to bill for services generally, and they tended to primarily use paper records for JIY. Washington Medicaid officials also cited their efforts to ensure newly enrolled correctional providers understand new processes and are supported as they bill Medicaid. These efforts include the state's development of in-depth billing guidelines for the CAA 2023 and Section 1115 demonstration benefits as well as retaining a third-party administrator to help the facilities and community providers serving JIY with billing and technical assistance. Officials consider this addition as a major operational component that essentially serves as a billing clearinghouse for the juvenile correctional facilities.

Federal officials noted that many juvenile justice facilities lack the technology and infrastructure needed to bill Medicaid for the pre-release services, thus challenging a state's ability to establish Medicaid billing processes for correctional providers. For example, New Mexico Medicaid officials noted that it has been difficult to ensure that the juvenile correctional facilities have the appropriate billing and electronic health records systems that they need to provide health care services and bill for Medicaid for them. According to these officials, the correctional facilities may not know that they need to upgrade their systems to enable the facility to receive and process information or that a system is needed for electronic medical records. New Mexico officials added that they are enrolling correctional providers in Medicaid as the state upgrades its Medicaid eligibility and provider payment systems, thus contributing to the complexity of adding new Medicaid providers and automating certain functionality until the new provider payment system is in place.

Cross-System Coordination for Serving JIY

Transitioning JIY from correctional settings to the community and ensuring access to Medicaid services requires coordination among state Medicaid, juvenile justice, child welfare, behavioral health, and other youth-serving systems. State officials face challenges to interagency coordination, including the complexity of arrangements, data sharing, and achievement of participation across correctional facilities.

Interagency relationships

Section 5121 of the CAA 2023 placed new requirements on state Medicaid agencies, but juvenile justice agencies, as well as adult correctional facilities that hold youth, play a critical role in implementing and operationalizing the necessary activities to fulfill the requirements. Several state officials whom we interviewed noted that partnerships and cross-system collaboration among these agencies, as well as child welfare, behavioral health, and other youth-serving systems, are key for implementation of the CAA 2023 provisions. State officials reported focusing on building the relationship between Medicaid and correctional agencies.

In some cases, state Medicaid agencies' existing relationships with the corrections agency helped with their ability to implement CAA 2023 requirements. For example, New Mexico's Medicaid and corrections agencies maintain a strong partnership since developing and implementing a targeted health program for incarcerated individuals in 2014. In addition, the agencies and long-term juvenile correctional facilities are in regular communication with each other as part of their work on an electronic file exchange. Washington Medicaid officials indicated that they rely on their existing relationship with the state's juvenile court administration association, which administers the juvenile correctional system, to build connections with other reentry stakeholders and achieve buy-in from the correctional facilities on the Medicaid agency's approach for implementing CAA 2023 requirements.

Ongoing coordination

State Medicaid and correctional agencies and facilities reported regular touchpoints to establish new processes needed to implement pre- and post- release services for JIY. For example, Maryland Medicaid officials noted that the Medicaid agency meets weekly with its correctional partners for both the Section 1115 demonstration and CAA 2023 work, including regular subgroup meetings on specific issues, such as legal requirements for data, that have helped protect sensitive juvenile information and increased data sharing across systems. Washington Medicaid officials also cited regular meetings between the Medicaid agency and the correctional facilities to discuss any operational questions and ensure compliance with the CAA 2023. In such meetings, the state Medicaid agency and third-party administrator answer questions and provide support as the facilities take on new tasks of screening for Medicaid eligibility, helping youth select managed care plans, and assisting with Medicaid applications. State Medicaid officials indicated that the team provides guidance and support to ensure that the facilities are comfortable with this new role.

Facility engagement

Although the CAA 2023 established requirements for state Medicaid agencies, it did not establish direct requirements for correctional facilities. As such, some officials noted the challenge of engaging some correctional facilities, even with the creation of new interagency connections. For example, officials in one state explained that correctional facilities are not mandated to attend meetings on CAA 2023 implementation and that different jurisdictions in the state have varying levels of interest in participating. Thus, the Medicaid agency has not been able to involve all correctional facilities at the local level. Another state similarly noted that there is no mandate to participate in the educational sessions that the state's Medicaid agency has developed for correctional facilities. As a result, officials noted that youth are "falling through the cracks" in some juvenile detention centers that have not engaged with the state and are not receiving prerelease services. Additionally, with correctional facilities facing a number of other state initiatives, they may not set priorities for Medicaid initiatives to transition released youth into the community.

Data sharing and systems

Barriers to data sharing between Medicaid and correctional agencies and facilities include technical complexity, use of paper (versus electronic) medical records in juvenile facilities, and limited funding for data infrastructure improvements. For example, one state official reported that the state has nearly 100 jails, each with its own data system for tracking inmates. The state is trying to build a centralized system but has faced difficulties consolidating the data from that number of facilities. Another state cited the challenge of sharing clinical information with community providers because most correctional facilities do not have electronic health records. An official from another state noted that the state has an outdated eligibility system that requires a substantial build but has not been able to set priorities for system upgrades. As a result, sharing data for Medicaid suspension and reactivation of coverage are cumbersome, manual processes in the state.

CMS officials whom we interviewed recognize that states may require additional support to improve their data infrastructure. These officials noted that potential resources for funding state data and infrastructure projects include Health Information Technology for Economic and Clinical Health Act funds, enhanced FFP for IT system expenditures with an Advance Planning Document, and implementation grants provided under the CAA 2024.

Complexities of Serving JIY

The suspension requirements established by the SUPPORT Act, the CAA 2023 requirements for pre- and post-release services for JIY, Section 1115 reentry demonstrations, and cross-agency coordination efforts provide opportunities to connect JIY with services and smooth their transition to the community. Even with these opportunities, officials whom we interviewed noted a number of complexities that can affect JIY's access to services, such as insufficient staffing, complex health conditions, and the availability of Medicaid providers. The frequent changes in placement that JIY experience and the involvement of their families can also present challenges to serving these youth.

Correctional staffing

Many youth detention facilities have an insufficient medical, therapeutic, and correctional workforce due to challenges with staff recruitment and retention. Federal and state officials as well as researchers and providers we spoke with noted that staffing shortfalls result in long wait times for necessary screenings and services in facilities and limited ability to transport youth to community-based appointments. Although officials described using telehealth to mitigate this issue, they noted that telehealth requires access to IT hardware and software, reliable broadband access, and a private space, which are not always available in juvenile correctional facilities. Interviewees also noted that recruitment for correctional health care providers can be challenging because these roles lack occupational prestige and are often located in rural, low-resource areas of the state. This scarcity is amplified when focusing on behavioral health providers. A federal

official mentioned the logistical and security rules that community-based providers must follow to enter justice facilities, including background checks, prescreening steps, dress code requirements, and security protocols. Workforce challenges extend beyond the facilities and affect probation and community-based services. Frequent turnover of probation officers can hinder youth's ability to access care after release, because youth may struggle building trust with new officers and may be less likely to express health needs. A shortage of probation officers also limits the resources available to support youth in accessing medical appointments.

Complex conditions

As noted above, JIY have complex and co-occurring health conditions and substantial behavioral health needs.[29] Such behavioral health conditions can be connected to trauma and adverse childhood experiences that are prevalent among JIY, prompting their need for trauma-informed care. A Medicaid official whom we spoke with indicated that the program must periodically consider whether its provider network is adept at addressing its population's needs when it encounters JIY who have considerable health concerns or who present with comorbidities. Additionally, such complex needs often translate to high health care and medication costs. Officials whom we interviewed, particularly those working in juvenile justice settings, explained that correctional facilities aim to provide comprehensive care while a youth is detained, since it is a unique period when youth are on the premises to attend appointments. However, providing comprehensive trauma-informed health care that addresses JIY's complex health needs increases the costs for the corrections system. One official whom we spoke with described correctional health care as "wildly underfunded" within state budgets, thus requiring facility leadership to make difficult decisions regarding the allocation of limited resources.

Provider availability

Once JIY return to the community, they face barriers accessing services due to a shortage of providers in the community or challenges finding Medicaid-enrolled providers. According to officials whom we spoke with, many communities—especially rural or underserved urban areas—face shortages of health care providers and long wait times to see the provider once they are able to locate one. As noted above, youth benefit from receiving care from child and adolescent specialists, such as adolescent psychiatrists; however, these providers are often not available in many communities. JIY also require tailored treatment options, especially related to substance use, as adolescents have different patterns of use and reasons for using compared to adults. However, adolescent behavioral health care remains an emerging field, with limited age-specific treatment options available in both the community and correctional settings.[30] Once youth return to the community, they may face barriers finding providers who participate in Medicaid. For example, one state official cited the few child and adolescent psychiatrists in the state and noted that reimbursement rates may not attract such developmentally appropriate providers for JIY.

Placement changes

Given JIY's complex medical needs, they benefit from having a consistent provider who is knowledgeable of their history and care requirements. However, many of these youth, especially those involved with the child welfare system, experience frequent changes in where they are placed in the community, which may result in reassignment of their MCO and subsequent changes in providers. As a result, care may be fragmented or discontinuous for these youth, and providers may lack complete medical records to provide consistent, high-quality services. Placement changes and a lack of an established health record can compound complex health needs by delaying timely access to initial or ongoing medical, therapeutic, or rehabilitative services. Additionally, because MCOs are often regionally based and are not always statewide, if a youth is placed within a different part of the state or in a different state altogether, they may have to navigate either a new MCO or Medicaid program. One state official whom we interviewed indicated that a statewide specialty health plan for all JIY could reduce these transitions and the resulting care fragmentation. However, another official noted that regionally based MCOs can benefit youth by offering specific knowledge about care in their service areas.

Family engagement

The involvement of a youth's family and caregivers, and their broader support system, are critical for reentry planning. Prerelease planning and treatment during incarceration and the reentry period are key touchpoints to promote shared decision making among youth, parents, and providers (Barnert et al. 2020). However, facilitating this engagement can be challenging and can have implications for a JIY's access to services. Officials whom we interviewed noted that parents may be unwilling or unable to engage in their child's care and planning for a variety of reasons, including distrust of state agencies and medical establishments or their own health challenges. In particular, mental illness and substance use can be multigenerational, and this may limit parents' abilities to support and engage with their children. According to an official whom we spoke with, challenges to family engagement are compounded by the lack of policies to support meaningful parental involvement in facilities while the youth is incarcerated. Additionally, given the substantial overlap between youth involved in the juvenile justice and child welfare systems, parental engagement may be limited by a court, thus challenging the ability to engage them in the youth's care.

Looking Ahead

In efforts to address access to care for youth leaving incarceration, CMS and states are relatively early in the implementation of CAA 2023 provisions as well as Section 1115 reentry demonstrations, where applicable. States are at different points in their efforts to connect youth with the required services and are working to address challenges to building their reentry programs according to their unique circumstances and priorities. Several stakeholders whom we interviewed expressed optimism about the opportunities that evolving federal Medicaid policies provide to better serve JIY and support transitions that could potentially change the course of further system involvement. With those efforts actively underway, much can be learned from federal and state experiences about the effects of the CAA 2023 on JIY and their communities in the coming years. Future data analysis may be needed to examine the extent to which the recent statutory changes are accomplishing the policy goals of supporting JIY transitions and reentry to the community.

Endnotes

[1] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) Section 1001 defines "eligible juveniles" as individuals younger than age 21 and individuals enrolled in the mandatory eligibility group for former foster care children. For this chapter, the term "youth" is synonymous with this definition (CMS 2021).

[2] Under Section 5121 of the CAA 2023, states can receive federal financial participation (FFP) for pre- and post-release services for Medicaid-eligible youth younger than age 21 and youth formerly in foster care younger than age 26 who are being held after adjudication. The requirement for states to provide these services also generally applies to JIY eligible for the State Children's Health Insurance Program (CHIP).

[3] Youth enter the juvenile justice system in a number of ways, such as through arrest or referrals from parents, schools, or probation officers (Barnert et al. 2016).

[4] A hardware-secure facility primarily uses construction and hardware, such as locks, bars, or fences, to restrict freedom, while a staff-secured facility uses continuous staff or contractor presence to control entrances and exits and prevent unauthorized exits from the facility (NPRC 2014).

[5] Among juvenile correctional facilities that screen incoming youth, there is wide variation in the types of screening tools used for assessment. Although some facilities use evidence-based tools, others use tools that may not be supported by evidence (Pilnik et al. 2025).

[6] For children who receive special education services, an IEP is a written statement of an educational program designed to meet their individual needs. An IEP, which is developed by key school staff and the child's parents, establishes learning goals for the child and specifies services that the school will provide for the child (CPIR 2022).

[7] Under Section 1905(a)(31) of the Social Security Act, as amended by Sections 5121 and 5122 of the CAA 2023, states are prohibited from using federal Medicaid funds to pay for care or services for inmates of public institutions, with three exceptions: (1) when inmates are admitted as patients to medical institutions such as hospitals; (2) for services provided to eligible juveniles under Section 1902(a)(84)(D); and (3) effective January 1, 2025, for states

that elect to provide full Medicaid coverage for juveniles pending disposition of charges.

[8] Individuals on parole include people released through discretionary or mandatory supervised release from prison. In comparison, probation is a court-ordered period of correctional supervision in the community, typically viewed as an alternative to incarceration (MACPAC 2021). Medicaid and the state corrections authority, which runs state prisons and youth correctional facilities, are typically housed in different state agencies that report to the governor. Jails are generally operated at the local level by a sheriff, police chief, or other local official who may be appointed or independently elected (Carson and Kluckow 2023).

[9] Section 1001 of the SUPPORT Act defines an "eligible juvenile" as an individual who is younger than age 21 and an individual younger than age 26 who is eligible for Medicaid under the mandatory former foster care children group, so states must work with both juvenile and adult facilities to suspend coverage for youth depending on where the youth is held.

[10] States may adopt one of two approaches to effectuate the requirements in the SUPPORT Act: suspension of eligibility or suspension of benefits. Under an eligibility suspension, the juvenile's eligibility is not terminated, but it is effectively paused. The juvenile cannot receive Medicaid coverage for services, and FFP is not available. Under a benefits suspension, an eligible juvenile continues to be enrolled in Medicaid, but coverage is limited to inpatient services furnished to the juvenile while admitted to a medical institution for at least a 24-hour inpatient stay, in accordance with the inmate payment exclusion described above (Section 1905(a)(30) of the Social Security Act) (CMS 2021).

[11] The Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42) extended the youth suspension requirements from the SUPPORT Act to adults as well, thus requiring states to suspend Medicaid coverage for all incarcerated individuals as of January 1, 2026.

[12] The Office of the Assistant Secretary for Planning and Evaluation's Report to Congress identified challenges to obtaining health care coverage and transitioning health care for individuals reentering the community after incarceration, such as the inability to access and afford treatment and medications for opioid use disorder (MOUD) and other SUDs as well as health-related social needs, including obtaining housing, accessing food, and securing employment, among other challenges. It also identified practices to support reentry, such as expanded access to MOUD within correctional settings, discharge planning, and use of community navigators and peer support specialists, among other practices (ASPE 2023).

[13] CMS's April 2023 guidance also notes that state evaluations could include measurement of cross-system communication and collaboration, connections between correctional settings and community services, provision of preventative and routine physical and behavioral health care, avoidable emergency department visits and inpatient hospitalizations, and all-cause deaths, among other outcomes of interest (CMS 2023a).

[14] The 19 states with approved reentry demonstrations are Arizona, California, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia. See Table 3-2 for the states that include youth in their demonstrations.

[15] The nine states that have pending reentry demonstrations are Arkansas, Connecticut, District of Columbia, Louisiana, Maine, Minnesota, Nevada, New Jersey, and New York. See Table 3-2 for the states that include youth in their pending demonstrations.

[16] CMS guidance on the requirements of the CAA 2023 specifies that because youth formerly in foster care are eligible for Medicaid until age 26, the guidance could affect youth held in adult jails and prisons as well. As such, the guidance further provides that states should conduct pre-release outreach and make eligibility and enrollment support available to all incarcerated youth in both juvenile and adult facilities (CMS 2024).

[17] The CAA 2023 requires state Medicaid programs to have a plan in place for covering within 30 days of an eligible juvenile's release, any screenings and diagnostic services that meet reasonable standards of medical and dental practice, as determined by the state or as otherwise indicated as medically necessary, in accordance with the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, including behavioral health screenings or diagnostic services. Under this requirement, states have the flexibility to use EPSDT standards for screening and diagnostic services or to develop additional standards (CMS 2024).

[18] The CAA 2024 authorizes CMS to issue state planning grants to address operational barriers to complying with requirements described in sections 1902(a)(84)(A) and 2102(d) of the Social Security Act (42 USC 1396a(a)(84)(A)-(D), 1397bb(d)), which were amended by Section 205 of division G of the CAA 2024. These planning grants may also be used to support suspension requirements under the SUPPORT Act as well as state implementation of optional Medicaid coverage for pre-adjudicated youth under Section 5122 of the CAA 2023.

[19] Although CMS specified that states may propose other uses of the fund, the planning grants may not be used to pay for or directly administer health care services to an individual under Medicaid or CHIP or to build prisons, jails, or other correctional facilities or pay for their related improvements. However, any improvements that help directly meet the healthcare needs of individuals who are incarcerated and eligible for medical assistance under Medicaid or CHIP are an allowable exception to facility-related improvements (CMS 2025).

[20] CMS guidance provides that up to $106.5 million will be awarded under this funding opportunity in four budget period increments of 12 months each over a four-year period of performance (CMS 2025). In January 2025, CMS announced that the first round of grants was awarded to 12 states and territories: Alaska, District of Columbia, Kentucky, Maine, Massachusetts, Nevada, New Mexico, North Dakota, Puerto Rico, South Dakota, Utah, and Virginia. The awards for these recipients ranged from $1.5 million to $5 million per state or territory. In August 2025, CMS announced that the second and final round of grants were awarded to 17 states: Alabama, Arkansas, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, Oklahoma, Pennsylvania, Rhode Island, and West Virginia. The awards for these recipients ranged from $1.2 million to $4.6 million per state.

[21] New Mexico's Justice-Involved Utilization of State Transitioned Healthcare program, developed in 2014, established system processes to automatically suspend enrollment for incarcerated individuals, including some youth, who are eligible for Medicaid after 30 consecutive days of incarceration. When the Medicaid program receives release information through an electronic file exchange, the system will automatically reinstate the youth's enrollment in the managed care organization that they were previously enrolled in.

[22] State legislation directed the Washington State Health Care Authority to suspend, rather than terminate, medical assistance benefits for persons who are incarcerated starting July 1, 2017, as an effort to provide continuity of care for individuals upon reentry into the community (WSHCA 2016).

[23] In an effort to address this challenge, state Medicaid officials indicated that they are developing a toolkit to provide to jails who are willing to interact with the Medicaid program to do this work. The aim of this toolkit is to have local jails implement the process as quickly as possible once the Medicaid program achieves local buy-in.

[24] The CAA 2023 provides states the option, beginning January 1, 2025, to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth held in public institutions before being adjudicated in a delinquency hearing.

[25] According to Washington officials as well as state guidance, correctional facilities can satisfy the requirements of the CAA 2023 by participating in the state's Section 1115 reentry demonstration, or they can opt to provide only the pre- and post-release services as required by the CAA 2023 without participating in the demonstration.

[26] Washington's capacity-building process required correctional facilities to describe their existing capabilities, operational gaps, and technical assistance that may be needed to provide services under the state's demonstration. From this process the state developed a cohort selection and milestone approach in which a facility would receive demonstration funding every time a facility met a milestone.

[27] New Mexico officials noted that the state launched Section 1115 demonstration services for adults in three state prisons and is working to implement these services in a cohort of five county detention centers, including one juvenile detention center. The state projects that these services will be in place in June 2026. State officials noted that extending demonstration services to JIY ensures that they will have 90 days of pre-release services under the approved demonstration, as opposed to 30 days of pre-release services under the CAA 2023.

[28] According to CMS guidance, an eligible youth may have been screened or have received a diagnostic service upon entry to the correctional facility, among other specified time periods outside of 30 days before their scheduled release. In this situation, if the state determines that such services

align with the state's established standards for screening and diagnostic services, the screening and diagnostic requirements in the CAA 2023 may be considered satisfied (CMS 2024).

[29] Behavioral health is a substantial challenge among JIY, with 50 to 75 percent having a diagnosable mental health or SUD and suicidality being a serious concern (MACPAC 2021, Owen et al. 2020). Youth with histories of trauma or polyvictimization often experience stress responses that result in maladaptive behaviors such as impulsivity, hyperarousal, and decreased ability to self-regulate; these, in turn, may be associated with delinquency and contact with enforcement (Owen et al. 2020). They are also more likely to receive diagnoses of externalizing disorders (Owen et al. 2020).

[30] A researcher and provider and state officials whom we interviewed emphasized the importance of therapy and psychiatric services for treating depression, anxiety disorders, mood dysregulation, externalizing behaviors, traumatic stress, and other trauma-related needs. However, identifying a behavioral health condition does not necessarily translate to treatment of identified needs. One study found that although two-thirds of JIY had behavioral health disorders and likely needed treatment, only 33 percent received mental health treatment and 27.95 percent received SUD-related services at any point before incarceration (White et al. 2019). Additionally, several interviewees with lived experience in the juvenile justice system reported that therapy was not available to them while they were detained.

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APPENDIX 3A: Commitment Rates Among Youth of Color, 1997 to 2023

TABLE 3A-1. Commitment Rates by Race and Ethnicity, 1997–2023

Year	Commitment rate (per 100,000 youth)						Ratio of commitment rates relative to white youth				
	White	Black	Hispanic	AI/AN	API	More than one race	Black	Hispanic	AI/AN	API	More than one race
1997	143	696	338	346	144	–	4.9	2.4	2.4	1.0	–
1999	151	672	316	415	136	–	4.5	2.1	2.7	0.9	–
2001	154	631	250	438	82	–	4.1	1.6	2.8	0.5	–
2003	140	519	230	354	74	–	3.7	1.6	2.5	0.5	–
2006	124	502	207	353	54	–	4.0	1.7	2.8	0.4	–
2007	114	482	192	317	49	–	4.2	1.7	2.8	0.4	–
2010	94	435	147	313	33	105	4.6	1.6	3.3	0.4	1.1
2011	82	372	133	312	25	92	4.5	1.6	3.8	0.3	1.1
2013	71	317	111	295	20	81	4.5	1.6	4.2	0.3	1.1
2015	62	299	89	215	17	67	4.8	1.4	3.5	0.3	1.1
2017	57	246	71	173	12	75	4.3	1.2	3.0	0.2	1.3
2019	49	185	49	163	12	47	3.8	1.0	3.3	0.2	1.0
2021	29	107	31	94	8	24	3.7	1.1	3.2	0.3	0.8
2023	31	139	35	86	8	28	4.5	1.1	2.8	0.3	0.9

Notes: AI/AN is American Indian or Alaska Native. API is Asian or Pacific Islander. White, Black, and API racial groups exclude persons of Hispanic ethnicity. Until 2006, the Census of Juveniles in Residential Placement (CJRP) collected six detailed race and ethnicity categories (white, Black, Hispanic, American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander) and an "other" category. In 2006, the "other" category was replaced with "two or more races" (labeled here as "more than one race"). Rates for the more than one race category are displayed for only 2010 to the present.

Committed youth include youth placement in the facility as part of a court-ordered disposition. Committed youth may have been adjudicated and disposed in juvenile court or convicted and sentenced in criminal court. The commitment rate is the number of youth in residential placement on the CJRP reference date per 100,000 youth age 10 through the upper age of original juvenile court jurisdiction.

The ratio of commitment rates was created by dividing the rates for each racial or ethnic minority group by the white rate. A ratio of 1.0 indicates the rates for the comparison group are equal. For example, if white and Black youth were detained at the same rate, the ratio would be 1.0. A ratio greater than 1.0 means that the rate for the racial or ethnic minority group is greater than the rate for white youth. A ratio less than 1.0 means that the rate for the racial and ethnic minority group is less than the rate for white youth.

– Dash indicates omitted data.

Source: OJJDP 2023d.