Promoting Public Health *and* Public Safety By Ending the Exclusion of Incarcerated Children from Access to Medicaid

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I. INTRODUCTION

As the Supreme Court observed over a half-century ago, delinquency-system-involved children receive "the worst of both worlds" – they receive neither the full panoply or rigor of due process protections afforded to adults, nor the rehabilitative approach and services promised to them in exchange for diminished rights.[1] Unfortunately, while the provision of due process has arguably improved since the Court's pronouncement in the 1960s, the delinquency system's provision of meaningful therapeutic and skill-building services continues to fall short. This is especially true for system-involved children who end up incarcerated in facilities that not only fail in their mission to "reform" youth, but also actually harm the youth in their charge.[2]

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[1] In re Gault, 387 U.S. 1, 17–18 n.23 (1967).

[2] Richard Mendel, *Why Youth Incarceration Fails: An Updated Review of the Evidence,* THE SENT'G PROJECT (Mar. 1, 2023), https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/ [https://perma.cc/LC84-TYY2].

In *Children are Not Inmates*,[3] Professor Den Houter effectively calls for the elimination of a particularly pernicious contributing factor preventing incarcerated youth from receiving the support they need – the Centers for Medicare and Medicaid Services' (CMS) exclusion of indigent incarcerated children from Medicaid coverage pursuant to the Medicaid Inmate Exclusion Policy (MIEP).[4] Den Houter grounds her article in the history and design of the delinquency system, highlighting how CMS' policy undermines the system's fundamental principles that kids are different from adults and should be rehabilitated.[5] She also grounds her article in the lived experience of system-involved youth, highlighting the manner in which the delinquency system disproportionally ensnares youth with behavioral health needs and then fails to provide them with adequate treatment.[6] The article also reviews a number of recent reforms to Medicaid that seek to expand access to treatment for system-involved youth before correctly concluding that those efforts, while marginally helpful, are insufficient.[7] In contrast, Professor Den Houter's proposed solution – to ensure that system-involved children have uninterrupted access to Medicaid by excluding children from the MIEP – is elegant, attainable, and addresses the shortcomings inherent to any reforms that continue to allow Medicaid coverage to lapse when a child is incarcerated.

However, while I wholeheartedly agree with Professor Den Houter's proposal, given that the delinquency system has largely failed to provide youth with meaningful, rehabilitative services for the past 125 years, making available such a significant source of potential funding to the delinquency system without specific guardrails for how that money can be used risks shifting even more power and control to the state without improving outcomes for system-involved youth. As a result, additional guardrails must be implemented alongside Professor Den Houter's proposal to ensure that system-involved youth receive the services they need to heal and thrive.

This response seeks primarily to build upon Professor Den Houter's well-reasoned analysis and important recommendation. Part I of this response begins by briefly providing additional context and support for why ensuring system-involved youth receive timely, uninterrupted, high-quality behavioral health services is critical to improving both public health and public safety. Part II analyzes the benefits and risks to Professor Den Houter's recommendation. Part III proposes several recommendations for how to implement Professor Den Houter's proposal to ensure incarcerated youth are empowered in their treatment and rehabilitation and receive the services they need to transition to a healthy adulthood.

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[3] *See generally* Jessica Den Houter, *Children Are Not Inmates*, 86 OHIO STATE L.J. 1 (2025).

[4] *See id.* at 55–58.

[5] *See id.* at 22, 27–31, 40–43.

[6] *See id.* at 2–8, 27–31.

[7] *See id.* at 46–58.

II. THE CRISIS OF CHILDHOOD TRAUMA

Professor Den Houter begins her article by identifying "two troubling and intersecting crises" facing today's youth – a behavioral health crisis and a mass incarceration crisis.[8] At the root of both crises – and particularly at their intersection in the form of incarcerated youth with behavioral health needs – is a crisis of childhood trauma.[9] Recognizing this underlying contributing cause further explains why access to meaningful, high-quality, uninterrupted behavioral health supports is critical to both helping youth thrive and improving public safety.

First, it is critical to recognize that childhood trauma is a costly public health issue and a significant contributing factor to the existing youth behavioral health crisis.[10] Childhood trauma – particularly early childhood and complex trauma – can literally embed itself in the brain and body by changing "the structure and function of neurophysiological systems."[11] This disrupted neurodevelopment, especially when paired with continuing exposure to toxic stress, "can influence well-being directly through inflammation and allostatic load."[12] It also "can initiate a developmental cascade of impaired cognitive, social, and emotional functioning" that "increases the likelihood that individuals will engage in health risk behaviors as compensatory or coping mechanisms [that have been] causally linked to adverse [health] outcomes."[13] More specifically, Adverse Childhood Experiences (ACEs) have been shown to have a strong, graded relationship to the adoption of health risk factors like smoking, drug abuse, and alcohol abuse, as well as to negative health outcomes like behavioral health disorders, heart disease, cancer, stroke, diabetes, chronic bronchitis or emphysema, and early death.[14] Recent studies estimate that childhood trauma costs the United States

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[8] *See* Den Houter, *supra* note 3, at 1.

[9] *See* Eduardo R. Ferrer, *Transformation through Accommodation: Reforming Juvenile Justice By Recognizing and Responding to Trauma*, 53 AM. CRIM. L. REV. 549, 551–52, 569–76 (2016) (explaining the negative impact that childhood trauma can have on youth behavioral health and the prevalence of childhood trauma among youth in the delinquency system).

[10] Johanna B. Folk et al., *Adverse Childhood Experiences Among Justice-Involved Youth: Data-Driven Recommendations for Action Using the Sequential Intercept Model*, 76 AM. PSYCHOL. 268, 273 (2021) (finding that ACEs are associated with "increased psychiatric symptoms or mental health problems" and "the likelihood of being diagnosed with a mental health condition or prescribed medication by a professional.").

[11] Alison Giovanelli et al., *Adverse Childhood Experiences: Mechanisms of Risk and Resilience in a Longitudinal Urban Cohort*, 32 DEV. & PSYCHOPATHOLOGY 1418, 1419 (2020). Allostatic load is the cumulative "wear and tear" that chronic stress can have on the brain and the body. Robert-Paul Juster, et al., *Advancing the Allostatic Load Model: From Theory to Therapy*, 154 PSYCHONEUROENDOCRINOLOGY 1–2 (2023).

[12] *See* Giovanelli, *supra* note 11, at 1419.

[13] *See id.*

[14] Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences*

"$14.1 trillion ($183 billion in direct medical spending and $13.9 trillion in lost healthy life-years)" annually[15] and that American adults with ACEs spent approximately $292 billion more on health care utilization and expenditures nationally in 2021 than similarly situated adults without ACEs.[16]

Second, childhood trauma is also a costly public safety issue and a significant contributing factor to the existing youth mass incarceration crisis. In addition to impacting the physical health of an individual, childhood trauma can also influence the development of the brain and the body of the child in ways that can effect the cognitive functioning of children and amplify the decision-making deficits of adolescence.[17] For instance, childhood trauma can impact the structure and activity of the brain in ways that negatively impact motor skills, attention, memory, and learning.[18] Childhood trauma also can condition children to become hypervigilant and/or hyper-aroused, making them more impulsive, further shortening their time orientation, and negatively impacting their executive functioning and self-regulation.[19] As such, experiencing toxic stress during childhood also has been shown to have a strong, graded relationship to criminal justice involvement.[20] Indeed, research on the prevalence of childhood trauma among system-involved youth has yielded estimates of between 70% and 98% of system-involved youth experiencing at least one ACE *prior to system-involvement*.[21] Additionally, youth who end up

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(ACE) Study, 14 AM. J. PREV. MED. 245, 249–52 (1998); *see also* Wenjie Gu et al., *Impact of Adverse Childhood Experiences on the Symptom Severity of Different Mental Disorders: A Cross-Diagnostic Study*, 35 GEN. PSYCHIATRY 1, 4–8 (2022); Maureen Sanderson et al., *Adverse Childhood Experiences and Chronic Disease Risk in the Southern Community Cohort Study*, 32 J. HEALTH CARE FOR THE POOR & UNDERSERVED 1384, 1386–97 (2021).

[15] Cora Peterson et al., *Economic Burden of Health Conditions Associated with Adverse Childhood Experiences Among US Adults*, JAMA NETWORK OPEN 1, 4 (2023), https://watermark.silverchair.com/peterson_2023_oi_231354_1701278614.05587.pdf.

[16] Thomas M. Selden et al., *Adverse Childhood Experiences: Health Care Utilization and Expenditures in Adulthood*, 43 HEALTH AFFAIRS 1117, 1124 (2024); *see also* OFFICE OF THE SURGEON GENERAL OF THE STATE OF CALIFORNIA, THE FINANCIAL COSTS OF ADVERSE CHILDHOOD EXPERIENCES (ACES) AND TOXIC STRESS 1–3; Glory Okwori et al., *Health Care Burden and Expenditure Associated with Adverse Childhood Experiences in Tennessee and Virginia*, 15 J. CHILD & ADOL. TRAUMA 727, 729–35 (2021).

[17] Ferrer, *supra* note 9, at 563–73.

[18] *See id.* at 569–71.

[19] *See id.* at 571–73.

[20] *See id.* at 570–71; *see also* Folk, *supra* note 10 at 277 (finding that youth with more ACEs offended at a younger age, had a higher number of arrests, were more likely to recidivate, and were more likely to be placed in a residential facility); Gloria Heui-Jong Graf et al., *Adverse Childhood Experiences and Justice System Contact: A Systematic Review*, 147 PEDIATRICS 1, 4 (Jan. 2021) (finding "compelling and consistent epidemiological evidence for a graded relationship between ACE score and juvenile justice system contact in the United States.").

[21] *See* Bo-Kyung Elizabeth Kim, et al., *Statewide Trends of Trauma History, Suicidality, and Mental Health Among Youth Entering the Juvenile Justice System*, 68 J. ADOL. HEALTH 300, 303 (2021); Michael T. Baglivio et al., *The Prevalence of Adverse*

incarcerated tend to have experienced even higher rates of complex trauma.[22] Effectively then, we are spending hundreds of thousands of dollars per child per year[23] to incarcerate traumatized youth in facilities where they do not receive the services they need and are often subjected to even more trauma.[24]

As a result, treating childhood trauma is critical to addressing the dual crises facing our youth today. For indigent, system-involved youth, Medicaid often provides the best path to getting therapeutic services that can address their childhood trauma. Yet, under current federal policy, when system-involved youth are incarcerated, their access to Medicaid is suspended.[25] This suspension interrupts relationships with existing behavioral health support teams and impedes efforts to connect system-involved youth with new services while incarcerated and during the reentry process.[26] This is why Professor Den Houter's proposed solution to change federal policy to exclude children from the definition of inmate for the purposes of Medicaid is so important – it would eliminate a key existing barrier to effectively treating a root cause of both the youth behavioral health and mass incarceration crises.

III. ASSESSING THE ELIMINATION OF THE APPLICABILITY OF THE MEDICAID INMATE EXCLUSION POLICY TO CHILDREN

While system-involved youth – and particularly those that are incarcerated – need access to services that address their childhood trauma, there are benefits

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Childhood Experiences (ACE) in the Lives of Juvenile Offenders, 3 J. JUV. JUST. 1, 8–10 (2014); Andrea J. Sedlak & Karla S. McPherson, *Youth's Needs and Services: Findings from the Survey of Youth in Residential Placement*, OFF. OF JUV. JUST. & DELINQ. PREVENTION 1, 2 (Apr. 2010).

[22] Jennifer E. Duchschere et al., *Addressing a Mental Health Intervention Gap in Juvenile Detention: A Pilot Study*, 8 EVID. BASED PRACT. CHILD ADOL. MENT. HEALTH 236, 236 (2023); Patrick Heller et al., *Prevalence Rates and Evolution of Psychiatric Disorders Among Incarcerated Youths in Comparison with Non-incarcerated Youths*, 12 FRONTIERS IN PSYCHIATRY 1, 4–6 (Jan. 2022).

[23] *Sticker Shock 2020: The Cost of Youth Incarceration*, JUST. POL'Y INST. (2020), https://justicepolicy.org/research/policy-brief-2020-sticker-shock-the-cost-of-youth-incarceration/ [https://perma.cc/AA2K-TYCU].

[24] Mendel, *supra* note 2; TAWANA BANDY-FATTAH & JOSH SPAULDING, COSTLY, PUNITIVE JUVENILE JUSTICE APPROACHES UNDERMINE HEALTHY ADOLESCENT DEVELOPMENT (2024).

[25] Letter from the Ctrs. for Medicare & Medicaid Servs. to State Medicaid Dirs., (Jan. 19, 2021) (Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions) https://www.medicaid.gov/sites/default/files/2021-12/smd21002.pdf; Liz Buck & Ruby Goyal-Carkeek, *Medicaid Opportunities to Support Youth Transitioning from Incarceration*, CTR. FOR HEALTH CARE STRATEGIES (Aug. 2024), https://www.chcs.org/resource/medicaid-opportunities-to-support-youth-transitioning-from-incarceration/ [https://perma.cc/LE25-RQLZ].

[26] *See* Den Houter, *supra* note 3, at 40–43.

and risks to Professor Den Houter's proposed recommendation that are worth exploring to ensure that the proposal is implemented effectively and does not inadvertently further disempower traumatized youth and their families.

A. *Benefits of Eliminating the Applicability of the Medicaid Inmate Exclusion Policy to Children*

Given the way Medicaid services are delivered, Professor Den Houter's proposal has the potential to shift some power to system-involved incarcerated children and to increase the likelihood that incarcerated children receive effective therapeutic services.

Maintaining a child's access to Medicaid while incarcerated could provide the child access to a host of holistic trauma-responsive services and multigenerational interventions not often offered with fidelity in juvenile prisons. Currently, youth prisons tend to prioritize behavior modification programs that focus primarily on the behaviors exhibited by the child in the community and in the facility rather than the underlying root causes of those behaviors.[27] Additionally, the locus of focus tends to be almost exclusively on changing the child and not on changing the context – whether it is the home, the school, or the neighborhood – to which the child will return. As such, current common carceral approaches fail to identify and address the underlying trauma that is often a significant contributing factor to the child's involvement in the delinquency system and incarceration. Continued access to Medicaid could change these dynamics.

First, maintaining access to Medicaid would enable the child to involve medical professionals outside the carceral system in the treatment planning. This will increase the likelihood that addressing the child's trauma is identified as a priority in any treatment plan. Moreover, maintaining Medicaid coverage while incarcerated could provide the child with greater access to a wider array of services more likely to effectively treat the child's trauma. In particular, the child could access services like Parenting with Love and Limits (PLL), Trauma Systems Therapy (TST), Multi-systemic Therapy (MST), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Family Functional Therapy (FFT) – all of which can address not only the impact of childhood trauma, but also hopefully treat a potential source of that trauma (i.e., the parent) or provide the parent with additional skills to bolster the protective nature of the home environment.

Second, because the child and parent are the beneficiaries of Medicaid, the child and parent will have a larger degree of involvement in choosing the particular type of intervention or provider. If Professor Den Houter's proposal were implemented, this power to choose Medicaid covered services would not

[27] Only 50% of detention centers report providing therapy. SARAH HOCKENBERRY & ANTHONY SLADKY, JUVENILE RESIDENTIAL FACILITY CENSUS 2020: SELECTED FINDINGS 11 (2024).

go away solely because the child is incarcerated. Nor would the power necessarily transfer to the state. Rather, continued access to Medicaid while incarcerated would provide the child with an opportunity to seek out providers willing to deliver medically necessary services in the facility in which the child is held. This approach would empower system-involved youth to engage in their own treatment planning. It would also enable incarcerated children to be matched with interventions that are determined by a medical professional to meet their individual needs rather than being matched to whatever existing programming – if any – the prison already provides. While the prison would have to agree to allow the provider access to the facility and to the child, the child's continued access to Medicaid would effectively enable the prison to expand the menu of therapeutic and rehabilitative services provided in the facility at a reduced cost to the state. Thus, continued access to Medicaid while incarcerated would enable children to take more ownership over their treatment and to connect with services more likely to meet their needs while the state would get to share the cost of this more individualized treatment with the federal government.

Finally, implementing Professor Den Houter's recommendation could also improve the continuity of care that system-involved youth experience. Currently, Medicaid recipients lose coverage once incarcerated and cannot access it again until released.[28] As a result, system-involved children lose access to the services and service providers with which they were engaged prior to incarceration and often are released without first being connected to community-based services. Professor Den Houter's proposal would enable youth to potentially continue working with providers with whom they were already connected prior to incarceration or to be connected with providers while incarcerated with whom they can continue working once they return to the community. Given that all incarcerated youth in the delinquency system return to their community at some point, improving continuity of care between the facility and community-based providers is critical both to addressing the needs of the youth while incarcerated and to the child's successful reentry.

B. *Risks of Eliminating the Applicability of the Medicaid Inmate Exclusion Policy to Children*

Unfortunately, Professor Den Houter's proposal also carries potential risks. Specifically, given the nature and history of the delinquency and behavioral health systems, Professor Den Houter's proposal could expand the power of the state vis-à-vis the child without improving access to high-quality, individualized treatment.

First and foremost, access to Medicaid funding alone does not guarantee access to high-quality services and service providers. Unfortunately, non-incarcerated youth who do have access to Medicaid funding too often do not

[28] *See* Den Houter, *supra* note 3, at 38–40.

have their behavioral health needs met now.[29] This is due to a variety of factors including a lack of providers and difficulty accessing services in the community.[30] These barriers to receiving behavioral health supports will only be compounded for incarcerated youth as providers would need to be willing to serve this population, accept Medicaid as payment, *and* deliver services in the facility. Additionally, facilities would also need to be willing to give these providers access to the facilities and facilitate regular meetings with their child clients and potentially the child's family. Thus, implementing Professor Den Houter's proposal is a necessary, but insufficient step to ensuring that incarcerated youth receive meaningful behavioral health services. More would need to be done to ensure that incarcerated youth receive meaningful behavioral health services through Medicaid.

Second, the ability for children to access Medicaid funding while incarcerated could further blur the lines between the public health and juvenile justice systems in a way that results in overall net widening and an expansion of youth prisons. Over the past few decades, we have seen a significant shift toward relying more heavily on public health interventions to respond to delinquency rather than carceral interventions. This shift is due in large part to a wealth of research that has helped us better understand adolescent development, adolescent decisionmaking, and desistance. The result has been a drastic decline in both the overall size of the delinquency system and the number of youth prison beds.[31] However, enabling incarcerated children continued access to Medicaid risks making juvenile prisons and, by extension, the delinquency system itself an attractive nuisance. In other words, as access to Medicaid funding makes juvenile prisons a place where people believe youth can get services, more youth will likely be sent there rather than receive community-based services. Unfortunately, this trend towards the institutionalization of youth enrolled in Medicaid already exists in the public health space[32] and would

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[29] MEDICAID AND CHIP PAYMENT AND ACCESS COM'N, ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS COVERED BY MEDICAID AND CHIP 88 (June 2021) ("among Medicaid and CHIP beneficiaries, only 54.1 percent of youth with MDE and 60.4 percent of youth with MDE with severe role impairment received some form of mental health treatment in the past year."); *see also* MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, ACCESS IN BRIEF: HEALTH CARE NEEDS AND USE OF SERVICES BY ADOLESCENTS INVOLVED WITH THE JUVENILE JUSTICE SYSTE 6 (Aug. 2021) (finding that "[f]rom 2015–2019, one-third (34.9 percent) of all youth who stayed in jail or juvenile detention reported receiving specialty mental health services in a juvenile justice setting and two-thirds (66.3 percent) reported receiving specialty or non-specialty mental health care in the past year.").

[30] CHRISTI A. GRIMM, A LACK OF BEHAVIORAL HEALTH PROVIDERS IN MEDICARE AND MEDICAID IMPEDES ENROLLEES' ACCESS TO CARE 1–4 (Mar. 2024).

[31] JOSHUA ROVNER, YOUTH JUSTICE BY THE NUMBER 1, 6 (2024).

[32] MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS COVERED BY MEDICAID AND CHIP 81 (June 2021) (highlighting that child Medicaid beneficiaries "have difficulty accessing

be even more politically palatable in the juvenile justice space. As such, without guardrails, Professor Den Houter's proposal risks net widening and exacerbating the mass incarceration crisis facing our children.

Finally, given the state's tendency to commodify poor youth and families,[33] another risk to Professor Den Houter's proposal is that juvenile justice agencies try to use elimination of the applicability of the MIEP to children to use Medicaid to defray the existing costs of facilities. For instance, rather than allow children to choose a provider and service that pushes into the facility, state agencies could require youth choose from a menu of their own services delivered by state employees. The profit from this service delivery model could then be used to fund other facility costs. This service delivery approach risks not only further eroding a child's ownership over their own treatment plan while potentially limiting their service options, but also further incentivizes an increased reliance on youth prisons due to the decrease in operating costs. As a result, Professor Den Houter's recommendation, if not coupled with some guardrails for implementation, risks shifting more power from the incarcerated child to the state without guaranteeing that the child receives meaningful access to high-quality behavioral health services.

IV. RECOMMENDATIONS FOR IMPLEMENTATION

While Professor Den Houter's proposal that children be excluded from the definition of inmate for the purposes of the MIEP has the potential to significantly improve the care that incarcerated youth receive, the proposal must be carefully implemented to ensure that the child retains ownership over their treatment and receives timely, high-quality services that address the child's needs. In particular, implementation should focus on three issues: 1) regulating Medicaid reimbursement eligibility for services provided to incarcerated youth; 2) incentivizing access to high-quality services; and 3) strengthening oversight and accountability.

A. *Regulate Medicaid Reimbursement Eligibility for Services Provided to Incarcerated Youth*

One key goal of ensuring incarcerated children maintain access to Medicaid is to empower children to engage in their own treatment, not to provide the state with access to another funding source that it can use as it sees fit. As a result, Professor Den Houter's proposal should be implemented in a manner that focuses on pushing services from the community into the prison – not in a

services in the community" and "were more likely than their privately insured peers to receive mental health treatment in a hospital or residential facility.").

[33] *See generally* Daniel L. Hatcher, *The Commodification of Children and the Poor, and the Theory of Stategraft,* 2024 WISC. L. REV. 559 (2024).

manner that centers the prison as the location where youth need to go to get services. There are several ways to accomplish this.

First, incarcerated children's participation in Medicaid covered services should be voluntary. Specifically, incarcerated child should have to willingly and affirmatively agree to engage in a Medicaid covered service. If the child objects or is not willing to consent, the service should not be reimbursable by Medicaid. This is not to say that the state cannot compel an incarcerated child in its custody to participate in a particular service. However, if the state chooses to do so, then the state should pay the full cost for that service to be implemented. Limiting reimbursement in this manner empowers the youth to seek out services on their own and incentivizes the state working closely with the young person to develop an individualized treatment plan over which the young person has ownership. Limiting reimbursement in this way also disincentivizes the state trying to unilaterally force youth to engage with particular providers or service modalities.

In addition, to help reinforce this voluntariness requirement and to promote pushing services into the juvenile prison, carceral institutions' eligibility for Medicaid reimbursements should remain limited.[34] In particular, carceral institutions should only be allowed to bill for screening and targeted case management (including referrals), but not for diagnostic services or treatment itself.[35] Limiting the ability of carceral institutions to bill Medicaid in this way would promote the detection of potential behavioral health needs, the referral of the incarcerated child to independent clinicians outside of the facility for diagnosis, and the connection to outside treatment services deemed medically necessary. However, the diagnosis itself, the determination of what services are medically necessary to treat the needs of the incarcerated child, and the treatment itself would be the responsibility of independent providers not directly employed by the carceral system.[36] Limiting the scope of the services for which the carceral facility can bill in this way will reduce the risk of coercion and self-dealing by the state. In doing so, this recommendation would help ensure that

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[34] Prior to January 1, 2025, the MIEP prohibited all juvenile jails and prisons from billing Medicaid for care in the facility. 42 U.S.C. 1396d(a)(xvii)(32)(A). Effective January 1, 2025, carceral institutions can now receive Medicaid reimbursement for "screenings, diagnostic services, referrals, and targeted case management" for incarcerated children completed within the thirty days prior to the child scheduled release. 42 U.S.C. § 1396d(a)(xvii)(32)(A); 42 U.S.C. § 1396a(a)(84)(D); *see also* Buck & Goyal-Carkeek, *supra* note 25.

[35] This recommendation would change current law in several ways. First, the restrictions on Medicaid reimbursement overall would limit only the carceral institution's ability to seek reimbursement for specified services provided to an incarcerated youth, not to private or non-carceral providers. Additionally, it would narrow the scope of covered services for which carceral institutions could bill to only screening and targeted case management. However, it would allow carceral institutions to bill for screening and targeted case management during the entirety of the incarcerated child's stay at the facility, not only during the last thirty days.

[36] *See also* Buck & Goyal-Carkeek, *supra* note 25.

access to Medicaid supplements not supplants existing funding for services provided to incarcerated youth and that Medicaid funding is used to pay for therapeutic services for the incarcerated youth not for the placement in which the youth is imprisoned.

B. *Incentivize Access to High-Quality Services*

One key goal of ensuring incarcerated children maintain access to Medicaid is to increase the likelihood that system-involved children receive individualized, high-quality, therapeutic services. While providing incarcerated children access to Medicaid coverage while incarcerated is a necessary first step, more will need to be done to incentivize providers to engage with and treat incarcerated children. At the very least, Medicaid regulations and/or state plans should make clear that providers working with incarcerated children can not only bill for the service itself, but also for the time and cost of travelling to the facility and for any time they spent waiting in the facility itself. This will ensure that providers receive reimbursement for the full cost of serving incarcerated children and do not perceive serving incarcerated children as unsustainable from a business perspective. However, given the often-negative perception of incarcerated youth and their hard-to-reach nature, convincing a wide variety of high-quality providers to engage with incarcerated youth will likely require additional incentives. As such, higher reimbursement rates should be offered to providers when serving incarcerated youth.[37]

Additionally, in exchange for carceral facilities being able to seek reimbursement for screening and targeted case management services, carceral facilities should be required to facilitate timely and meaningful access to diagnostic and treatment providers so that they can deliver those services to incarcerated youth. This requirement would include in-person access to the facilities during after-school business hours and on the weekends; a quiet, confidential meeting place for the youth and service provider; coordinated access with family members for therapeutic visits when appropriate; and access to virtual or telephonic visitation with diagnostic or treatment providers when necessary. Targeted case management staff should be responsible for coordinating in-person visits between the incarcerated youth, the facility, and the diagnostic and treatment providers, and such time should be eligible for Medicaid reimbursement as well.

C. *Strengthen Oversight & Accountability*

To ensure that incarcerated children receive the services for which they would be eligible under Professor Den Houter's proposal, it is critical that states,

[37] Even higher reimbursement rates or additional monetary incentives may be offered for specific therapeutic modalities and for providers who provide continuity of care in the transition from the facility to the community.

carceral facilities, and service providers be held accountable for identifying, coordinating, and delivering those services. Oversight and accountability should occur at both the individual and systemic levels.

First, Professor Den Houter's provides a means of self-help to incarcerated youth insofar as the proposal empowers incarcerated youth to seek out and obtain Medicaid covered services the proposal. Oversight and accountability should build on this idea of self-help and regulations accompanying implementation of Professor Den Houter's proposal should provide incarcerated youth with expanded means to individually redress the carceral facility or the state's failure to meaningfully provide screening, case management, diagnostic, or treatment services to the child. This could look similar to the procedural protections and remedies available under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act.[38] For example, procedural protections could include the right to examine records, obtain an independent evaluation, participate in treatment planning, participate in mediation, and file a complaint.[39] Remedies available to incarcerated youth should include compensatory care, reimbursement for services paid directly, or an order requiring that the state provide a particular service to the incarcerated youth.[40]

Moreover, the state agencies responsible for administering Medicaid and CMS should work to ensure that incarcerated youth are receiving meaningful access to services. In addition to enrolling providers and setting reimbursement rates, state agencies should develop separate "standards" and "methods for monitoring and enforcing such standards"[41] specific to providers serving incarcerated youth and to the facilities in which youth are incarcerated to ensure providers have meaningful access to youth Medicaid beneficaries. These standards and methods should align with the recommendations in this article. Finally, CMS should also take an active role in overseeing state plans and providing guidance to state agencies to ensure that the promise of Professor Den Houter's proposal is fully realized.

V. CONCLUSION

Childhood trauma sits at the root of both the behavioral health and mass incarceration crises facing American youth. As such, mitigating the negative

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[38] 20 U.S.C. § 1400 *et seq.*; 29 U.S.C. § 794. This approach could layer onto the existing process for appealing the denial, suspension, or termination of a beneficiary's eligibility or services. *See* ANDY SCHNEIDER & VICTORIA WACHINO, THE MEDICAID RESOURCE BOOK 143–44 (July 2002) (briefly describing the appeals process).

[39] *See* 20 U.S.C. § 1415.

[40] *See* 34 C.F.R. § 104.6(a); Barnes v. Gorman, 536 U.S. 181, 189 (2002) (recognizing injunctive relief and compensation as two of the remedies available under Section 504); Reid ex rel. Reid v. District of Columbia, 401 F.3d 516, 524 (D.C. Cir. 2005) (discussing the calculation of compensatory education awards).

[41] *See* SCHNEIDER & WACHINO, *supra* note 38, at 142.

impacts that toxic stress can have on development is critical to improving both public health and public safety. Professor Den Houter's proposal to exclude children from the Medicaid Inmate Exclusion Policy (MIEP) is a critical step to ensuring that incarcerated youth receive meaningful behavioral health care. However, careful regulation, strategic incentives, and meaningful oversight are needed to improve the likelihood that the proposal is implemented in a manner that empowers youth, avoids reinforcing the harms and failures of the delinquency system, and ensures youth receive the supports they need to heal and thrive.