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A Medicaid Primer for Juvenile Justice Officials

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Juvenile justice agencies face a significant challenge meeting the health needs of the youth in their systems. Medicaid, which provides health coverage to more than half of all low-income children in this country, can be a vital partner in juvenile justice reform efforts.[1] However, coordination between juvenile justice systems and state Medicaid programs can be much improved. It may help many juvenile justice officials to learn more about Medicaid and how it can be used to improve their programs and the lives of the young people they work with. Thus, the purpose of this *State Health Policy Briefing* is to provide those who work with system-involved youth with an introduction to Medicaid and its key concepts, as they pertain to the juvenile justice system.

More than two million juveniles are arrested each year, and nearly 100,000 youth in this country are at present in a juvenile justice facility. Young people involved in the juvenile justice system suffer disproportionately from unmet mental and physical health needs, including mental health disorders, oral health problems, reproductive health issues, and substance abuse issues.[2] The significant health needs of many of these adolescents may be part of the reason that led to their arrests or involvement in the juvenile justice system. If their health needs remain unaddressed, they are much less likely to live productive lives and succeed in school or work, and are more likely to face re-arrest after release.

Medicaid, a partnership between the federal and state governments, is the primary source of health coverage for low-income children in the United States. More than 28 million children, or 26 percent of children in this country, are enrolled in Medicaid.[3,4] All 50 states and the District of Columbia have distinct Medicaid programs, with different policies and procedures. Yet all programs have identical fundamental elements defined by federal law, and programs are administered within broad federal guidelines and oversight.

Federal/State Partnership

Within broad limits set by federal law and regulations, each state administers and determines the scope of its Medicaid program. Federal guidelines spell out a minimum set of services that states are required to provide to certain low-income individuals. The federal government and the states also share financing responsibilities for Medicaid. This section details this federal/state partnership, including financing, program design, the state plan, and the ability of states to "waive" some federal requirements.

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FINANCING

Medicaid is funded jointly by the federal government and the states, and the federal match is at least dollar for dollar. The federal share of Medicaid funding (called the Federal Medical Assistance Percentage or FMAP) changes annually and varies by state and type of cost. For example:

- In 2008, the federal government is paying between 50 percent and 76 percent of the cost of allowable services. The rate is adjusted annually and is calculated from a formula designed to ensure that the federal government pays a larger share in states with lower per capita incomes and a smaller share in states with higher per capita incomes.
- The federal share of costs for Medicaid benefits varies and averaged 57 percent in 2006.[5]
- The federal government pays at least half of allowable administrative costs and up to 90 percent for some costs, such as family planning services, which are matched at a higher rate due to their important role in prevention of future care and costs.

PROGRAM DESIGN

States have flexibility to determine how their programs are designed. Within federal guidelines, states can determine:

- Who is eligible for Medicaid,
- What benefits are covered,
- How much to pay providers for services,
- How services will be delivered, and
- How "medically necessary" will be defined.[6]

STATE PLAN AMENDMENTS

Each state documents the choices it has made about the design and operation of its Medicaid program in its state plan. If a state wishes to change any of those choices, it must amend its state plan. These amendments are referred to as State Plan Amendments (SPAs) and must be approved by the federal agency that oversees the Medicaid program, the Centers for Medicare and Medicaid Services (CMS). The SPA process allows states considerable flexibility to design their Medicaid programs and it provides the federal government with opportunities for oversight to ensure states are operating within federal guidelines. For example, through this process states may:

- Provide or remove coverage to an optional eligibility group,
- Establish methods for counting income when determining eligibility,
- Set most provider payment rates, and
- Provide or remove optional benefits and determine the amount, duration, and scope of those benefits.[7]

WAIVERS

While State Plan Amendments are used by states to document their policy choices within federal guidelines, the Secretary of Health and Human Services can, at a state's request, waive provisions of Medicaid and State Children's Health Insurance Program (SCHIP) law to enable states to implement policies that are otherwise not allowable under standard federal guidelines. Under a waiver, states can change eligibility, benefits, and cost-sharing requirements in their programs, either broadly or for specific services or populations. Waivers allow states to use federal funding to test new models and strategies – with the important caveat that the change must be "budget neutral" for the federal government (that is, it results in no increase to federal Medicaid costs).[8]

Eligibility for Children

MANDATORY AND OPTIONAL GROUPS OF CHILDREN

Federal law requires states to cover the following groups of children in their Medicaid programs:

- Children under age 6 in families with income up to 133 percent of the Federal Poverty Level (FPL).
- Children 6 to 19 in families with income up to 100 percent FPL.
- Pregnant women with income up to 133 percent FPL.
- Infants to age 1 born to Medicaid-eligible pregnant women, as long as the infant remains in the mother's household and the mother remains eligible, or would be eligible if she were still pregnant.[9]
- Children in families who would have qualified for Aid to Families with Dependent Children under the state's guidelines that were in place on July 16, 1996.

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- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.[10,11]

In addition, states have the option to extend coverage beyond these minimum standards – and still qualify for federal matching funds – to several groups, including:

- Children above the federal minimum income levels,
- Pregnant women and infants under age 1 above 133 percent of the federal poverty level, and
- Children who qualify as "medically needy," either immediately or by "spending down" into Medicaid coverage through paying out-of-pocket medical expenses to lower their income to a predetermined level.[12]

OPTIONAL YOUNG ADULTS (19 TO 21 YEAR OLDS)

In most states, when previously eligible adolescents turn 19, they become ineligible for Medicaid unless they can qualify as adults (such as for pregnancy coverage or as a parent). There are a few ways, however, that some 19- and 20-year olds may remain Medicaid eligible. For example:

- Fifteen states have adopted the "Ribicoff Children" option to extend coverage to those ages 19 and 20. Ribicoff children are young adults who meet income eligibility but would not be eligible ordinarily because of their age. Income limits for Ribicoff Children vary from 23 percent to 150 percent FPL, depending on the state.[13]
- States can also implement the "Chaffee option" to extend Medicaid eligibility to 19- and 20-year olds who have "aged out" of foster care, including those who are also involved in the juvenile justice system.[14] Currently, 17 states have acted to provide Medicaid coverage to youth in this way.[15]
- Another way 19- and 20-year olds may be able to access Medicaid benefits is through medically needy programs. Medically needy programs may allow those ages 19 and 20, among others, to qualify immediately or "spend down" their income with allowable medical expenses to a predetermined level to become eligible for Medicaid coverage.[16] Currently 17 states have medically needy programs that include young adults up to age 21.[17]

METHOD FOR DETERMINING ELIGIBILITY

States use family income and may also consider family assets (often referred to as resources) to determine children's eligibility for Medicaid.[18] States have considerable flexibility in establishing both income and resource limits.

States also have considerable flexibility in establishing the methodology they will use to count income and resources. States must "disregard," or not count, certain types and amounts of family income. The same is true for resources, if the state chooses to consider resources. At a minimum, states are required to use the same disregards that were in place on July 16, 1996 and disregard a family's income from certain types of federal benefits, such as Low Income Energy Assistance payments.[19] States may choose to disregard additional amounts or types of income. For example, many states disregard a child-care allowance of $175 per month for each child over age two and $200 per month for each child under two years old who is in child care. Also, in almost all states, the first $50 of child support payments is disregarded.[20] Finally, some states have chosen to disregard certain amounts of income – such as all income between 100 percent FPL and 150 percent FPL. In effect, these deductions and disregards raise the income limit and allow more children to become eligible.

For the purposes of eligibility determination for those under 21 years old, states can consider the income of the individual's parents but not the income of any other relatives – even the income of those who reside in the same household, such as siblings. When a state considers income to be available to the applicant, this is called "deeming." When a family member has income that cannot be deemed to a Medicaid applicant, some states establish smaller eligibility units within the household and determine each unit's eligibility separately.[21]

PRESUMPTIVE ELIGIBILITY

Presumptive and continuous eligibility are two strategies states have implemented to facilitate the Medicaid enrollment and renewal process. Presumptive eligibility allows certain "qualified entities" approved by the state to determine temporary Medicaid eligibility for children. Once presumptive eligibility has been determined – usually by health care providers – children can access needed care without having to wait for a final determination to be made on their Medicaid application. During the presumptive eligibility period, providers are guaranteed payment for the care they deliver, and states are guaranteed regular matching funds from the federal government, regardless of the final eligibility determination. The presumptive eligibility period generally lasts between 30 and 60 days. Currently, 14 Medicaid programs have adopted presumptive eligibility for children.[22]

CONTINUOUS ELIGIBILITY

Families are required to make timely reports of any change in circumstances that may affect their Medicaid eligibility.[23] However, states have the option to provide continuous eligi-

Table 1 States that have implemented key Medicaid options for children and young adults

States with presumptive eligibility for children[a]	States with continuous eligibility for children[b]	States that cover 19-and 20-year old "Ribicoff Children"[c]	States with the Chafee Option to cover youth aging out of foster care[d]
California	Alabama	Alaska	Arizona
Colorado	California	California	California
Connecticut	Idaho	Connecticut	Florida
Illinois	Illinois	Iowa	Indiana
Kansas	Kansas	Maine	Iowa
Louisiana	Louisiana	Maryland	Kansas
Massachusetts	Maine	Minnesota	Massachusetts
Michigan	Michigan	New Jersey	Mississippi
Missouri	Mississippi	New York	Nevada
New Hampshire	New Jersey	North Carolina	New Jersey
New Jersey	New York	North Dakota	Oklahoma
New Mexico	North Carolina	Ohio	Rhode Island
New York	South Carolina	Pennsylvania	South Carolina
Wisconsin	Washington	Tennessee	South Dakota
	West Virginia	Vermont	Texas
	Wyoming		Utah
			Wyoming

SOURCE:

a. Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Fact New Hurdles* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2008).

b. Ibid.

c. Sonali Patel and Martha A. Roherty, *Medicaid Access for Youth Aging Out of Foster Care*, American Public Human Services Association, 2007.

d. Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, "The Public Health Insurance Cliff for Older Adolescents," Fact Sheet No. 4, Incenter Strategies. April, 2007.

bility for up to 12 months to children. Continuous eligibility guarantees children Medicaid coverage for an entire year, regardless of changes in family circumstances or income. In 2006, 16 states had continuous eligibility for children.[24] Children in states with continuous eligibility who enter and exit the juvenile justice system during the 12-month eligibility period remain eligible for Medicaid after they are released.

ELIGIBILITY FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

Some young people who otherwise meet eligibility criteria may be ineligible for Medicaid if they are inmates in a correctional facility. According to federal law, Medicaid funding cannot be provided for "any such payments with respect to care or services for any individual who is an inmate of a public institution."[25] A public institution is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."[26] 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.[27]

Federal regulations do not state that those in public institutions must lose eligibility once they become inmates. Rather, the state cannot receive federal Medicaid funding for care or services delivered to those who are, at the time of delivery, inmates in such institutions. To clarify the statute and regulations, the Department of Health and Human Services (HHS) issued a letter to all regional Medicaid administrators that stated that federal funds are available for children who have been sentenced to placement in non-secure facilities, regardless of their having been found "guilty" of a crime.[28] An additional letter clarified that "states need not terminate

Medicaid eligibility during an individual's period of incarceration."[29]

To summarize, states may adopt policies to improve access to Medicaid for those in the juvenile justice system. States may enroll youth into Medicaid at the time of institutionalization and suspend rather than terminate their eligibility, to be reinstated upon release. Also, states with 12-month continuous eligibility policies can keep institutionalized youth enrolled in Medicaid if their period of institutionalization falls within the continuous eligibility period. Finally, though Medicaid does not pay for services for youth in public institutions, federal matching funds are available for services provided to youth in other settings, such as group homes (if under 16 beds), non-residential facilities, and private facilities.

Medicaid Benefits and Service Delivery

States are required to provide certain benefits, when medically necessary, to all enrolled individuals. Within federal guidelines, states establish what benefits they will cover in their benefits packages, and they define what is medically necessary, or when an individual may access those covered benefits. Medicaid benefit packages must include the "mandatory" services that states are required to provide to most groups of beneficiaries. States may also expand their benefit packages to include one or more "optional" services. All states cover at least some optional services.[30]

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

One of the mandatory services that federal law requires Medicaid programs to provide is a very comprehensive set of benefits and services to children called EPSDT (Early and Periodic Screening, Diagnosis, and Treatment).[31] EPSDT requires that states provide comprehensive child health screenings, equivalent to well-child visits, that by law include physical and mental health exams; screenings for growth, development, and nutritional status; hearing and vision tests; and dental examinations. Medicaid must provide any further investigation and care for any conditions detected during screenings and provide medically necessary treatment[32] under EPSDT requirements.[33] EPSDT also requires outreach and care coordination to identify children with actual or potential health problems. A key feature of EPSDT is that states are required to provide treatment for conditions identified during visits, even if the necessary services are not covered under the state plan but are allowed under federal Medicaid rules.

COST SHARING

States may, within strict limits, require some Medicaid enrollees to share some of the cost for their coverage in the form of premiums for coverage or coinsurance and co-payments for services. In general, children who qualify for Medicaid as a member of a mandatory group are exempt from cost sharing. States may choose to require cost sharing for children who qualify for Medicaid as a member of an option group as follows:

- Premiums: States cannot require families whose incomes are at or below 150 percent FPL to pay premiums for their children's coverage. They can, however, require families with incomes over 150 percent FPL to pay a premium of up to five percent of the family's income.[34] States can terminate eligibility if nonpayment of premiums continues for 60 days.
- Co-payments: A co-payment is a fixed amount, regardless of the cost of the service, that some beneficiaries must pay at the point of service when certain services are delivered. States may charge a co-payment of up to $3 (indexed to inflation) for certain services delivered to children ages 6 to 18 years old in families with income under 100 percent FPL.[35]
- Coinsurance: Coinsurance is a percentage of the cost of certain services that some beneficiaries must pay at the point of service delivery. For children in families with income between 100 and 150 percent FPL, states can require coinsurance payments of up to 10 percent of the cost of many items or services. For children in families with income above 150 percent FPL, states can require coinsurance payments of up to 20 percent of the costs.[36,37] However, states are required to exempt all preventative services for children, family planning services, and emergency services, from cost-sharing requirements.

SERVICE DELIVERY

In designing and administering their Medicaid programs, each state determines how services are to be delivered to Medicaid beneficiaries. There are two types of service delivery in Medicaid: fee-for-service (FFS), the traditional method of service delivery, in which providers are paid a specific amount for each service, and managed care. Under managed care, there are two major models, risk and primary care case management (PCCM).

Managed care

One major managed care model is a "risk program." A risk program is a contract between a state Medicaid agency and a managed care entity or risk contractor to provide (or arrange for the provision of) a specified set of services, in exchange for a set monthly fee per person enrolled. The fee does not vary from month to month based on the services used by an individual enrollee, so the managed care entity is assuming the financial risk of providing services to the enrolled population.

There are two types of contractors that participate in risk programs, Managed Care Organizations (MCOs) and Prepaid Health Plans (PHPs).

- MCOs are entities that contract with the state Medicaid agency to provide comprehensive benefits. To be "comprehensive," a benefits package must include inpatient hospitalization and at least one of the following services: outpatient hospital and rural health clinic, other laboratory and x-ray, skilled nursing facility, physician, or home health. Contracts that exclude inpatient hospitalization but include three or more of the groups of services may also be considered comprehensive.
- PHPs are risk contractors that provide less than comprehensive benefits. PHPs may or may not provide (or arrange for the provision) of any inpatient hospital or institutional services.

The second model of managed care is primary care case management (PCCM). A PCCM program assigns the responsibility to coordinate and monitor Medicaid beneficiaries to a specific primary care provider, who receives payment on a fee-for-service basis and generally assumes no risk for providing care for enrollees.[38]

Delivery of mental health and substance abuse services in managed care

States can and do contract for comprehensive and less-than comprehensive services simultaneously. For example, a state may cover both mental and physical health services under managed care, but the services may not be provided under the same plan. The Medicaid agency may contract with a comprehensive MCO for physical health services delivery and a PHP to deliver mental health services.[39]

Managed care contracts vary from state to state and are often exceedingly complex arrangements with a variety of fiscal incentives for providers and varying benefits packages for beneficiaries. Juvenile justice workers will need to learn as much as possible about their local arrangements to help their clients navigate the service delivery systems in their state.

Conclusion

Improving access to health care for system-involved youth is a critical issue facing the juvenile justice system. Medicaid is central to reform efforts, as it can provide a significant source of state and federal funding for the health care of youth at most points in the juvenile justice system – youth who may be eligible for wide-ranging, mandatory screening and treatment services. By improving the interface between Medicaid and juvenile justice, officials can confront more effectively the challenges of meeting the significant health needs of this vulnerable population.

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10 Kaiser, *The Medicaid Resource Book*, op. cit., 12.

11 Centers for Medicare & Medicaid Services, "Medicaid Overview," http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage.

12 Individuals may qualify as medically needy immediately if their income falls above the income limit for traditional (categorical) eligibility but below the state-established medically needy income level (MNIL). This is especially relevant for those ages 19 to 21. Individuals may also qualify for medically needy programs because they have recurring medical expenses and "spend down" their income to below the state's MNIL on services such as institutional care or prescription drugs. See Dan Belnap, "Medically Needy: An Option worth Revisiting?" *State Health Policy Monitor*, National Academy for State Health Policy, December 2007.

13 Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, "The Public Health Insurance Cliff for Older Adolescents," *Fact Sheet No. 4*, Incenter Strategies. April, 2007, page 2.

14 The juvenile justice and foster care populations often overlap. According to one study, more than half of those aging out of foster care had been involved in some way with the juvenile justice system. See Mark Courtney, Sherri Terao, and Noel Bost, *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of Youth Preparing to Leave State Care* (Chicago, IL: Chapin Hall Center for Children, 2004), 48.

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25 Social Security Act, Sec. 1905(a)(28)(A). Viewed at http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

26 42 CFR 435.1009.

27 42 CFR 435.1009.

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31 Health Resources and Services Administration, "EPSDT Overview," available at http://www.hrsa.gov/epsdt/overview.htm, accessed January 25, 2008.

32 While EPSDT covers only medically necessary services, it should be noted that the Medicaid Act's definition of medical necessity is much broader than that of commercial coverage. Under EPSDT, Medicaid must cover "necessary health care, diagnostic services and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions." [42 U.S.C. § 1396d(r)(5)] Medicaid must

cover services that correct, compensate for, or improve a condition, or prevent a condition from worsening, even if the condition can not be prevented or cured. See Maureen O'Connell and Sidney Watson, "Medicaid and EPSDT," March 2001. Available at http://www.nls.org/conf/epsdt.htm. Accessed 28 February 2008.

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34 According to SMDL#6-015, "Total cost sharing, including cost sharing for prescription drugs and non-emergency use of emergency rooms, may not exceed 5 percent of the family income, as applied on a monthly or quarterly basis, as specified by the State."

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