NATIONAL ACADEMY *for* STATE HEALTH POLICY

Improving Access to Health Coverage *for* Transitional Youth

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Executive Summary

Youth in the juvenile justice and foster care systems often share many traits: a history of abuse or neglect, mental health and substance abuse needs, low incomes, and likely eligibility for public insurance programs. For both populations, custody transitions provide an opportunity to screen youth for Medicaid and State Children's Health Insurance Program (SCHIP) eligibility. This paper describes ways for states to expand Medicaid and SCHIP eligibility to youth in the juvenile justice and foster care systems; key transition points for these youth; and opportunities to better enroll and keep them in programs that encourage healthy growth and development.

Many options exist for states to expand eligibility to better cover transitional youth. Most of these youth who are younger than 18 are income-eligible for Medicaid. However, they are likely to age out of children's eligibility categories when they turn 19 unless their state has enacted a Medicaid option to extend coverage through age 20.

The federal Medicaid statute preventing states from receiving a federal match for services provided to "inmates of a public institution" is a major challenge in covering youth in the juvenile justice system. However, states have the opportunity to provide Medicaid coverage to children in the process of entering or leaving the juvenile justice system. For example, many such youth are placed in community-based programs – including small-group homes, treatment foster care, and day treatment – that allow youth to receive services financed by Medicaid.

Who are transitional youth?

For the purposes of this paper, we define "transitional youth" to mean all youth who are entering, leaving, or moving within the juvenile justice or foster care systems and are at risk of losing health coverage. There is significant crossover between these populations. According to one regional study, more than half of all youth who age out of foster care are involved with the juvenile justice system. Many experience significant barriers to becoming productive adults, including higher rates of physical, developmental, and mental health problems.

Youth in the foster care system also tend to face gaps in coverage between the time they are placed in state custody and the time they are reunified with their family, emancipated, or adopted. These gaps in coverage often lead to gaps in treatment.

Given these challenges, we have focused on three ways to improve states' ability to keep youth enrolled in Medicaid and SCHIP:

1) Simplify enrollment,
2) Enhance retention through the transitions, and
3) Better integrate and coordinate services with partners.

Simplify enrollment - Enrollment in Medicaid and SCHIP can be difficult processes for transitional youth seeking medical services. The following strategies for simplifying enrollment are designed to lessen the burden on applicants. These strategies include adopting the following:

- Screen youth at intake to ensure that all those entering the juvenile justice and foster care systems are considered for eligibility.
- Use presumptive eligibility to allow youth to receive health care services more quickly.
- Use information already on file with the juvenile justice and child welfare systems to expedite the application process.
- Auto-enroll youth into Medicaid or SCHIP once they enter state custody.

- Use states' flexibility to count only the youth's own income and resources rather than the income of the whole family from which the child was removed.
- Improve coordination between Medicaid and SCHIP for youth who transition into higher-income families.
- Minimize the burden of citizenship and identity documentation requirements.

Enhance retention during transitions - Because youth within the juvenile justice and foster care systems are subject to custody transitions, they may be more likely to fall off the program rolls because of paperwork or documentation requirements. States can boost the retention of transitional youth in Medicaid or SCHIP by focusing on these administrative areas:

- Provide 12 months of continuous eligibility so that status does not need to be redetermined at every custody transition.
- Conduct "administrative renewals" of Medicaid eligibility on behalf of the family based on information received through other agencies and programs.
- Provide a grace period before enrollment lapses to allow youth extra time to collect necessary information and documentation.
- Suspend, rather than terminate, eligibility for youth in the juvenile justice system so that eligibility can be reinstated upon discharge.
- Continue Medicaid or SCHIP coverage for youth in detention who are awaiting trial.
- Conduct case reviews of those in foster care to determine whether there have been inappropriate terminations of eligibility.

Better integrate and coordinate services with partners - There are many opportunities for state Medicaid agencies to work with partners at the state and local level to improve access to coverage and identify potential enrollees. These opportunities include adopting the following strategies:

- Use federal Medicaid and SCHIP administrative funds to provide outreach and enrollment services for transitional youth.
- Engage in outreach and partnerships with agencies that have close contact with transitional youth.
- Integrate Medicaid screening into regular discharge planning within the foster care and juvenile justice systems.

The transition from adolescence to adulthood is a difficult time for many youth. Involvement with the juvenile justice and foster care systems adds additional complexity to the lives of youth as they transition between custody arrangements. Medicaid and SCHIP play an important role in providing supportive services for these youth, but only if they enter the programs and stay enrolled.

Introduction

Youth in the juvenile justice and foster care systems tend to share many traits: a history of abuse or neglect, mental health and substance abuse needs, low socioeconomic status, and likely eligibility for public health insurance programs. For both populations, transitions between home, state, and other custody provide an opportunity to screen them for Medicaid and State Children's Health Insurance Program (SCHIP) eligibility and provide the services they need for healthy growth and development. This paper describes the key transition points for youth in the juvenile justice and foster care systems, ways for states to extend Medicaid and SCHIP eligibility to them, and opportunities to better enroll and retain this population.

Who Are Transitional Youth and Why Is Access to Medicaid Important?

For the purposes of this paper, we define "transitional youth" to mean all youth who are entering, leaving, or moving within the juvenile justice and foster care systems and are at risk of losing health coverage. There is significant crossover between these populations. According to one regional study, more than half of all youth who age out of foster care are involved with the juvenile justice system.[1] Many of these youth experience significant barriers to becoming productive adults, including higher rates of physical, developmental, and mental health problems.

Unfortunately, many families who are unable to afford or access medical care for their children relinquish custody in hopes that they will get needed care. A 2003 study by the U.S. General Accounting Office found that 12,000 families in 19 states relinquished custody of their children for the sole purpose of accessing mental health services they could not otherwise find or afford. About 9,000 of these children were sent to the juvenile justice system; the remaining children were sent to the child welfare system.[2] A 1999 survey by the National Alliance for the Mentally Ill found that 20 percent of parents whose children had serious mental disorders were told by authorities to relinquish custody to either the child welfare or juvenile justice system to get the intensive mental health services their children needed.[3]

Youth in the juvenile justice system

In 2003, 2.2 million youth under the age of 18 were arrested.[4] While the juvenile crime rate has decreased since the mid-1990s,[5] an average of 100,000 youth are held in juvenile residential facilities each day.[6] Unfortunately, the juvenile justice system has become a system of last resort for many marginalized children, especially the poor and those who have experienced trauma and/or mental disorders.

Health status of youth in the juvenile justice system

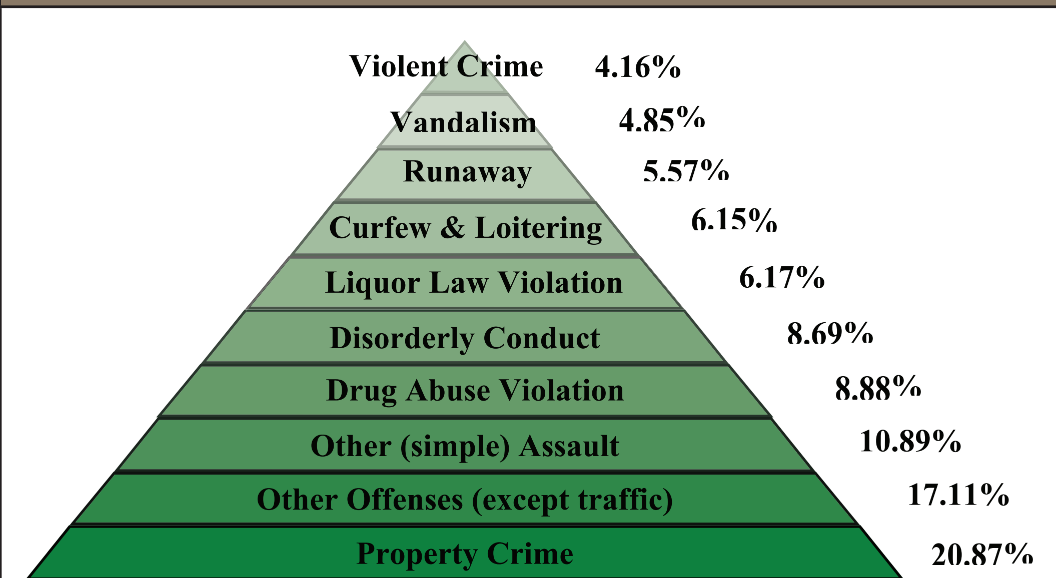
Both mental health and substance abuse issues are common among these youth. These issues often explain the behaviors that led them to the juvenile justice system and make it critical that they receive medical services both in the system and upon their release. Evidence suggests that more than 70 percent of those in the juvenile justice system have a mental health disorder,[7] and approximately 20 percent have a serious mental illness.[8] Youth in the juvenile justice system also have higher-than-average rates of substance abuse.[9] Drug screening upon admittance reveals positive results in approximately 60 percent of the youth.[10]

In addition, youth in the juvenile justice system often have health issues, including exposure to sexually transmitted diseases and inadequate dental care. Other common medical problems include asthma, ear infections, and improperly healed bone fractures.[11] Many also lack health insurance coverage. One study

showed that only one-third of juvenile justice youth reported having a regular source of medical care, and only 20 percent had a private physician.[12] Because many youth in the juvenile justice system are from low-income, at-risk families, they are likely to be eligible for Medicaid or SCHIP.[13]

Two-thirds of the 2.2 million arrested youth were required to report to court for juvenile justice processing.[14] Of those awaiting trial, 20 percent are detained in a justice facility rather than being released before trial. Generally, youth who are detained and youth who are committed are housed in separate facilities. Of those who are tried, 23 percent are committed to a residential facility or institution to serve a sentence, and a large majority, 62 percent, are ordered to probation in a community setting.[15] Community settings vary in size and can be publicly or privately operated. They include group homes, wilderness programs, residential treatment facilities, and training schools. By federal law, state juvenile justice systems must provide timely and appropriate physical and mental health services to youth in the system, specifically those held in commitment facilities.[16]

Figure 1: Overall Juvenile Crime by Most Serious Offenses



*Property Crime includes burglary, larceny-theft, motor-vehicle theft, & arson.

**Violent Crime includes murder, non-negligent manslaughter, forcible rape, robbery, & aggravated assault.

***Offenses with less than 2% of the juvenile crime rate are not included (i.e. weapons, stolen property, driving under the influence, sex offenses, drunkenness, fraud, offenses against families and children, forgery/counterfeiting, vagrancy, gambling, suspicion, prostitution, & embezzlement).

****Other Offenses (except traffic) includes all violations of state or local laws not identified above such as trespassing, littering, etc.

Source: Howard Snyder and Melissa Sickmund, *Juvenile Offenders and Victims: 2006 National Report* (Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2006).

Youth in the foster care system

Foster care is a temporary placement in the home of foster parents or relatives, in a group home, or in a residential facility. Nationwide, there are approximately 513,000 youth in the foster care system.[17] The rate of children in foster care has nearly doubled since 1962.[18] This increase has been attributed to several dynamics, including mandated reporting laws, higher rates of entry than exit, high rates of re-entry, and placement of children from other systems.[19] However, within the past five years, the child welfare system has seen a small but steady decline in foster care youth.

Youth enter the foster care system because of family problems such as the physical or mental illness of a parent, child abuse or neglect, or abandonment. Most children (60 percent) enter foster care as a result of abuse or neglect; another 17 percent enter due to abandonment related to a parent's illness, disability, or death.[20] Poverty also is closely linked to foster care. One study found that a child's removal from home

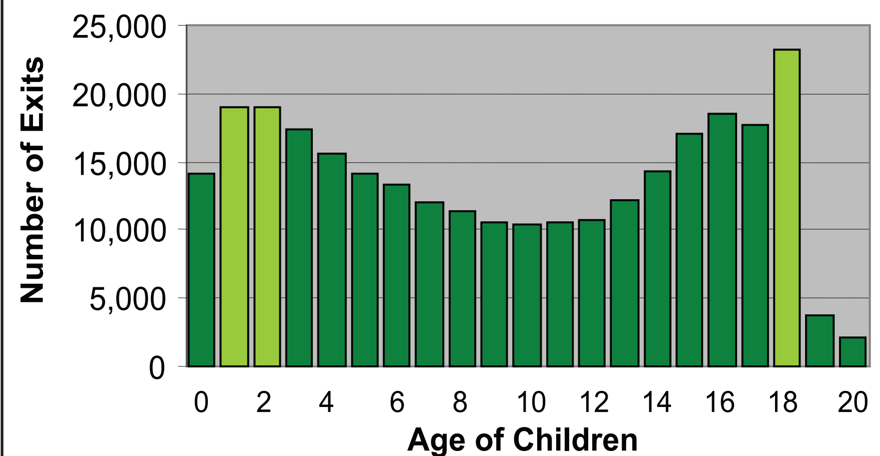
often was tied to a lack of stable parental income rather than maltreatment.[21] In 1999, more than half of all children in foster care qualified for federally assisted foster care (Title IV-E) because their parental income was below the poverty line and within the income limits of the former welfare program, Aid to Families with Dependent Children (AFDC).[22]

Health status of youth in the foster care system

Children in foster care are also at higher risk of physical, developmental, emotional, and behavioral problems. One study estimated that one-half to two-thirds of all children entering foster care have behavioral or emotional problems that warrant mental health treatment.[23] Furthermore, they are likely to suffer from physical health problems including upper respiratory infections, dermatologic disorders, dental caries, and malnutrition.[24] Even the prevalence of sexually transmitted diseases is higher among youth in foster care than in the general population.[25]

While many of these health issues are associated with abuse and neglect before entry, including prenatal alcohol and drug exposure, they can be exacerbated by multiple placements within the foster care system. Studies report a direct relationship between the number of placements a child experiences and the level of hostility he or she displays.[26] While most children have relatively short stays in foster care, with one or two placements, 21 percent experience three or four placements, and 16 percent experience five or more placements.[27]

Figure 2: Ages of Children Exiting Foster Care



Source: Administration on Children, Youth and Families, *The AFCARS Report: Preliminary Estimates for FY 2005* (Washington, D.C.: U.S. Department of Health and Human Services, 2006).

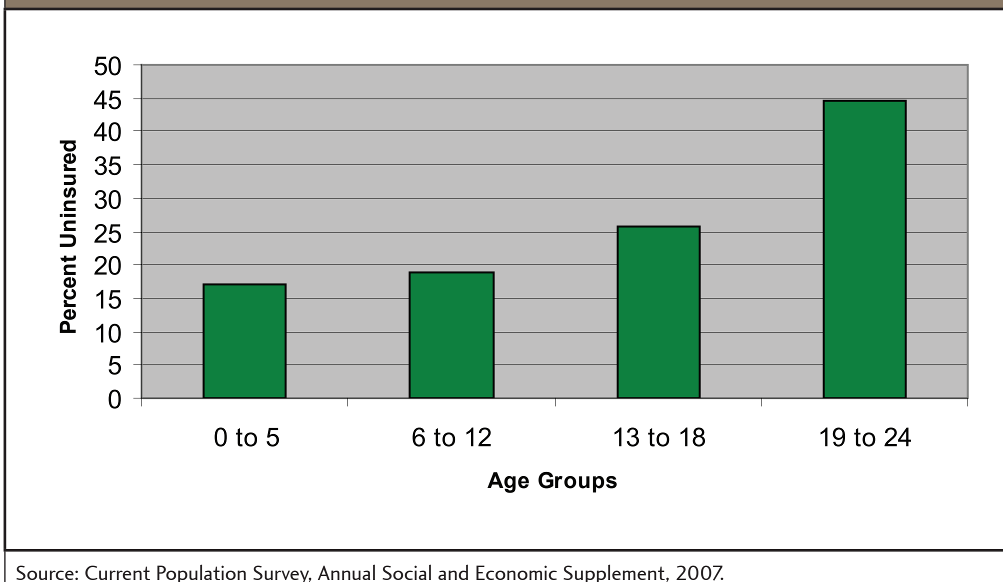
Children exit the foster care system at various ages. However, Figure 2 illustrates that these exits peak around ages 2 and 18. More than half (54 percent) return to their parents or primary caretakers upon exit.[28] However, many children experience foster care until they "age out" and are emancipated from the system, typically at age 18. In fact, an average of 20,000 adolescents are forced to leave the foster care system to live independently each year.[29] Often these youth have limited housing, educational, and financial resources. Within 18 months of emancipation, 40 to 50 percent of foster youth become homeless. While their graduation rates are only slightly lower than the general population, they are twice as likely to drop out of high school, are significantly underrepresented in post-secondary schools, and more likely to trail at least one grade behind their peers.[30] Lower earning potential is another concern among emancipated youth. One-third of foster care alumni have incomes at or below the poverty level and lack health insurance.[31]

Brief Review of Federal Medicaid and SCHIP Eligibility for Children and Young Adults

Medicaid eligibility

Under federal Medicaid law, there are certain groups of people that states must cover, others that states have the option to cover, and still others that states may only cover with special permission from the federal government, called a waiver. States must cover infants under age 2 and pregnant women with incomes up to 133 percent of the federal poverty level (FPL); children ages 2 to 18 with family incomes up to 100 percent of the FPL; and Title IV-E-funded foster children younger than 18. Thirty-five states provide Medicaid and SCHIP coverage for children ages 18 and under with family incomes up to 200 percent of the FPL. Ten states cover children with family incomes less than 300 percent of the FPL. Only six states do not cover children with family incomes up to 200 percent of the FPL, and all but two states cover children up to 185 percent of the FPL. States may cover additional, higher-income children younger than 18 or those ages 19 and 20 through options discussed below.[32] However, states that do cover those 21 and older must apply for a waiver, also discussed below.

Figure 3: Uninsured Rate of Poverty Level Children and Youth Rises by Age



Source: Current Population Survey, Annual Social and Economic Supplement, 2007.

SCHIP eligibility

SCHIP eligibility levels build on Medicaid. States can use federal SCHIP funds to finance coverage for children whose family incomes are too high to qualify for Medicaid. States can cover children through a separate program or a combined Medicaid-SCHIP program. Eighteen states have separate SCHIP programs, 8 states and the District of Columbia have Medicaid expansion programs, and 24 states use the combination approach.[33] SCHIP generally is only available to cover children through age 18. States used to get federal waivers to use SCHIP funds to cover childless adults. But the Deficit Reduction Act of 2005 barred CMS from covering childless adults with SCHIP funds after October 1, 2005.

Aging out of Medicaid or SCHIP

At age 19, adolescents in most states become ineligible for Medicaid or SCHIP and must meet a specific adult coverage category (for example, if they are pregnant or a parent themselves) to qualify for continued coverage. This is a major reason many young adults lack insurance. In 2006, 45 percent (approximately 2 million) of young adults ages 19 to 24 with incomes below the poverty level were uninsured.[34]

State Options For Covering Transitional Youth and Young Adults

Several options exist to cover transitional youth. These options generally allow states to draw down federal matching funds through Medicaid or SCHIP to provide health care. Unfortunately, these options are somewhat limited and do not cover transitional youth across all ages, incomes, and phases of life. Below are options states have to reach transitional youth and young adult populations.

Coverage for low-income young adults ages 19 and 20

Under the Ribicoff eligibility pathway, named for Sen. Abraham Ribicoff who sponsored the legislation, states may provide Medicaid coverage to those under 21 who meet the former AFDC program's income and resource criteria but do not qualify as "dependent children." While AFDC standards now average 49 percent of the FPL,[35] states have authority to disregard income and asset limits above the original AFDC levels when covering additional young adults ages 19 and 20.[36]

Fifteen states – Alaska, California, Connecticut, Iowa, Maine, Maryland, Minnesota, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Tennessee, and Vermont – already provide Medicaid coverage for young adults ages 19 and 20 through a Ribicoff program.[37] As of 2006, 12 of these 15 states covered this group at or above 50 percent of the FPL, and three of these states covered them at or above 100 percent of the FPL.[38] States can opt to cover the entire population or "reasonable classifications" such as foster children or children in nursing homes, intermediate care facilities for the mentally retarded, or inpatient psychiatric hospitals. Under this option, parental income does not apply to children who do not reside in their parents' homes.

Targeted Medicaid eligibility for youth in state custody

Separate from the Ribicoff eligibility pathway is a lesser known but important eligibility category for youth under age 21 who are taken into state custody.[39] This option allows states to extend Medicaid eligibility to those under 21 in the foster care and juvenile justice systems regardless of the income or resources of biological or foster parents.[40] However, children with income or resources of their own in excess of the state's July 16, 1996, AFDC standards would not be eligible. This option is derived from: (1) the option to cover reasonable categories of children under S. 1905(a)(i) of the Social Security Act, and (2) the prohibition against attributing the income and resources of either the biological or foster care parents to the child.[41]

This "targeted Medicaid eligibility for youth in state custody" option is helpful because under other foster care-related eligibility options, a state must count biological parents' income for the first month of placement, which creates a delay in enrolling in Medicaid and accessing key services at a critical time. However, under this option, Medicaid eligibility can be effective as soon as a child enters state custody. The child welfare agency or juvenile justice authority must certify that the child was in state custody and without substantial income or resources in his or her name. The state Medicaid agency then could issue a Medicaid card effective on the date of placement. See the section "Medicaid and Juvenile Justice: The Challenge" on page 12 for more information about the use of federal Medicaid dollars for youth in state custody.

Coverage for foster care leavers

The Foster Care Independence Act of 1999,[42] known as the Chafee option for Sen. John Chafee, allows states to extend Medicaid coverage for youth who have aged out of foster care. It provides optional Medicaid coverage for those in foster care from their 18th birthday to age 21. States also may restrict these

foster care leavers to reasonable classifications such as Title IV-E-funded youth, youth who attend college, or youth who remain in foster care until they are 21. States may, but do not have to, restrict eligibility based on income. States also may allow children who didn't apply for Medicaid on their 18th birthday to apply any time prior to their 21st birthday. Extending coverage to youth aging out of the foster care system in other states is another option.[43] As of 2006, 17 states – Arizona, California, Florida, Iowa, Indiana, Kansas, Massachusetts, Mississippi, New Jersey, Nevada, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, and Wyoming – had extended their Medicaid program to foster care leavers using the Chafee option.[44] In 2007, Washington state passed legislation to cover foster care leavers up to age 21. Other states have proposed this option.

Coverage for youth receiving adoption assistance

Title IV-E funds finance two major child welfare programs: foster care and adoption assistance. Children adopted from foster care are eligible for Title IV-E adoption assistance if two conditions are met. First, the foster child must be determined to have "special needs" by meeting three requirements: he is unable to return to the home of his legal guardian; attempts to place him without the adoption assistance were unsuccessful; and he has a factor or condition that qualifies him as having special needs.[45] While special needs are defined by each state, common factors include: ethnic background, age, membership in a sibling group, medical, physical, or emotional condition or disability. Second, the child must meet one of four eligibility requirements: AFDC eligibility during the month he entered foster care or in the prior six months; SSI eligibility; having a parent in foster care who received Title IV-E funds that covered both the parent and child when the adoption was initiated; or receiving adoption assistance before an adoptive parent died or was dissolved. States are required to provide Medicaid to all children eligible for federal IV-E adoption assistance up to age 18. Federal adoption assistance may be extended to age 21 if a state determines that the youth has a physical, mental, or emotional disability. In that case, Medicaid eligibility can continue as well.

Coverage for youth with high medical expenses

"Medically needy" is a state option that allows certain groups of people with high medical expenses to "spend down" into Medicaid. As of 2006, 16 states covered 19- and 20-year-olds in their medically needy programs.[46] Nine states cover 19- and 20-year-olds at 50 percent of the FPL or higher, and seven states cover them below 50 percent of the FPL.[47] A state that opts to put together a medically needy program must cover children under 18 and pregnant women and may cover other groups, including those ages 19 and 20. The maximum medically needy income limit is 133 percent of the 1996 AFDC payment, which in 2007 averaged 65 percent of the FPL.[48] However, states can use flexibility provided by §1902(r)(2) of the Social Security Act to set their income-eligibility standards higher. States have the flexibility to restrict medically needy benefits, but most states choose not to. Eligible individuals also must meet a spend down requirement every one to six months.

Coverage of young adults through Medicaid waivers

States also have the ability to negotiate waivers with the federal government to cover a broader group of childless young adults. Under Section 1115 of the Social Security Act, the federal government has broad authority to waive statutory and regulatory provisions of Medicaid and SCHIP for research and demonstration purposes. Some Section 1115 waivers are small and focus on a particular population or type of services. Others are broader and result in a dramatically redesigned Medicaid program. In 2001, the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) initiative encouraged states to seek Section 1115 waivers to expand coverage within existing resources and offered increased waiver flexibility.

States applying for Section 1115 waivers must prove budget neutrality, meaning federal costs under a waiver cannot be more than projected federal costs without the waiver. Budget neutrality requires states to compare, over a five-year period, federal Medicaid expenditures if the waiver were approved versus federal Medicaid expenditures without the waiver. States must make a projection of expenditures with and without a waiver and then defend the credibility of the assumptions, which are actively negotiated with CMS during the waiver-approval process. Some states have met the budget neutrality requirements by using Medicaid Disproportionate Share funds to expand coverage. Other states have met this requirement by trimming benefits for existing beneficiaries to expand coverage to new populations.

Section 1115 waivers that cover childless adults

As of April 2008, 12 states provided comprehensive coverage to all categorically ineligible adults with incomes up to at least 100 percent of the FPL, through either Section 1115 waivers or by using 100 percent state funding.[49] Income eligibility in these waiver programs ranges from 35 percent of the FPL to 300 percent of the FPL, but most states are in the 100 percent to 200 percent range. Low-income transitional youth who are otherwise ineligible for Medicaid are likely to be eligible for coverage in these waiver and state-funded programs. Many waiver programs do not provide full Medicaid benefits. Some provide slim packages with no mental or oral health coverage, limited office visits, limited prescriptions, and limited inpatient services. Some waivers also require cost-sharing ranging from no deductibles to deductibles similar to the private market. Co-payments for most services are between $1 and $5; emergency room coverage generally costs more. In addition, some newer waivers are tied to employment. Transitional youth may not be able to satisfy such work requirements.

Section 1115 family planning waivers

States also can apply for Section 1115 waivers to cover family-planning services. These programs are based on the principle that preventing unwanted pregnancies saves the state money because pregnant women and births otherwise would be covered by Medicaid.[50] Twenty-six states have federal approval to extend Medicaid eligibility for family-planning services to people who otherwise would not be eligible. Seventeen states provide Medicaid family planning benefits to individuals based on income, with most states setting the income ceiling at 200 percent of the FPL. Six states have extended eligibility for family planning services to women who lose Medicaid coverage after giving birth. In these cases, eligibility usually lasts for one year. Two states provide family-planning benefits to women who lose Medicaid for any reason. In addition, seven states provide services to both men and women. In eight states, services are limited to women who are at least 19 years of age.

Buy-ins to Medicaid or SCHIP

An additional option for states interested in covering transitional youth is allowing them and their families to buy into Medicaid or SCHIP. Seven states allow buy-ins to SCHIP for higher-income families.[51] Some states allow children up to age 21 to buy into SCHIP at full cost. The existing programs are small, and most have only a few hundred participants, but New York and Florida have thousands. In states with programs, premiums are modest – $100 to $200 per child per month. States also could choose to subsidize a portion of the premium for transitional youth.

State-funded programs

A handful of states provide state-funded coverage for low-income adults without children. Some of these states use Medicaid funding and also provide additional state funding to cover low-income adults, includ-

ing youth 19 and older. For example, Massachusetts' Commonwealth Care program subsidizes coverage for childless adults up to 300 percent of the FPL. There is no premium for adults up to 100 percent of the FPL, and a sliding-scale premium is used for adults between 100 and 300 percent. Coverage is offered by Medicaid HMOs and includes doctor visits, hospitalization, mental health care, and substance abuse services. Health reforms in Massachusetts also will require adults 19 and older to purchase insurance if affordable.

Other states rely solely on state funds to subsidize coverage. For example, in Washington, Basic Health is a state-funded program for childless adults with income up to 200 percent of the FPL. The state subsidizes coverage using a sliding-scale premium and a deductible with some co-pays. The benefits are more limited than Medicaid but include mental health and chemical dependency services.

Gaps in coverage

While the majority of children under age 18 leaving the juvenile justice and foster care systems are eligible for Medicaid or SCHIP, the options for young adults are much more limited. For example, the Chafee eligibility option only applies to youth leaving foster care. The Ribicoff option affects only custodial parents or young adults with very low incomes. The medically needy option requires that strict income limits be met every six months to maintain coverage. Significant gaps remain. No federal program covers young adults – other than under a budget-neutral Medicaid waiver – and only a few state programs cover non-custodial, able-bodied young adults beyond age 20. Substantial changes in federal law would be required to allow states to provide broader coverage options to better reach the medical needs of these young adults.

There are a number of key transition points in both the juvenile justice and foster care systems. These present both challenges and opportunities to connect transitional youth with health coverage and other needed services. During these transitions, eligibility for Medicaid and SCHIP can change as income and family status change. In addition, placement in certain juvenile justice institutions or foster care locations can determine when federal Medicaid and SCHIP funds are available. However, if proper systems are in place, these transitions offer ideal opportunities to reconnect youth with Medicaid or SCHIP and needed health services.

Key Juvenile Justice Transitions

Arrest and pre-adjudication

Entry into the juvenile justice system usually starts with an arrest. Cases referred to juvenile courts are first screened by an intake department, which decides whether to dismiss the case or resolve it, either formally or informally. If it is determined that a case should be handled formally, a petition is filed and the case is placed on the court calendar for a hearing. Before a judicial decision, an arrested youth may be sent home or placed in a detention facility. Whether a youth is placed in a detention center awaiting the hearing rests on a number of factors, including his or her prior record, the seriousness of the offense, and whether a parent or guardian is able and willing to keep the youth until trial. In 2002, one in five arrested youth were detained between referral to court and case disposition.[57]

If a youth is not ordered to a detention center while awaiting a hearing, he or she may continue to receive Medicaid services from home. However, confusion exists around detained youth awaiting a hearing. Some states provide Medicaid coverage during this time based on federal regulations stating that

Medicaid and Juvenile Justice: The Challenge

It can be a challenge to keep youth in the juvenile justice system enrolled in Medicaid because of longstanding federal law that prohibits federal Medicaid dollars from providing "care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[52] This law is often understood to mean that Medicaid is not available to youth in the juvenile justice system. However, states can receive Medicaid funding for youth in some juvenile justice settings, and even youth ordered to public institutions can continue to be enrolled in Medicaid.

First, states can in fact receive Medicaid funding to pay for medical services for eligible youth in private institutions, such as privately run group homes, or in public institutions with fewer than 16 beds. The regulations define a public institution as a place that is "the responsibility of a governmental unit or over which a governmental unit exercises administrative control."[53] Under the regulations, "a public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that services no more than 16 residents, or a child care institution with respect to children receiving foster care or foster care payments."[54] In December 1997, the U.S. Department of Health and Human Services issued a letter to all regional Medicaid administrators that clarified the Medicaid statute and regulations.[55] The most important clarification was that federal Medicaid funds are available for eligible youth who have been placed in a non-secure setting regardless of whether they have been found guilty of a crime.

Second, even youth ordered to public institutions may remain enrolled in Medicaid. Federal Medicaid rules do not say that inmates of public institutions are ineligible for Medicaid or lose Medicaid eligibility. In a September 1999 letter, the law was clarified by defining that "there are no federal requirements which preclude an inmate of a public institution from retaining Medicaid eligibility status."[56] This means that youth in the juvenile justice systems can be kept on the Medicaid rolls while in a public institution as long as federal Medicaid funds are not used to pay for their care. This may ensure continuity of coverage and care for youth moving from a secure facility to a different setting (see "Suspend – instead of terminating – Medicaid eligibility for youth in the juvenile justice system" on page 23).

Medicaid funds are available if a youth is in a public institution for a temporary period pending other arrangements appropriate to his needs.[58] Other states either suspend Medicaid benefits once the youth has been detained in a public institution or terminate Medicaid eligibility. A recent Centers for Medicare and Medicaid Services (CMS) interpretation suggests that the agency will not approve state Medicaid plan amendments if states seek to use federal finances for Medicaid-eligible youth who are temporarily placed in juvenile detention facilities.[59] (See "Continue Medicaid coverage during detention" on page 24 for more information.)

Table 1: When Can a Youth Receive Medicaid or SCHIP Services with the Federal Match if Involved with the Juvenile Justice System?

Movement through the Juvenile Justice System	Eligible for Medicaid/SCHIP Services with the Federal Match?		
Arrest through Adjudication	**Detained upon arrest: (i.e. detention facility)** **Maybe** **(Depends on size and operation of facility; see Commitment and Disposition)**	**Returned to parental custody:** **Yes** **(If family is found eligible for Medicaid)**	**Voluntary placement with community-based program or day treatment center:** **Yes** **(If family is found eligible for Medicaid)**
Commitment and Disposition	**Large Public Institution: (>16 beds)** **No***	**Small Public Institution: (≤ 16 beds):** **Yes**** **(Youth could be eligible as a family of one)**	**Private Institution: (small or large)** **Yes**** **(Youth could be eligible as a family of one)**
Post-Commitment	**Yes** **If youth is ≤ age 18, then post-commitment family must be found eligible. If youth is > age 18, then must be found eligible under existing Medicaid category.**		

*Any committed youth who is admitted to a hospital is eligible for Medicaid services with the federal match.

** Allowable community-based corrections: intensive supervision, day treatment, probation, electronic monitoring, house arrest, alternative school, group home, treatment foster care, day treatment, or other non-residential program

Adjudication

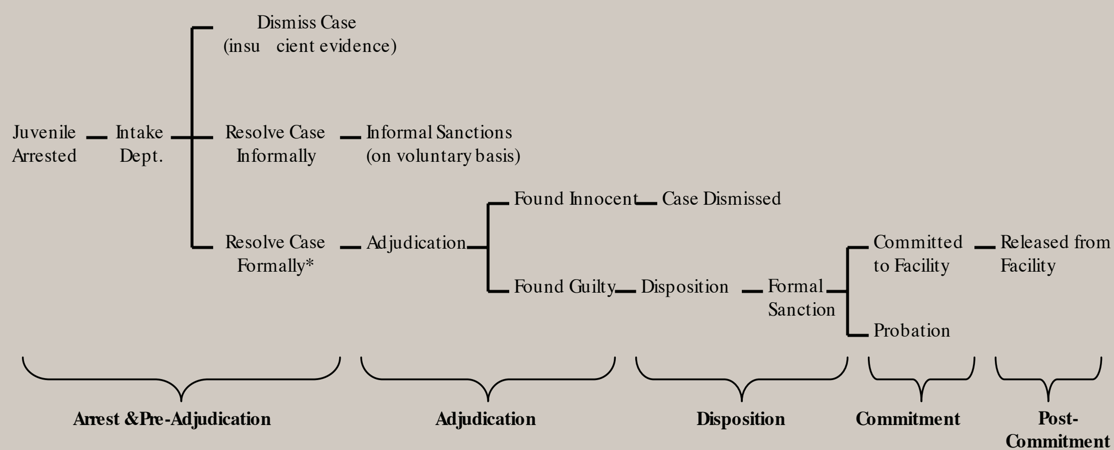
Adjudication is the stage in juvenile court proceedings where arguments, testimony, and evidence are presented to determine whether a youth committed the alleged offense. If the individual is found innocent, the case is dismissed. If the youth is an adjudicated delinquent, the judge often recommends that he or she take voluntary action toward change (i.e. rehabilitation services, therapy, etc.) before the disposition hearing.[60] Medicaid funds are available to pay for services in the arrest and pre-adjudication stages.

Disposition

A disposition hearing is the final step in the juvenile court process and is held only when a juvenile has taken responsibility for a crime or is an adjudicated delinquent. After reviewing a report by the probation department that includes the child's family circumstances and prior behavior, the judge decides on the most appropriate sanction.[61] Judges can choose from a range of options, including a juvenile justice institution, a group or foster home, probation, referral to an outside agency, day treatment, a mental health program, or a fine or community service.[62]

Many sanctions provide opportunities for youth to receive Medicaid services. Community-based programs and facilities such as intensive supervision, day treatment, probation, electronic monitoring, house arrest, and alternative schools allow youth to receive Medicaid.[63] Placement in a group home with fewer than 16

Figure 4: Process of Youth through the Juvenile Justice System



*Youth may be detained in a facility throughout the judicial process.

Source: Anne L. Stahl et al. *Juvenile Court Statistics 2003–2004* (Pittsburgh, PA: National Center for Juvenile Justice, 2007).

beds, treatment foster care, day treatment, and other non-residential programs also may allow youth to receive services financed by Medicaid.

Commitment

As a result of the disposition hearing, the judge may order that the youth be committed to a juvenile facility. Committed youth can be placed in one of the following facilities: a detention center while awaiting

residential placement, a shelter, a reception/diagnostic center, a group home, a boot camp, a ranch/wilderness camp, or a training school. These facilities differ in supervision and security. All youth sent to public institutions can remain enrolled in Medicaid. However, services cannot be billed to Medicaid unless the youth is admitted to a hospital under inpatient status. Youth ordered to publicly operated community residences with fewer than 16 beds or private institutions regardless of size can continue to receive Medicaid services with the normal federal match.

Post-commitment

After youth serve their sentence, they are released and placed on parole. Parole is the supervised release of a juvenile with certain conditions. Parolees must participate in aftercare services to help them rejoin the community. Aftercare services range from education, employment, and vocational training to mental health counseling, substance abuse treatment, and life-skills training.[64] Medicaid-eligible youth on parole can receive services paid for with federal Medicaid funds.

Key Foster Care Transition Points

Entering the foster care system

Removal from home

A child can be removed from his or her home after a Child Protective Services (CPS) investigation of substantiated abuse, neglect, or absence of parents. However, in rare instances, a child may be removed and placed in out-of-home care at the request of his or her parents. Once CPS makes a recommendation to the court to file a petition, a series of judicial hearings begins. In emergency situations, the court will order a child removed from the home and placed in emergency or temporary foster care until a decision is made regarding his or her safety and welfare at home. In other situations, the child may remain at home – with or without supervision and support services – until the court makes a decision at the disposition hearing. During this time, most youth within the foster care system are eligible for Medicaid through one of the following pathways:

- Eligibility based on Title IV-E status,
- Poverty level categories,
- State eligibility categories targeted to foster care youth, or
- Disability categories.[65]

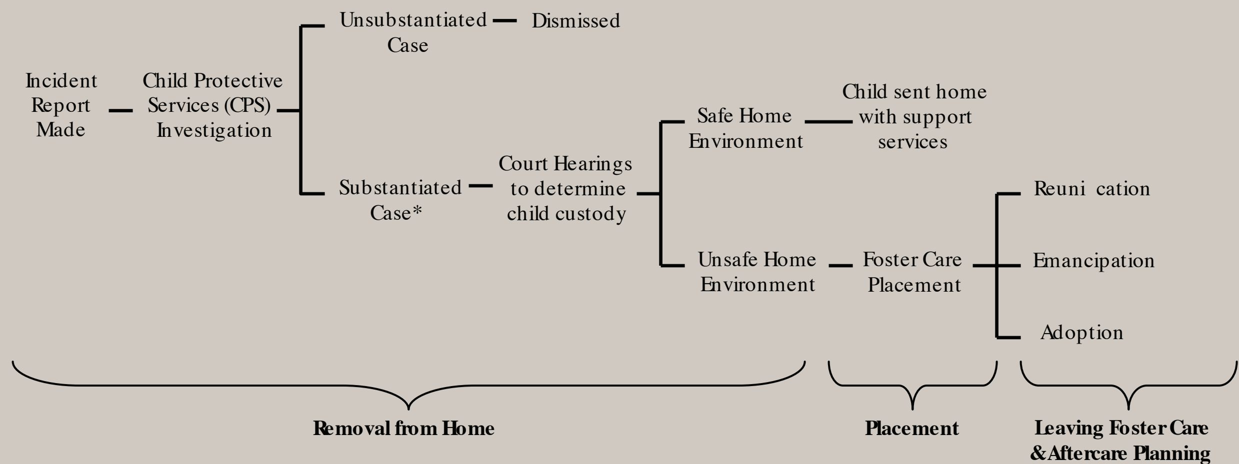
Placements

Children removed from home are placed in state custody under the child welfare agency and can be placed in a variety of settings including a foster family home, a relative foster home, an institution, a group home, or a pre-adoptive home.[66]

Leaving foster care and aftercare planning

There are three primary options for youth leaving foster care: emancipation, adoption, or reunification with family. In Fiscal Year (FY) 2005, 287,000 children exited the foster care system.[67] Upon exit, aftercare services are provided to youth and their parents or legal guardians to assist with reunification. Services may include regular counseling with youth and their parents, scheduled visits from a social worker, and community support to ensure a successful transition.[68]

Figure 5: Process of Youth Through the Foster Care System



*Youth may be removed from home and placed in temporary foster care immediately after a case has been substantiated by CPS.

Source: Sue Badeau and Sarah Gesiriech, *A Child's Journey Through the Child Welfare System* (Washington, D.C: The Pew Commission on Children In Foster Care, 2003).

Reunification with family

Sixty-five percent of children leaving the foster care system in FY 2005, or nearly 188,000 children, were reunified with their families or primary caretakers.[69] Parents undergoing reunification are likely to have trouble determining their children's eligibility for health coverage and navigating the application or renewal process.[70] These children are at risk of coverage interruptions unless their state assists them in keeping Medicaid or enrolling in SCHIP. Federal rules stipulate that a child's Medicaid coverage continues until the state has determined whether the child is still eligible.[71] Therefore, many children remain eligible for Medicaid when returning to their families, but their eligibility categories may change. This could lead to gaps in coverage. Furthermore, many families are unaware of their child's eligibility or have trouble collecting the necessary application documents.[72]

Emancipation or "aging out" of foster care

Approximately nine percent or 24,000 children exiting the foster care system were emancipated, or "aged out" in FY 2005.[73] They emancipate either by formal release at their own request or when they turn 18 or 21, depending on the state. Unlike younger children, many of those aging out are no longer eligible for Medicaid or SCHIP when they turn 19, unless their state has taken steps to offer them coverage (discussed in greater detail below).

Adoption

Eighteen percent of children, or 51,000, exiting foster care in FY 2005 were adopted.[74] Some children adopted through the foster care system may be eligible for continued Medicaid coverage. Children who receive Title IV-E federal adoption assistance are automatically eligible, and children who receive state-funded adoption assistance are eligible for publicly funded health coverage with a benefits package equivalent to Medicaid.[75]

Table 2: When Can a Youth in Foster Care Receive Medicaid or SCHIP Services with the Federal Match?

Movement through the Foster Care System	Eligible for Medicaid/SCHIP Services with the Federal Match?			
Removal from Home	**If the youth meets Title IV-E eligibility guidelines upon removal:** **Yes**	**If the youth's family income upon removal was below the state's child poverty level guidelines:** **Yes***	**If the youth is eligible under a disability pathway:** **Yes**	**If the state in which the child was placed in foster care has a targeted Medicaid eligibility program for youth in state custody:** **Yes**
Placement	**Yes**** **NOTE: The Institution for Mental Disease (IMD) exclusion would not apply for youth in foster care because youth under age 21 are exempt from this exclusion.**			
Leaving Foster Care & Aftercare Planning	**Reunification:** **Yes** **(If the family is found eligible)**	**Adoption:** **Yes** **(If the family is found eligible or the child is eligible for federal adoption assistance)**		**Emancipation:** **Yes** **(If the individual meets state-established poverty guidelines or other state-approved guidelines)**

*After one month in foster care, biological parent income can no longer be attributed to the youth in foster care. Therefore, a child without substantial income themselves will most likely be eligibly under a state poverty guideline in Medicaid.

**Allowable placements: family foster home, foster home of relatives (kinship care), group home, emergency shelter, residential facility, or other child care institution

Medicaid Process Improvements to Promote Enrollment and Retention of Transitional Youth

A recent survey of state and community juvenile justice and Medicaid agencies assessed Medicaid policies.[76] It showed that in some areas, delinquent youths are actively disenrolled from Medicaid, and in others, little effort is made to connect them with Medicaid. In addition, differing responses from justice and Medicaid agencies highlighted a lack of communication.[77] Similarly, many youth transitioning out of the foster care system have trouble maintaining health insurance coverage or even qualifying for affordable health insurance. Despite federal rules[78] to avoid gaps in medical coverage, complicated application procedures and lack of coordination place additional burdens on youth and families.

There are a number of ways that states can make it easier for transitional youth to enroll or stay enrolled in Medicaid and SCHIP. They include improved administrative processes to:

- Simplify enrollment,
- Enhance retention, and
- Better integrate and coordinate services with partners.

In many cases, the improvements discussed below can be made at the Medicaid or human service agency's discretion, without state legislative approval. However, in some cases, the policy change must occur in the state legislature.

Simplify Enrollment

States may need to act to ensure enrollment of youth transitioning in and out of the foster care and juvenile justice systems. Some youth entering the juvenile justice system are actively disenrolled from Medicaid, while some entering the foster care system face administrative delays. Youth transitioning out of foster care through reunification and emancipation face the greatest struggles to maintain consistent coverage, often due to administrative procedures. A 2003 survey showed that agency efforts to enroll formerly committed youth in Medicaid after release from a juvenile facility were relatively uncommon. Justice agencies in particular were unlikely to report that Medicaid eligibility was assessed or Medicaid applications were filed for youth upon their release. Medicaid agencies were more optimistic in their assessment of re-enrollment practices. The results from this survey show a lack of coordination between juvenile justice and Medicaid offices regarding enrollment, suggesting that improvements are needed to better meet the health needs of transitional youth.

Screen transitional youth for Medicaid eligibility at intake

States should consider working with juvenile justice and foster care agencies to ensure that all youth are screened for Medicaid eligibility upon entry. Nearly all foster care children are found eligible for Medicaid at intake, but many children do not receive services quickly enough because of delays in obtaining a Medicaid card (see "Automatic Enrollment Strategies" on page 20 for more information).[79] Unlike the foster care system, few youth in the juvenile justice system are even considered for Medicaid eligibility, in part because of the mistaken assumption that they are ineligible. Enrollment upon entry into the system expedites access to benefits upon release and ensures that youth receive prompt medical attention if they are admitted to a hospital or have urgent-care needs. A screen for Medicaid eligibility during intake can save the facility and youth from having to apply at a later and more difficult time.

If youth in the juvenile justice system are screened at intake for Medicaid eligibility, states can suspend

rather than terminate their eligibility. States that provide 12 months of continuous Medicaid eligibility then can keep youth enrolled during periods of institutionalization, which often are brief. This allows Medicaid to pay for services for youth who are serving their sentences in facilities that are not public institutions, such as group homes with fewer than 16 beds, therapeutic foster care,[80] day treatment, private facilities, or other nonresidential facilities. Some states have found it worthwhile to screen and enroll youth in these placements for eligibility so that federal matching funds – and not just state dollars – can be used to pay for services.

Allow presumptive eligibility in Medicaid and SCHIP for children

Lack of information about Medicaid eligibility and difficult application processes often impede participation of youth whose family situations are in flux. Presumptive eligibility is a state option that allows qualified entities to determine, based on a simplified calculation of family income, whether a child is likely to be eligible for a Medicaid or SCHIP. This option can help transitional youth under age 19[82] qualify for temporary Medicaid and SCHIP eligibility. Most importantly, youth are able to receive health care services more quickly, pending a final eligibility determination. As of July 2007, 14 states had adopted presumptive Medicaid and/or SCHIP eligibility for children (CA, CO, CT, IL, KS, LA, MA, MI, MO, NH, NJ, NM, NY, and WI).[83]

States have flexibility to deem agencies that provide services – including juvenile justice programs and foster care systems – as "qualified entities" [84] to determine presumptive eligibility as long as the secretary of HHS approves them. Qualified entities must: 1) notify the parent or caretaker that a determination of presumptive eligibility has been made, 2) provide a full Medicaid application, and 3) notify the state agency within five working days that a child is presumptively eligible. The period of presumptive eligibility lasts until a final determination is made or one month after the end of the month in which the presumptive eligibility began, whichever occurs first.[85]

Texas' Approach[81]

Texas has taken a unique approach to connecting youth in the juvenile justice system with Medicaid. The Texas Juvenile Probation Commission uses a screening process to determine Medicaid eligibility of referred youth at two points: upon arrest and during the trial process. Initially, there was little movement to enroll this population because of the ban on the use of Medicaid funds for people in public institutions. However, since only three percent of Texas youth are committed to public institutions, leaving the other 97 percent eligible for Medicaid-funded treatment, the state has reconsidered. Local probation officers complete a social history of each arrested youth through an intake process that formalizes the referral. This includes gathering income information that can be used to enroll the youth in Medicaid. Upon completion of the intake process, the youth and family are encouraged to take the information to their local Medicaid office. Another Medicaid screening is completed if a hearing is scheduled, and the juvenile justice system is mandated to work closely with the local Medicaid office to enroll the youth, if eligible. The judge is then informed of Medicaid eligibility to determine the best placement for the youth. This small step, which takes about 10 minutes, has greatly increased the number of Medicaid enrollees.

States can draw down the federal Medicaid match during the presumptive eligibility period even if a child ultimately is deemed ineligible for Medicaid. If a child was presumed eligible for SCHIP but ultimately was determined ineligible for either Medicaid or SCHIP, expenses would be charged to the states' regular SCHIP funds and reimbursed at the enhanced SCHIP match rate.[86]

However, there are limitations on the effectiveness of presumptive eligibility as an enrollment strategy.[87] Presumptive eligibility lasts only 60 days or until the application is approved, whichever is shorter. In many states, an individual can be enrolled in presumptive eligibility just once a year. Some experts find that the

most successful presumptive eligibility programs are those that conduct intensive follow-up with families to gather the documentation necessary to complete the application process.[88] This follow-up is particularly important in light of citizenship and identity verification requirements imposed in 2006. These require Medicaid applicants to provide citizenship and identity documentation during the application process. States have responded by using data matches, providing individual assistance to applicants, extending the time applicants have to provide documentation, and partnering with community organizations and health clinics to verify documentation.

Use existing information for applications

Often the information necessary to complete a Medicaid or SCHIP application is readily available for transitional youth. States can use information – household composition, residence, parental or caretaker means of support, immigration status – already on file with the child welfare agency.[89] Similar information can be found in some states' files for youth in the juvenile justice system. States also may request information from other federal and state agencies to verify a parent or caretaker's income through the Income and Eligibility Verification System.[90] In addition, for youth with disabilities, the SSI application information is on file with the Social Security Administration.

Necessary application information also can be found using data gathered by other welfare programs such as the Food Stamp Program, the National School Lunch Program, and the Special Supplemental Program for Women, Infants, and Children (WIC).[91] These resources keep applicants from needing to produce additional documents that are often difficult for transitional youth to find. Unfortunately, many programs use incompatible computer systems. This makes information-sharing difficult. However, allowing Medicaid and SCHIP agencies permission to view databases under "read only" formats could facilitate communication between programs with similar eligibility requirements, ultimately lessening the burden on transitional youth.

The Connection Between Title IV-E, Foster Care, and Medicaid

Title IV-E funds are available for any youth entering foster care who meets AFDC (former cash assistance program) income eligibility levels at the time of removal from home.[93] These funds are always available for very low income children. In 2006, the average income eligibility was 49 percent of the FPL.[94] In 2004, 47 percent of youth entering foster care, or 193,700, were eligible for Title IV-E funds.[95] Children receiving Title IV-E are automatically eligible for Medicaid.[96] However, two separate applications are made, resulting in a delay before youth can receive medical services. Because Title IV-E has a lower income qualification than Medicaid, states could automatically enroll Title IV-E youth in Medicaid programs. States may run into problems with their Medicaid and foster care information technology systems because they lack the ability to communicate. Therefore, there is a clear need for Medicaid and foster care agencies to share data to make the enrollment process quicker for children in foster care.

Automatic Enrollment Strategies

Some experts encourage the use of automatic enrollment in Medicaid and SCHIP. Automatic enrollment would allow states to enroll eligible individuals in Medicaid or SCHIP based on information used to enroll them in other means-tested programs. Current federal rules prohibit health programs from relying on final income determinations of other programs because income calculation methods are slightly different and because signatures are required on applications.[92] However, if states were able to overcome these barriers, auto-enrollment could be used to simplify the enrollment process for youth entering the foster care system who receive Title IV-E funds – who are by definition eligible for Medicaid – and shorten the period

before services can be received. No states currently employ automatic enrollment as described here, but many are looking for new ways to automate enrollment by enabling agencies to share data.

Treatment of family income and resources

Medicaid income and resource standards and methodologies differ from state to state. A standard is a dollar-amount threshold under which an individual or family is eligible. A methodology determines how the applicant's income and resources are counted for the purposes of applying the standard.

In the case of foster care children who are not Medicaid-eligible through the Title IV-E pathway, federal Medicaid law prohibits states from attributing the income and resources of foster care parents to foster children. The income of biological parents is attributable to a foster child only prior to placement and for one month thereafter (unless the state child welfare agency places the child with a biological parent).[97] However, if a child has any income or resources of his or her own, that amount is counted in determining Medicaid eligibility.

In the case of other children, such as those in the juvenile justice system, states have the option of not counting parental income if the parent and child do not live together.[98] It is the responsibility of the state to characterize where the child lives.

Improving coordination with SCHIP for youth who transition into higher-income families.

Some states have worked to ease transitions between Medicaid and SCHIP to help children keep coverage. As many as 2.4 million children transition between Medicaid and SCHIP each year.[99] As of February 2008, there were 51 SCHIP programs using a variety of structures. Eight states and the District of Columbia operate SCHIP as an extension of Medicaid, 18 states operate state-designed programs, and 24 states use a combination of the two styles.[100]

Under federal law, states are required to screen all children who apply for SCHIP coverage to identify those who qualify for Medicaid.[101] Children found eligible must be enrolled in Medicaid. This rule has become known as the "screen and enroll" requirement. Effective screen and enroll procedures help prevent children from losing out on coverage if a parent applies to the wrong program and ensure that children eligible for Medicaid receive the program's full benefits and protections. Screen and enroll procedures also allow for a smooth transfer between programs as family circumstances change. Likewise, federal SCHIP regulations require state Medicaid agencies to adopt processes to facilitate enrollment in SCHIP when a child is found ineligible for Medicaid at initial application or redetermination.

Many states have worked to improve coordination between Medicaid and SCHIP programs at renewal. Federal rules require state Medicaid agencies to develop a process that facilitates enrollment in SCHIP if a child is found ineligible for Medicaid.[102] States have different ways of doing this:

- Some transfer information electronically from Medicaid to SCHIP.
- Others place eligibility workers for both programs in the same location to eliminate delays in transferring information.
- Some develop official Medicaid notices that are simple to read and include information about the child's potential eligibility for SCHIP.
- Some develop joint renewal forms or synchronize Medicaid and SCHIP renewals.

Minimizing the impact of Medicaid's citizenship and identity requirements

The Deficit Reduction Act of 2005 (DRA), which was signed by President Bush in February 2006, requires everyone applying for Medicaid to provide documentation of his or her citizenship status and identity. Previously, federal law allowed states to attest to individuals' citizenship under penalty of perjury and required documentation only in certain circumstances. The language in the DRA did not have specific exemptions for transitional youth, but technical amendments passed as part of the Tax Relief and Health Care Act of 2006 (TRHCA) specify that children who receive foster care or adoption assistance under Title IV-E are exempt from Medicaid citizenship documentation.[103] However, other transitional youth, such as those leaving foster care or the juvenile justice system, will have to prove citizenship and identity under the law and may have difficulty meeting this requirement because they lack proper documentation.

The TRHCA includes an exemption for children in foster care who receive services under Part B of Title IV-E. Part B funds a broad array of services to children in the child welfare system. At least some of these services are made available to all children in foster care. By exempting children receiving Title IV-E and foster children for whom Title IV-B services are available, all children in foster care are exempt from having to prove citizenship or identity in order to qualify for Medicaid.

The new provision exempting foster children also added a requirement that, under Title IV, state child welfare agencies are responsible for verifying the citizenship or immigration status of children in foster care. The new requirements for child welfare agencies became effective on June 20, 2006.

Retaining Medicaid Coverage through the Transitions

Federal rules prevent states from automatically terminating an enrollee's Medicaid coverage due to a status change: states must examine whether individuals may remain eligible before acting to end coverage.[104] This is particularly important for transitional youth. Access to benefits allows individuals released into the community or to an institution to receive services more quickly.

Experts have suggested the following actions for states to assist transitional youth in retaining their Medicaid coverage: conduct regular case reviews within foster care; suspend rather than terminate eligibility for youth entering the juvenile justice system; and use 12 months of continuous eligibility to keep youth enrolled during transitional periods, which are often shorter than a year.

12 months of continuous eligibility

Under the Balanced Budget Act of 1997, states may provide up to 12 months of continuous eligibility in Medicaid.[105] Under this option, youth may remain enrolled in Medicaid or SCHIP for a specified period of time – generally 12 months – regardless of fluctuations in family income.[106] In addition, continuous eligibility allows states to reduce administrative costs due to processing disenrollments and re-enrollments.[107] States that have not implemented continuous eligibility may want to consider this option. As of July 2007, only 16 states provided continuous eligibility for children in Medicaid, yet the majority of states with separate SCHIP programs – 27 of 37 – provided it in SCHIP.[108]

With continuous eligibility, a child leaving foster care or a non-institutional juvenile justice placement could continue to receive Medicaid without interruption – regardless of whether emancipated, adopted, or reunified with family – through the 12-month period. This gives families time to meet requirements to renew coverage. States that do not have continuous eligibility may have to take more complicated steps to ensure that children discharged from foster care retain coverage.

For example, in Illinois, if a foster care youth's case closes at age 18 because he or she is no longer in state

custody, the youth maintains Medicaid eligibility until age 19 as a result of the state's policy of granting 12 months of continuous eligibility for children.[109] However, in some states, continuous eligibility policies specifically exclude children in foster care who are being reunited with their families.[110] In other cases, computer problems have resulted in children returning home with a right to continuous eligibility but without an automatic continuation. States may need to investigate whether foster children and foster care leavers have been overlooked in the implementation of continuous eligibility policies.

Conduct administrative renewals

Retention rates improve dramatically when states conduct administrative renewals, a process by which the state updates income information on behalf of the family based on information received through other agencies and programs.[111] For example, Louisiana's Medicaid and SCHIP programs have streamlined their renewal processes to prevent coverage disruption. Caseworkers now search the benefits database to see if families are receiving benefits from other programs. If they are, caseworkers can verify income and continue coverage without interruption. In cases where verification is still required but an applicant isn't able to provide income information, data from the state's Department of Labor confirming reported wages can be used to maintain coverage.[112]

In early 2006, Illinois also began a new administrative renewal process for many children enrolled in Medicaid and SCHIP. Families are sent preprinted renewal forms that must be returned only if there are changes to report. These changes also can be reported by phone. Proof is required when changes in income or financial support (child or spousal) occur.[113]

Provide a grace period before disenrollment

In addition to, or instead of, 12-month continuous eligibility, states may want to provide a grace period before disenrolling transitional youth who may need extra time to respond to requests for information. Federal law requires at least 10 days of notice before termination.[114] In addition, states may be able to put transitional youth on "pending" status while trying to get the information necessary to retain eligibility.[115] However, some states provide an additional grace period to make it easier. For example, in Wisconsin, a youth who becomes ineligible for Medicaid between the first and 15th day of the month loses coverage by the end of that month. However, if he or she becomes ineligible after the 15th day of the month (for example, January 17th) benefits don't end until the first day of the following month (for example, March 1). This may help reinforce the message that health coverage is available to those leaving the juvenile justice and foster care systems.

Suspend – instead of terminating – Medicaid eligibility for youth in the juvenile justice system

As mentioned earlier, federal law prohibits Medicaid payments for care or services for certain inmates of public institutions. Some states choose to terminate an individual's Medicaid eligibility when the agency learns that an enrollee in the juvenile justice system has been incarcerated.[116] The youth is then required to reapply for Medicaid when released and must await an eligibility determination before access to services is renewed.

However, states are not required to terminate an individual's Medicaid eligibility upon incarceration.[117] In a letter to all state Medicaid directors, CMS encouraged states to suspend but not terminate Medicaid benefits while a person is in a public institution." [118] The letter goes on to clarify that an individual's Medicaid eligibility is not affected by his or her status as a resident of a public institution and that states can simply suspend an eligible inmate so that he or she can receive Medicaid benefits immediately after release.[119] Suspended youth stay on the Medicaid rolls, but the institutional setting cannot receive reimbursements.

Suspending Medicaid eligibility may be helpful because states can fully restore benefits upon release without repeating the application process.[120]

The secretary of HHS made clear in 2000 that "a state must ensure that the incarcerated individual is returned to the [Medicaid] rolls immediately upon release, unless the state has determined that the individual is no longer eligible for some other reason."[121] This allows released individuals to go directly to a Medicaid provider and access services.

Medicaid eligibility periods for children generally range from 6 months to 12 months, and the average stay in juvenile detention (in a public facility) is only 3.5 months, or 105 days.[122] Youth in the juvenile justice system whose Medicaid has been suspended rather than terminated may be more likely stay enrolled and connect with needed services and benefits after release.

In order to suspend Medicaid status, states may need to update computer systems that allow individuals to be deemed only "eligible" or "not eligible." A complicating factor is that SSI also stops payment of cash benefits when an individual becomes an inmate. When the state Medicaid office is notified of the SSI suspension, it often terminates an individual's Medicaid coverage as well. However, the Social Security Administration has the ability to place inmates in a suspension category if their incarceration lasts less than 12 months.[123] This could prevent many youth receiving SSI from Medicaid termination and allow quicker reinstatement of Medicaid services upon release.

Continue Medicaid coverage during detention

Federal Medicaid regulations leave room for Medicaid to continue to pay for services until the final disposition of a case. If a youth is in a "public institution for a temporary period pending other arrangements appropriate to his needs," he is not considered an inmate of a public institution and thus federal Medicaid funds are available.[124] Some states have interpreted this to mean that Medicaid can cover youth temporarily placed in detention until the final disposition of their case places them in a commitment facility or releases them from custody. And, if they are released from custody, they can keep their Medicaid coverage. The average stay in detention is two weeks, much shorter than the average five months that youth spend in commitment facilities.[125]

However, a recent interpretation from CMS suggests that the agency will not approve Medicaid state plan amendments if states seek to use federal finances for services for Medicaid-eligible youth who are temporarily placed in a juvenile detention facility.[126] As its reasoning, CMS states: [127]

> Specifically, the proposed SPA would exclude from consideration as public institutions 'juvenile detention facilities when the youth has been in a facility for less than 60 days and has not yet been fully adjudicated.' This proposal is inconsistent with the federal regulatory definition of a public institution at 42 CFR 435.10101. While the state's proposal appears to be based in part on a federal regulator exception to 'inmate' status at 42 CFR 435.1010, inmate status is an individualized determination distinct from facility status. Furthermore, the state errs in relying on that exception, which applies to individuals 'in a public institution for a temporary period, pending other living arrangements appropriate to his needs.' Pursuant to CMS guidance (issued in a December 12, 1997, memo to CMS Associate Regional Administrators) this exception does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Nor does it apply to individuals living in one public institution who are then transferred to

another public institution. We understand from the information the state provided that the youths at issue would be involuntarily residing in juvenile detention facilities and thus these individuals would be considered inmates. In sum, the proposed SPA would incorrectly exclude the facilities from consideration as public institutions, and would improperly apply an exception to inmate status to individuals involuntarily living in a detention facility.

Conduct a case review of foster care cases

One way to determine whether there have been inappropriate terminations is to conduct negative case reviews. As part of the Medicaid eligibility quality-control program, states may conduct alternative case reviews to focus on specific issues or populations.[130] A review of children discharged from foster care can provide states with information about whether Medicaid coverage is being inappropriately terminated. Reviews also can help states assess retention efforts.

Integration and Coordination with Partners

There are many opportunities for state Medicaid agencies to collaborate with partners at the state and local level to improve access for transitional youth. Federal Medicaid funds may be used to support certain outreach and enrollment activities. States can partner with foster care organizations and court systems and even provide judicial training. Medicaid applications can be integrated into discharge planning.

Detention versus Commitment: What is the Difference?

Within the juvenile justice system, a clear distinction is made between detention and commitment. Detention refers to the temporary placement of a youth into a secure facility. According to the Office of Juvenile Justice Delinquency and Prevention, youth "may be detained prior to adjudication or after adjudication while awaiting disposition or placement elsewhere."[128] Commitment refers to the placement of a youth into a secure facility as part of a court-ordered disposition. Of the youth who are sent to out-of-home facilities, placement in a detention facility typically occurs before a court adjudicates a case. Placement in a commitment facility typically occurs after a judge decides the case. However, if the youth is sentenced to a residential commitment facility after disposition, "but no placement beds are available, detention may continue until a bed becomes available."[129]

Use federal Medicaid and SCHIP administrative funds for outreach and enrollment

According to CMS, "Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan."[131] Most often, non-Medicaid agencies such as local health jurisdictions, health departments, federally recognized tribes, and schools use the Medicaid administrative match for outreach and enrollment services. However, government entities that do not traditionally assist with application procedures for Medicaid and SCHIP but that encounter populations frequently eligible for these programs also may qualify for the Medicaid administrative match.

These non-Medicaid agencies can work with state Medicaid departments to receive federal matching funds to help cover administrative costs of enrolling transitional youth. Matching funds are available for identifying potential beneficiaries, informing them about Medicaid and SCHIP, and helping them apply for benefits. The amount of reimbursement a state can claim depends on whether the outreach activity is associated with the state's Medicaid program, a separate SCHIP program, or a joint Medicaid-SCHIP outreach activity. It is important to note that schools' ability to use federal Medicaid funds for these functions may

be limited if CMS's school-based services regulations go into effect.[132]

In Medicaid, administrative expenses like outreach and enrollment are generally reimbursed at a 50 percent matching rate, meaning for every dollar the state spends, it receives 50 cents in federal Medicaid matching funds. These matching funds are not capped, so there is no limit on the amount of allowable outreach expenditures states can claim.

Each year, states receive a capped allotment of SCHIP funds. States may use up to 10 percent of their allotment for program administration, direct child-health services, and outreach. Administrative costs associated with a state's SCHIP-funded program are reimbursed at the state's SCHIP matching rate. (SCHIP matching rates range from 65 to 85 percent, a higher rate than Medicaid.) However, each state's allocation is limited, so the amount available for outreach also is limited.

King County, Washington

Since 1997, the Juvenile Court Services Division of the King County Supreme Court has used the administrative funds option for outreach and enrollment services with the support of the state's Medicaid department.[133] When a child enters the county juvenile justice system, case managers help the youth and his or her family complete a Medicaid eligibility application with the local Medicaid office. These services trigger the federal 50 percent matching rate, and the division is compensated for its efforts. On the busiest court day each week, King County also assigns a public health worker to address the medical issues of youth involved in the justice system. To date, King County is the only county in Washington to use the Medicaid Administrative Match for enrollment and outreach services for youth in the juvenile justice system.

Engage in outreach and partnerships with agencies and organizations that have close contact with transitional youth

Foster care organizations

States can educate foster care organizations about Medicaid and SCHIP. In addition to posting fliers and distributing applications, these organizations may be able to assist with the enrollment process. These organizations – whether state agencies or private nonprofits – may be positioned to reach families with children who have returned home as well as children in foster care. Furthermore, many children are monitored in their homes by state child welfare agencies, and some foster care agencies provide parenting classes to families whose children have not been removed.

Court systems

States also may want to conduct outreach with judges and their staff about the availability of health coverage for foster care children who return home, youth in the juvenile justice system who are assigned community sanctions, and committed youth who are released into the community. Judges may not be aware that their state provides publicly funded health coverage to children with incomes above the poverty line. Judges also can require that steps be taken so that eligible children retain Medicaid or enroll in SCHIP. For example, many foster cases require a judge's approval of the child welfare agency's discharge plan. States and localities may want to consider using a similar strategy for youth in juvenile court.

Judicial training

States also can inform juvenile court judges of the health services available to youth. By learning about the range of medical services and sources of funding, judges are able to make informed decisions to provide appropriate rehabilitation in addition to sanctioning youth for delinquent behavior.

Integrate health coverage applications into discharge planning

For youth in the foster care system, child welfare agencies could facilitate the continuation of coverage by completing relevant paperwork during discharge planning. State Medicaid agencies also can assist youth in the juvenile justice system with their applications before release, or they can train juvenile correction staff on the Medicaid eligibility process, which would help them screen youth before they leave the system.

Juvenile justice aftercare planning models

California

California recently passed legislation that will help youth in the juvenile justice system obtain Medicaid eligibility before they are released. [134] Chapter 657 of the California statute requires juvenile facilities to inform welfare departments responsible for Medicaid processing of a committed youth's name and scheduled date of release upon his or her commitment to a facility for more than 30 days. This information is used by the welfare department to process the youth's application by contacting the youth's parent or guardian to obtain additional information. Interestingly, this law means all committed youth will be screened for eligibility. Each youth's parent or guardian is sent a letter about the process but is required to respond only if he or she wishes to halt the Medicaid eligibility process.

When possible, the juvenile facility will submit the required information to the county welfare department at least 90 days prior to release for youth with disabilities and no less than 45 days prior to release for non-disabled youth. If the youth is found eligible for Medicaid benefits, a temporary card is sent to the detention facility and given to the youth upon release. A permanent Medicaid card will be mailed to the youth soon after. This process attempts to address the gap in the receipt of services for youth exiting the juvenile justice system by designing a streamlined approach to enroll every eligible child.

Texas

In addition to screening at arrest and during the trial process, Texas provides a third intercept point to connect youth leaving a secure placement with Medicaid services.[135] Youth committed to a secure facility for more than 30 days are removed from the Medicaid rolls and must apply for coverage upon release. In an effort to assist youth who are approaching their release date, Texas created the Institution Transition Medicaid Program. Approximately 30 days before release, the juvenile justice staff determine if: a) the family has another child with an active Medicaid case; and, if not, b) assist youth and their families in acquiring the information, documents and signatures needed for a complete Medicaid application. If the family is found eligible, they submit a request to add the juvenile to the existing active Medicaid case. The youth receives an active Medicaid card upon discharge, thereby eliminating the wait time typically experienced by this population.

Conclusion

Access to health coverage improves a youth's chances of becoming a healthy, productive member of society. However, because of the likelihood of behavioral and health problems, ensuring access to health care for youth involved in the foster care and juvenile justice systems is especially critical. This report is intended to help states work through many complex eligibility and process options in their Medicaid and SCHIP programs to provide health coverage for these populations. Additional work by NASHP will continue to address models for improving the delivery of services and access to care.

Appendices

Appendix A- December 12, 1997 Letter Clarifying Medicaid Coverage Policy for Inmates of a Public Institution

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

DEC 12 1997

FROM: Director
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

SUBJECT: Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

TO: All Associate Regional Administrators
Division for Medicaid and State Operations

The purpose of this memorandum is to clarify current Medicaid coverage policy for inmates of a public institution. Recently, central office staff have become aware of a number of inconsistencies in various regional office directives on this subject which have been sent to States. Moreover, the growing influx of inquiries from the internet has prompted us to expand and, in some cases, refine our coverage policy in this area. Therefore, in the interest of insuring consistent and uniform application of Medicaid policy on inmates of a public institutution, we believe that this communication is necessary.

Statute and Parameters

Section 1905(a)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. An individual who is voluntarily residing in a public institution would not be

considered an inmate, and the statutory prohibition of FFP would not apply. Likewise, an individual, who is voluntarily residing in a public educational or vocational training institution for purposes of securing education or vocational training or who is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made, would not be considered an inmate. It is important to note that the exception to inmate status – based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, a facility is a public institution when it is under the responsibility of a governmental unit; or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling or transferring ownership rights of the prison's medical un (including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

Exception to Prohibition of FFP

As noted in the above cited statute, an exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and

the 'inmate' is Medicaid-eligible. We would note that in those cases where an 'inmate' becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available.

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

Policy Application

As a result of a significant number of recent inquiries from the internet and regional offices, we have provided policy guidance involving issues where inmates receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination.

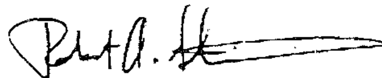
Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e.g., transfer to a community residence)
6. Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control
4. Inmates receiving care as an outpatient
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If there are any questions concerning this communication, please contact Thomas Shenk or Verna Tyler on 410 786-3295 or 410 786-8518, respectively.



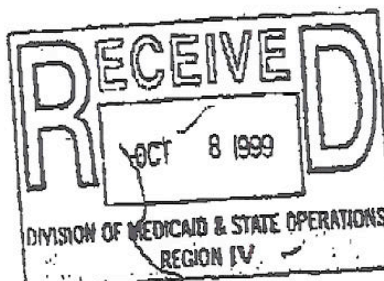
Robert A. Streimer

Appendix B- September 29, 1999 Letter on Medicaid Eligibility for Inmates of a Public Institution

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850



SEP 29 1999

Mr. Robert J. Raubach
Georgia Advocacy Office
100 Crescent Centre Parkway, Suite 520
Tucker, Georgia 30084

Dear Mr. Raubach:

Thank you for your letter dated September 27, 1999, requesting confirmation of the Medicaid policy on inmates of a public institution. Specifically, you are asking whether Medicaid payment can be made for services provided to an individual while incarcerated in a public institution. You also question whether Medicaid eligibility is retained during the period of incarceration.

Section 1905(a)(A) of the Social Security Act specifically excludes Federal financial participation (FFP) for medical care provided to inmates in a public institution, except when the inmate becomes a patient in a medical institution. To elaborate, HCFA has interpreted that FFP is not available for any individual involuntarily residing in a detention center (such as a county jail), prison, or any other penal facility. Whereas, FFP is available when an inmates becomes an "inpatient" in a Medicaid certified provider such as a hospital, nursing facility, or intermediate care facility for the mentally retarded. It is important to note that the Medicaid program does not cover care provided to any individual age 22-64 residing in an institution for mental disease (IMD), including any individual who may have been an inmate immediately preceding admission to the IMD.

Regarding the question of eligibility, there are no Federal requirements which preclude an inmate of a public institution from retaining Medicaid eligibility status. The standard rules for determining Medicaid eligibility apply equally to all individuals, including inmates.

We wish you well with the resolution of this issue.

Mary Jean Duckett

Mary Jean Duckett
Director
Division of Benefits, Coverage and Payment

cc: Atlanta RO

Appendix C- April 6, 2000 Letter on Retaining Eligibility and Suspending Payments for Inmates

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 6 2000

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-3215

Dear Mr. Rangel

Thank you for your letter requesting clarification of Federal law regarding the eligibility of detainees/inmates in the New York City jail system. You asked if Federal policy requires or allows States to suspend (or end) Medicaid eligibility for inmates entering the New York City Jail System at Rikers Island. You also asked about Federal policy on reinstating Medicaid eligibility upon release of such an inmate. I regret the delay in this response.

Since Federal Financial Participation is not available for services rendered to a Medicaid-eligible individual during the period of incarceration (see section 1905(a) of the Social Security Act), Federal policy permits (but does not require) States to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed. In addition, for inmates with longer periods of incarceration, a State can periodically redetermine eligibility as required by 42 CFR 435.916, but use simplified procedures to do so. Regardless of the simplified procedures used, a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason.

I have asked Ms. Judy Berek, the Health Care Financing Administration's Regional Administrator for the New York area, to contact the State and ensure that Federal policy is understood and implemented correctly.

I appreciate your bringing this matter to our attention.

Sincerely,

Donna E. Shalala

Appendix D- September 14, 2000 Letter Regarding Suspending Medicaid Payment and Redeterming Medicaid Eligibility for Inmates

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Refer to

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

September 14, 2000

Kathryn Kuhmerker, Director
Office of Medicaid Management
New York State
Department of Health
Corning Tower - Room 1441
Empire State Plaza
Albany, New York 12237

Dear Ms. Kuhmerker:

As you know, we have received some inquiries regarding Medicaid eligibility for detainees and inmates in the New York City jail system. Since Federal Financial Participation is not available for services rendered to Medicaid-eligible individuals during the period of incarceration (Section 1905(a) of the Social Security Act), Federal policy permits States to use administrative measures that include temporarily suspending eligible individuals from payment status during the period of incarceration.

Additionally for inmates with longer periods of incarceration, specifically a period of time that exceed the State's customary period of time before a eligibility redetermination would be conducted, States can use simplified procedures to redetermine eligibility as required by 42 CFR 435.916. However, a State does not need to do a redetermination as long as the individual remains incarcerated, but once the discharge appears imminent, States must do a redetermination. As per the Health Care Financing Administration's letter of April 7, 2000, States cannot terminate individuals from Medicaid until a redetermination has been conducted, including an ex-parte review.

Regardless of the simplified procedures used, unless a State has determined that an individual is no longer eligible for Medicaid, States must ensure that incarcerated individuals are returned to the rolls immediately upon release. Thus, allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility.

If you have any questions or would like to discuss this further, please contact Patricia Ryan of my staff at (212) 264-9122.

Sincerely,

Sue Kelly
Associate Regional Administrator
Division of Medicaid and State Operations

Appendix E–May 25, 2004 Letter on Suspending and Not Terminating Medicaid Benefit for People in a Public Institution or Institute for Mental Disease

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

TO: State Medicaid Directors
CMS Associate Regional Administrators for Medicaid

CC: Charlene Brown, CMSO Deputy Director

FROM: Glenn Stanton
Acting Director
Disabled and Elderly Health Programs Group (DEHPG)

SUBJ: Ending Chronic Homelessness

DATE: May 25, 2004

The United States Interagency Council on Homelessness, recently chaired by HHS Secretary Thompson, is working to develop and implement a comprehensive national approach to end chronic homelessness in the United States through interagency, intergovernmental, and intercommunity collaborations. CMS has been supporting the efforts of the council in several ways. First, we worked with our federal partners to release a new tool on our website entitled *First Step on the Path to Benefits for People who are Homeless*. The *FirstStep* product is an easy-to-use, interactive tool designed to assist case managers and outreach workers in helping people who are homeless to gain access to mainstream programs. The tool may be found on the CMS website at http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html.

Second, I am pleased to announce that we have posted a report on our website that is entitled *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*. This report focuses on practices that have increased Medicaid access for people experiencing chronic homelessness, including assisting people leaving psychiatric facilities and correctional facilities to obtain Medicaid quickly. We hope this report will provide useful information about state efforts as you address chronic homelessness issues in your state. The report may be found on CMS's website at http://www.cms.hhs.gov/promisingpractices/ or at http://www.cms.hhs.gov/medicaid/homeless/.

Finally, CMS is encouraging states with this letter to "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons

benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs[1] affects only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.

Thus, states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility.

Given the high incidence of substance abuse, mental illness, and physical illness among those who have been incarcerated or otherwise held in involuntary custody, I encourage states to coordinate prison health services and other health care services provided during involuntary confinement with Medicaid services. By working with parole officers and other social services professionals who deal with inmates and residents of IMDs who are to be released, State Medicaid programs can assure that eligible persons are enrolled in Medicaid prior to release and can create an ongoing continuum of care for these individuals, regardless of the source of funding for such care.

In closing, I want to thank you for your ongoing efforts to improve access to Medicaid for all persons, and particularly for those who are homeless.

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10 Ronald Feinstein et al., "Medical Status of Adolescents at Time of Admission to a Juvenile Detention Center," *Journal of Adolescent Health* 22, (1998): 190-196.

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13 Snyder and Sickmund. The connection between poverty and delinquency may not be direct, but the existence of poverty does exert a strong influence on family disruption and can lead to criminal activity.

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17 Administration on Children, Youth and Families, *The AFCARS Report: Preliminary Estimates for FY 2005* (Washington, D.C.: U.S. Department of Health and Human Services, 2006).

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39 Andy Schneider and Kristen Fennel, *Medicaid Eligibility Policy for Children in Foster Care* (Washington, D.C.: National Academy for State Health Policy, 1999).

40 Ibid.

41 Schneider and Fennel, Social Security Act §1905(a)(i), and 42 CFR §435.601(d). First, the Social Security Act, as implemented by federal regulations, authorizes states to provide Medicaid coverage to "reasonable categories" of youth under the age of 21 who are not receiving cash assistance. While the statute does not define "reasonable categories," the regulations provide some examples including "individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility" and "individuals under age 21 receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan." Second, the Social Security Act, as implemented by federal regulations, prohibits states from attributing "income and resources of any relative as available to an individual."

42 P.L. 106-169, Social Security Act §1902(a)(ii)(XVII), and §1905(w)(1).

43 For details about the different Chafee option implementation, see the Patel and Roherty report. It includes survey responses, Medicaid state plan amendments, and state statutes.

44 Sonali Patel and Martha Roherty, *Medicaid Access for Youth Aging Out of Foster Care* (Washington, D.C.: American Public Human Services Association, 2007) and information gathered by NASHP.

45 Child Welfare Information Gateway, *Adoption Assistance for Children Adopted from Foster Care* (Washington, D.C.: U.S. Department of Health and Human Services, 2004).

46 Fox, Limb, and McManus.

47 Ibid.

48 Calculations based on AFDC levels in 1996 and the 2007 federal poverty levels.

49 Keavney Klein and Sonya Schwartz, National Academy for State Health Policy, unpublished data, April 2008. Arizona, Delaware, Hawaii, Maine, Massachusetts, New Mexico, New York, and Oregon provided coverage through Medicaid Section 1115 waivers. VT, DC, MN, and WA used state-only dollars to provide such coverage. Many of these states went above 100 percent of FPL in extending eligibility. A number of states provided limited benefits or limited eligibility, coverage for childless adults, including PA, using state-only dollars, and by Arizona, DC, Iowa, Idaho, Indiana, Maryland, Michigan, Missouri, Montana, New York, Oklahoma, Tennessee, and Utah using 1115 waivers, and MO plans to implement a similar program. These states either covered a limited subset of non-categorical adults (such as those working for small firms) or provided fewer benefits than are offered by typical employer sponsored insurance.

50 For more information about Medicaid family planning programs, see a series of NASHP briefs on this topic at: http://www.nashp.org/_docdisp_page.cfm?LID=9D8D9A9A-BF45-42DD-91723CC247FD7D6B.

51 Neva Kaye et al, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, 2006), 21.

52 Social Security Act § 1905(a)(28)(A). As amended and related enactments through January 1, 2007.

53 See 42 CFR § 435.1009 and 42 CFR § 435.1010

54 Ibid.

55 Letter from Robert A. Streimer, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, to All Associate

Regional Administrators, Division for Medicaid and State Operations, December 12, 1997.

56 Letter from Mary Jean Duckett, Director, Centers for Medicare and Medicaid Services Division of Benefits, Coverage and Payment, to Robert Raubach, Georgia Advocacy Office, September 29, 1999.

57 Snyder and Sickmund, 168.

58 42 CFR § 435.1010, See definition of inmate of public institution, Section b.

59 Letter from Kerry Weems, Acting Administrator, CMS, to Robin Arnold-Williams, Secretary, Department of Social and Health Services, Washington State, November 8, 2007.

60 Anne Stahl et al., *Juvenile Court Statistics 2003–2004* (Pittsburgh, PA: National Center for Juvenile Justice, 2007).

61 Jane Koppelman, *Mental Health and Juvenile Justice: Moving Towards more Effective Systems of Care* (Washington, D.C.: National Health Policy Forum, 2005), 11.

62 Ibid.

63 National Council of Juvenile and Family Court Judges. "Juvenile Graduated Sanctions E-Tool." NCJFCJ. Retrieved 19 February 2008. http://www.ncjfcj.org/content/view/752/456.

64 Steve Gies, "Aftercare Services." September 2003. Office of Juvenile Justice and Delinquency Prevention. Retrieved 31 January 2008. http://www.ncjrs.gov/html/ojjdp/201800/contents.html#acknowledge

65 Pat Redmond, *Children Discharged From Foster Care: Strategies to Prevent the Loss of Health Coverage at a Critical Transition* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2003).

66 Sue Badeau and Sarah Gesiriech, *A Child's Journey Through the Child Welfare System* (Washington, D.C: The Pew Commission on Children in Foster Care, 2003).

67 Administration on Children, Youth, and Families.

68 Missouri Department of Social Services. "Foster Care/Out of Home Care/After Care." May 2007. Missouri Department of Social Services. Retrieved 31 January 2008. http://www.dss.mo.gov/cd/fostercare/fcac.htm.

69 Administration on Children, Youth and Families. 54 percent are reunified with parents/primary caretakers and 11 percent lived with other relatives.

70 Redmond.

71 42 CFR § 435.930.

72 Administration on Children, Youth and Families.

73 Ibid.

74 Ibid.

75 Social Security Act § 471(a)(21) and Redmond. For children not eligible for federal Title IV-E adoption assistance but receiving state-funded adoption assistance, the state providing the adoption assistance must provide health insurance coverage equivalent to Medicaid if it is determined that due to the child's special needs for medical, mental health or rehabilitative care, the child cannot be placed with adoptive parents without medical assistance.

76 Alison Evans Cuellar et al, "Medicaid Insurance Policy for Youths Involved in the Criminal Justice System," American Journal of Public Health 95, no. 10 (Oct. 2005).

77 Ibid.

78 42 CFR § 435.930.

79 Pat Redmond.

80 States' ability to use federal Medicaid funds for therapeutic foster care will be limited if the rehabilitation regulations proposed by CMS go into effect. Medicaid Program; Coverage for Rehabilitative Services, 72 Fed. Reg. 45201 (August 13, 2007).

81 Erin Espinosa, Texas Juvenile Probation Commission, phone interview by Sonya Schwartz and Melanie Glascock, March 2008. Cindy Weisinger, Texas Juvenile Probation Committee, phone interview by Karen Clark, May 2006, cited in Shelly Gehshan and Karen Clark, *Meeting the Needs of Youth Involved in the Juvenile Justice System* (Washington, D.C.: Joint Center for Political and Economic Studies Health Policy Institute, 2007).

82 42 CFR § 436.1100(a). The SCHIP presumptive eligibility rules are at 42 CFR § 457.355.

83 Donna Cohen Ross and Aleya Horn, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2008), Table 5. More specifically, 9 states have presumptive eligibility in both their Medicaid and separate SCHIP programs, 3 states have presumptive eligibility in both their Medicaid and SCHIP expansion programs, and 2 states only have presumptive eligibility in their Medicaid programs.

84 42 CFR § 436.1101 Definition of Qualified entity (10).

85 42 CFR § 436.1102.

86 Rachel Klein, "Presumptive Eligibility," The Future of Children 13, no. 1 (Spring 2003): 230-237. In addition, Medicaid includes retroactive eligibility, beginning three months prior to the date of an application for Medicaid. If the child incurred medical bills and would have been eligible during that time, Medicaid could cover these services. Therefore, presumptive eligibility would not add to the cost of delivering care to children who are sick or have a chronic condition, as long as they are eligible for Medicaid.

87 See Vikki Wachino and Alice Weiss, "Maximizing Enrollment of Eligible Children in Medicaid and SCHIP: Retracing Seven Steps to Help States Find their Way Forward," The National Academy for State Health Policy, forthcoming.

88 Ibid.

89 Pat Redmond.

90 The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, *Putting Express Lane Eligibility Into Practice* (Washington, D.C.: TCP and Kaiser, 2000).

91 Stan Dorn and Genevieve Kenney, A*utomatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (New York, NY: The Commonwealth Fund, 2006).

92 Ibid.

93 Bazelon Center for Mental Health Law. "Federal Programs for Transition-Age Youth with Serious Mental Health Conditions: Title IV-E Payments for Children in Foster Care." Bazelon. Retrieved 19 February 2008. http://www.bazelon.org/publications/movingon/Introduction.pdf.

94 Calculations based on AFDC levels in 1996 and 2007 federal poverty levels.

95 Pew Charitable Trusts, *Time for Reform: Fix the Foster Care Lookback* (Philadelphia, PA: Pew Charitable Trusts, 2007).

96 Social Security Act § 473(b) and § 1902(a)(10)(A).

97 Social Security Act § 1902(a)(17); 42 USC § 1396(a)(17); and 42 CFR § 435.602.

98 42 CFR § 435.602(a)(2).

99 A study estimated that each year 27 percent of SCHIP enrollees, approximately one million children, switch to Medicaid, and 6 percent of Medicaid enrollees, roughly 1.4 million children, switch to SCHIP. Benjamin Sommers, "The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP," *Health Affairs* 24, no. 6 (November/December 2005): 1611-1618.

100 Centers for Medicare and Medicaid Services. "State Children's Health Insurance Program: Plan Activity as of February 4, 2008." CMS. Retrieved 20 April, 2008. http://www.cms.hhs.gov/LowCostHealthInsFamChild/ downloads/SCHIPStatePlanActivityMap.pdf.

101 42 CFR § 431.636. (For more information, see the Administration's Responses to Questions About the State Children's Health Insurance Program, Q.84A, July 29, 1998 available at http://www.cms.hhs.gov/smdl/downloads/ smd012398.pdf)

102 42 CFR § 431.636(b)(4).

103 The bill passed by Congress was numbered H.R. 6111. It was previously H.R. 6408, but was renumbered for technical reasons. Those who wish to see the text of the bill on Thomas (the Library of Congress website) should look for H.R. 6408. It became law on December 20, 2006.

104 42 CFR § 435.930(b) says that the state must continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible. There is no similar requirement in SCHIP.

105 42 CFR § 435.916.

106 Notably, even in states with the 12-month continuous eligibility option, youth may be disenrolled from SCHIP for non-payment of premiums. 42 CFR § 457.320(e)(2).

107 Carol Irvin et al., *Discontinuous Coverage: Implications For 12-month Continuous Coverage for Children* (Cambridge, MA: Mathematica Policy Research, 2001).

108 Ross and Horn, Table B. More specifically, 14 states have 12 month continuous eligibility in both their Medicaid and SCHIP expansion programs, 13 states have 12 month continuous eligibility in both their Medicaid and separate SCHIP programs, and 2 states only have 12 month continuous eligibility in their separate SCHIP programs.

109 Patel and Roherty.

110 Pat Redmond.

111 Uchenna Ukaegbu and Sonya Schwartz, *Seven Steps Toward State Success in Covering Children Continuously* (Portland, ME: National Academy for State Health Policy, 2006).

112 Ibid.

113 Ibid.

114 42 CFR § 431.211 and § 431.213.

115 Memorandum from Timothy Westmoreland, Director, U.S. Department of Health and Human Services, Health Care Financing Administration, to State Medicaid Directors, Apr. 7, 2000. Available at: http://www.cms.hhs.gov/ smdl/downloads/smd040700.pdf. Federal guidance describes this as a strategy states can use to assure that families leaving TANF do not lose Medicaid benefits.

116 Cuellar et al. A 2003 survey showed that Medicaid disenrollment may not be happening systematically and, in fact, occurs less often for youths in detention than may be believed. The survey also indicated that at the time, many states had a Medicaid policy of disenrolling youth in detention, but the implementation was relatively weak. These results do not necessarily generalize for youth in commitment facilities. The survey showed that 46 percent of state and local Medicaid agencies reported that facilities had a practice of disenrolling youth, while only four percent of local detention facilities and one-third of state justice agencies claimed to have such a practice. In order to disenroll beneficiaries, Medicaid programs must become aware of which youth are in detention. And while a substantial proportion of state and local Medicaid agencies responded that they were notified about new detention episodes, only 17 percent of state justice agencies and four percent of local agencies reported that they notified Medicaid agencies.

117 Memorandum from Robert Streimer, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Health Care Financing Administration, to All Associate Regional Administrators, Clarification of Medicaid Coverage Policy for Inmates of a Public Institution, Dec. 12, 1997. A state may not terminate anyone from Medicaid without first determining whether the individual qualifies under other Medicaid-eligibility categories. States must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible" (42 CFR § 435.930(b)).

118 Letter from Donna Shalala, Secretary, Health and Human Services, to Honorable Charles Rangel, House of Representatives, Apr. 5, 2000; Letter from Sue Kelley, Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State Department of Health, Sep 14, 2000. State officials can "use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed."

119 Memorandum from Glenn Stanton, Acting Director, Disabled and Elderly Health Programs Group, Centers for Medicare and Medicaid Services, to State Medicaid Directors, Ending Chronic Homelessness, May 25, 2004.

120 Council of State Governments, Criminal Justice/Mental Health Consensus Project (New York, NY: Council of State Governments, 2002), 108. Available at: http://consensusproject.org/the_report/. The report notes, "Suspending, instead of terminating, the detainee's enrollment in Medicaid enables staff to effect the reinstatement of the benefits immediately upon release, guaranteeing the individual access to the treatment and medications likely to keep him or her from coming into contact with the criminal justice system again."

121 Letter from Donna Shalala.

122 Snyder and Sickmund.

123 Chris Koyanagi, *For People With Serious Mental Illness: Finding the Key to Successful Transition from Jail to Community: An Explanation of Federal Medicaid and Disability Program Rules* (Washington, D.C.: Bazelon Center for Mental Health Law, 2001).

124 42 CFR § 435.1010. See definition of inmate of public institution, Section b.

125 Melissa Sickmund et al., *Juvenile offenders and victims: 1997 update on violence* (Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, 1997).

126 Letter from Kerry Weems, Acting Administrator, CMS, to Robin Arnold-Williams, Secretary, Department of Social and Health Services, Washington State, November 8, 2007.

127 Ibid.

128 Snyder and Sickmund.

129 Ibid.

130 42 CFR § 431.812

131 Centers for Medicare and Medicaid Services, "Medicaid School-Based Administrative Claiming Guide." 2003. U.S. Department of Health and Human Services. Retrieved 3 April 2008.

132 Medicaid Program; Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School, 72 Fed. Reg. 73,635 (December 28, 2007).

133 Susie Bridge Weber, King County Supreme Court, Juvenile Court Services, phone interview by Melanie Glascock, March 2008.

134 Memorandum from Vivian Auble, Chief, Medi-Cal Eligibility Division, Letter No.: 07-34, Medi-Cal Pre-Release Application Process for Wards in County Juvenile Facilities, Jan. 2, 2008.

135 Erin Espinosa, Texas Juvenile Probation Commission, phone interview by Sonya Schwartz and Melanie Glascock, March 2008.

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