DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail
Stop S2-26-12
Baltimore, Maryland21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 24-004

RE: Provision of Medicaid and CHIP Services to Incarcerated Youth

July 23, 2024

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance to address the statutory requirements in the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328), which was signed into law on December 29, 2022.[1] The CAA, 2023 includes two provisions impacting the availability of certain state plan services for incarcerated[2] youth in Medicaid and the Children's Health Insurance Program (CHIP). The CAA, 2023 also includes another provision that modifies CHIP eligibility requirements for children who become incarcerated. All of these provisions are effective January 1, 2025.

States will need to submit Medicaid and CHIP state plan amendments (SPA) with an effective date no later than January 1, 2025, to implement the required coverage described in section 5121 of the CAA, 2023. States may submit a Medicaid and/or CHIP SPA with an effective date no earlier than January 1, 2025, to implement the optional coverage (regarding services during incarceration pending disposition) described in section 5122 of the CAA, 2023. When submitting SPAs for this coverage, states must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Background on Medicaid and CHIP Eligibility and Coverage During Incarceration

Medicaid regulations at 42 C.F.R. § 435.1010 generally define an inmate of a public institution as "a person who is living in a public institution"[3] and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit

[1] https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.
[2] For purposes of this SHO, the term incarcerated means an inmate of a public institution.
[3] 42 C.F.R. § 435.1010 further specifies that an individual is not considered an inmate if they are in a public educational or vocational training institution for purposes of securing education of vocational training or in a public institution for a temporary period pending other arrangement appropriate to their needs.

exercises administrative control."[4] These same definitions are also applied to separate CHIPs through cross-reference at 42 C.F.R. § 457.310(c)(2)(I). As clarified in State Health Official letter (SHO) 16-007,[5] a public institution includes a correctional institution, and CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution.

In Medicaid, incarceration status is not a condition of eligibility and does not render an individual ineligible. Individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid. However, federal Medicaid funds generally may not be used to pay for services for such individuals while they are incarcerated, except when they are inpatients in a medical institution[6] as provided in paragraph (A) following the last numbered paragraph of section 1905(a) of the Social Security Act (the Act), hereinafter referred to as the "inmate payment exclusion." As described in SHO 16-007, qualifying inpatient stays are those in facilities, such as hospitals, nursing homes, psychiatric residential treatment facilities, or other medical institutions for an expected duration of 24 hours or more, in which there is an admission of the individual to the facility as an inpatient.

Unlike in Medicaid, incarceration status *is* a factor of eligibility in CHIP. A child who is an inmate of a public institution is excluded from the definition of a targeted low-income child and, therefore, generally is ineligible for a separate CHIP.[7]

However, under CHIP regulations,[8] CMS does not consider incarceration an exception to continuous eligibility (CE) in CHIP. Thus, in the case of a child currently enrolled in CHIP, incarceration is not a permissible reason to terminate coverage during a CE period. This means that children determined eligible for CHIP at initial application or renewal who later become incarcerated during a CE period remain eligible. As described in SHO 23-004,[9] states may elect either to suspend coverage during a child's CE period or provide coverage for services covered under the CHIP state plan that are not otherwise covered by the carceral setting through the end of their CE period. If a child remains incarcerated at the end of their CE period, the state must terminate the child's CHIP coverage because they no longer meet the definition of a targeted low-income child.

---

[4] In accordance with 42 C.F.R. § 435.1010, a public institution does not include a medical institution, intermediate care facility, publicly operated community residence that serves no more than 16 residents, or a child-care institution with respect to children for whom foster care maintenance payments are made under title IV-E of the Social Security Act (the Act) and children receiving AFDC-foster care under title IV-A of the Act.

[5] SHO 16-007, To Facilitate successful re-entry for individuals transitioning from incarceration to their communities. Available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

[6] As defined in 42 C.F.R. § 435.1010

[7] Targeted low-income child is defined in Section 2110(b) of the Act and 42 C.F.R. § 457.310.

[8] 42 C.F.R. § 457.342.

[9] SHO 23-004, Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023. Available at https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf.

Introduction to Sections 5121 and 5122 of the CAA, 2023

Under amendments made by Division FF, Title V, section 5121 of the CAA, 2023, starting January 1, 2025, state Medicaid and CHIP programs are required to have a plan in place and, in accordance with such plan, provide for the following for an eligible juvenile who is within 30 days of their scheduled date of release from a public institution following adjudication:

Medicaid Services

In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, the state must provide any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health[10] screening or diagnostic service.

In the 30 days prior to release and for at least 30 days following release, the state must provide targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

CHIP Services

In the 30 days prior to release, the state must provide screening, diagnostic, and case management services otherwise available under the CHIP state plan (or waiver of such plan).

Eligibility

For Medicaid, these requirements apply with respect to an "eligible juvenile" as defined in section 1902(nn)(2) of the Act. An eligible juvenile is an individual who is under 21 years of age who was determined eligible for any Medicaid eligibility group, or an individual determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution.

Additionally, for purposes of this SHO, the term "eligible juveniles" also includes incarcerated youth under age 19 in CHIP who are eligible for services under section 2102(d)(2) of the Act, as added by section 5121 of the CAA, 2023. A more detailed description of eligible juveniles is provided in the "Mandatory Requirements of Section 5121 of the CAA, 2023" section of this letter.

For CHIP, section 5121(c) of the CAA, 2023, also permits states to suspend or continue providing services rather than terminate CHIP coverage while a child is an inmate of a public

[10] Throughout the SHO, we use the term "behavioral health" to encompass mental health and substance use disorders (SUD).

institution. Since CHIP does not have an inmate payment exclusion like Medicaid, states that do not elect to suspend CHIP coverage may continue providing CHIP state plan services otherwise not covered by the carceral facility.[11] In addition, section 5121(c) of the CAA, 2023 requires redeterminations of coverage prior to their release.

Optional Coverage before Adjudication

Under amendments made to section 1905(a) of the Act by section 5122 of the CAA, 2023, starting January 1, 2025, states will have the option to provide Medicaid coverage to eligible juveniles who are inmates of a public institution during the period pending disposition of charges and receive federal financial participation (FFP) under Medicaid for expenditures for services that are provided during this period. Additionally, in CHIP, instead of applying the eligibility exclusion at section 2110(b)(2)(A) of the Act, states will have the option to consider children who are inmates pending disposition of charges as eligible for CHIP during that time. As a reminder, if children are already enrolled in CHIP coverage while pending disposition of charges, that coverage may not be discontinued during the CE period.

Background on Justice-Involved Youth[12]

Youth Data

According to data from 2019, on any given day, over 36,000 youth in the United States are confined in juvenile justice detention centers and juvenile long-term secure facilities; and over 3,000 in adult carceral facilities, including prisons and jails.[13],[14] The median length of stay in youth correctional facilities was 64 days in 2019.[15] Between 2000 and 2020, there has been a 77 percent decline in the number of detained and committed youth overall.[16] Of note, the number

[11] For purposes of this guidance, "carceral facility" includes all types of facilities in both the juvenile justice system and adult criminal justice system.

[12] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[13] Office of Juvenile Justice and Delinquency Prevention (OJJDP), *One Day Count of Youth in Residential Placement Facilities*, (Washington, DC, August, 28, 2023), https://ojjdp.ojp.gov/statistical-briefing-book/corrections/faqs/qa08201.

[14] Zeng, Zhen, Ann Carson, and Rich Kluckow, "Just the Stats Juveniles Incarcerated in U.S. Adult Jails and Prisons, 2002–2021," Bureau of Justice Statistics (BJS), June 2023, https://bjs.ojp.gov/juveniles-incarcerated-us-adult-jails-and-prisons-2002-2021.

[15] OJJDP, *OJJDP Statistical Briefing Book*, (Washington, DC, May 21, 2021), https://www.ojjdp.gov/ojstatbb/corrections/qa08405.asp?qaDate=2019. Note: This does not include youth who are pending adult charges but are being detained in a juvenile facility; these youth have much longer lengths of stay.

[16] OJJDP, *Highlights From the 2020 Juvenile Residential Facility Census* (Washington, DC, October 2022), https://www.ojjdp.gov/ojstatbb/snapshots/DataSnapshot_JRFC2020.pdf.

of incarcerated youth has declined over the past decade as more youth are placed on supervised probation in the community.[17] Males currently account for approximately 85 percent of incarcerated youth, with females at about 15 percent.[18]

As with the adult incarcerated population, youth of color account for a significantly higher proportion of those in all types of carceral facilities, with minority youth accounting for 67 percent of youth in juvenile correctional facilities in 2017, most of whom were black males.[19] The national detention rate for black youth was more than six times the rate for white youth, and their commitment rate was more than four times the rate for white youth.[20, 21]

Multiple reports have found that lesbian, gay, bisexual, transgender, queer, and other sexual minority (LGBTQ+) youth in detention facilities experience increased rates of emotional abuse, physical abuse, and time in isolation.[22] LGBTQ+ youth represent 13 percent to 15 percent of incarcerated youth, which may be underestimated due to a lack of data collection.[23]

Correctional Facility Types Housing Juveniles

Nationwide, there are approximately 1,323 youth carceral facilities, including 599 detention centers, 452 residential treatment centers, and 136 long-term secure facilities, while the remainder are group homes, camps, diagnostic centers, and shelter homes.[24] Youth carceral facilities include state-operated facilities, locally operated facilities, and privately operated facilities, including for-profit and not-for-profit private facilities.[25] Although the rates of youth incarceration have been dropping since the late 1990s, locally operated facilities account for an increasing percentage of both the facility type and the number of incarcerated youth.[26]

---

[17] OJJDP, *Formal, Post-Adjudication Juvenile Probation Services*, Development Services Group, Inc., Literature review (Washington, DC, August 2017), https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/formal_post_adjudication_juvenile_probation_services.pdf.

[18] Puzzanchera, Charles, Sarah Hockenberry, and Melissa Sickmund. Youth and the Juvenile Justice System: 2022 National Report. Pittsburgh, PA: National Center for Juvenile Justice, 2022. Page 191. https://ojjdp.ojp.gov/publications/2022-national-report.pdf.

[19] OJJDP and National Institute of Justice (NIJ), Juveniles in Residential Placement, 2017, Sarah Hockenberry, National Report Series Bulletin NCJ 254498 (Laurel, MD, June 2020), https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/media/document/juveniles-in-residential-placement-2017.pdf.

[20] OJJDP, *Detention Rates by Race/Ethnicity*, (Washington, DC, August 28, 2023), https://ojjdp.ojp.gov/statistical-briefing-book/special_topics/faqs_fairness/qa11802.

[21] OJJDP, *Residential Placement Rates by Race/Ethnicity*, (Washington, DC, August 28, 2023), https://ojjdp.ojp.gov/statistical-briefing-book/special_topics/faqs_fairness/qa11801.

[22] Owen, Mikah C., Stephenie B. Wallace, Elizabeth M. Alderman, Richard Chung, Laura K. Grubb, Janet Lee, Makia E. Powers, Maria H. Rahmandar, and Krishna K. Upadhya. "Advocacy and Collaborative Health Care for Justice-Involved Youth." Pediatrics 146, no. 1 (2020). https://doi.org/10.1542/peds.2020-1755.

[23] OJJDP, *LGBTQ Youths in the Juvenile Justice System, Development Services Group, Inc.*, Literature review (Washington, DC, August 2014), https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/lgbtq_youths_in_the_juvenile_justice_system.pdf.

[24] OJJDP, "Facility capacity by facility operation, facility size, and facility type," January 10, 2023. https://ojjdp.ojp.gov/statistical-briefing-book/corrections/faqs/qa08522.

[25] OJJDP, Highlights From the 2020 Juvenile Residential Facility Census.

[26] Id.

Youth who commit serious crimes may be charged and incarcerated outside of the juvenile corrections system and treated as if they were adults. Across the country, youth may be housed in adult correctional facilities, including both jails and prisons. This is particularly the case for teens who may be charged as adults, with age ranges varying by state, carceral setting, and the type of crime. Although teenagers' brain development is different from that of mature adults,[27] youth may serve time in facilities with programming and services designed for adults. Youth may also be at greater risk of victimization in facilities that house primarily adults.[28] Incarceration of youth in adult facilities also may lead to poorer physical and mental health, increased engagement in risky behaviors like substance abuse, increased risk for violence and victimization, and early mortality.[29]

Health Care Challenges for Incarcerated Youth

Incarceration during adolescence and early adulthood is associated with worse physical and mental health later in adulthood, as well as increased risk of adult incarceration.[30] Like adult carceral facilities, youth detention facilities are variable in terms of health care provided, with very few meeting minimum standards of care.[31] Recent research indicates that early identification of needs, the provision of quality services, and comprehensive information sharing between the juvenile justice system and the legal caregiver as incarcerated youth are released are key to improving outcomes for youth and decreasing further involvement in the youth correctional system.[32] Providing screening for physical and behavioral health needs while incarcerated and facilitating linkages to physical and behavioral health care in the community will support youth who are incarcerated with transitioning more successfully back to the

[27] Cohen, Alexandra O., and B.J. Casey. 2014. "Rewiring Juvenile Justice: The Intersection of Developmental Neuroscience and Legal Policy." *Trends in Cognitive Sciences* 18 (2): 63–65. https://doi.org/10.1016/j.tics.2013.11.002.

[28] Ahlin, Eileen M., and Don Hummer. "Sexual Victimization of Juveniles Incarcerated in Jails and Prisons: An Exploratory Study of Prevalence and Risk Factors." *Victims & Offenders* 14, no. 7 (August 28, 2019): 793–810. https://doi.org/10.1080/15564886.2019.1658675.

[29] Silver, Ian A, Daniel C Semenza, and Joseph L Nedelec. 2023. "Incarceration of Youths in an Adult Correctional Facility and Risk of Premature Death." *JAMA Network Open* 6 (7): e2321805–5. https://doi.org/10.1001/jamanetworkopen.2023.21805.

[30] Barnert, Elizabeth S., Rebecca N. Dudovitz, Bergen B. Nelson, Tumaini R. Coker, Christopher Biely, Ning Li, and Paul J. Chung. "How Does Incarcerating Young People Affect Their Adult Health Outcomes?" *Pediatrics* 139, no. 2 (February 1, 2017). https://doi.org/10.1542/peds.2016-2624.

[31] Gallagher, Catherine L., and Adam Dobrin. "Can Juvenile Justice Detention Facilities Meet the Call of the American Academy of Pediatrics and National Commission on Correctional Health Care? A National Analysis of Current Practices." *Pediatrics* 119, no. 4 (April 1, 2007): e991–1001. https://doi.org/10.1542/peds.2006-0959.

[32] Applegarth, D. Michael, and Benjamin Adams. "Screening, Service Provision, and Information Sharing Practices of Juvenile Facilities." Children and Youth Services Review 148 (May 1, 2023): 106883. https://doi.org/10.1016/j.childyouth.2023.106883.

community.[33] There is evidence of a positive correlation between primary care use upon release and a reduction in youth recidivism in juvenile detention facilities.[34]

Untreated behavioral health needs for youth often contribute to offenses, leading the juvenile justice system to address not only rehabilitation related to offenses, but also screening, assessment, and referral of juveniles for behavioral health needs. Appropriate screening and referral leads to treatment,[35] and early treatment of youth mental health and SUDs has been associated with effective diversion from the justice system.[36,37] Roughly two-thirds of youth in the correctional system report at least one substance-related problem, yet 12 percent of justice-involved youth are in residential placement programs that do not offer SUD-related services.[38] Youth who are justice-involved have a very high incidence of adverse childhood experiences, with as many as 90 percent of such youth having experienced trauma. They are also at higher risk for having experienced sexual and physical abuse and for having behavioral health disorders.[39,40] Justice-involved youth experience suicidal ideation, and also attempt and die by suicide at rates two to three times greater than those for youth in the general population.[41] Additionally, incarcerated youth have very high rates of post-traumatic stress disorder (PTSD) due to having experienced extremely high rates of trauma.[42] Screening for suicidal ideation and suicide risk among detained youth is extremely important, as is connecting youth to needed

[33] Braverman, Paula K., and Pamela J. Murray. "Health Care for Youth in the Juvenile Justice System." Pediatrics 128, no. 6 (December 1, 2011): 1219–35. https://doi.org/10.1542/peds.2011-1757.

[34] Aggarwal, Shelley, and John Will. "Juvenile Detention and Primary Care Utilization: Are They Related?" Journal of Correctional Health Care 29, no. 2 (April 1, 2023): 115–20. https://doi.org/10.1089/jchc.21.10.0112.

[35] Soulier, Matthew F, and Anne McBride. "Mental Health Screening and Assessment of Detained Youth." Child and Adolescent Psychiatric Clinics of North America 25, no. 1 (January 1, 2016): 27–39. https://doi.org/10.1016/j.chc.2015.08.002.

[36] Albertson, Elaine Michelle, Christopher A. Scannell, Neda Ashtari, and Elizabeth S. Barnert. "Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration." American Journal of Public Health 110, no. 3 (March 1, 2020): 317–21. https://doi.org/10.2105/ajph.2019.305400.

[37] Liebenberg, Linda, and Michael Ungar. "A Comparison of Service Use among Youth Involved with Juvenile Justice and Mental Health." Children and Youth Services Review 39 (April 1, 2014): 117–22. https://doi.org/10.1016/j.childyouth.2014.02.007.

[38] Heaton, Leanne L. "Racial/Ethnic Differences of Justice-Involved Youth in Substance-Related Problems and Services Received." American Journal of Orthopsychiatry 88, no. 3 (January 1, 2018): 363–75. https://doi.org/10.1037/ort0000312.

[39] Baglivio, Michael T., Nathan Epps, Kimberly Swartz, Mona Sayedul Huq, Amy Sheer, and Nancy S. Hardt. "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders." *Journal of Juvenile Justice* 3, no. 2 (Spring, 2014): 1-23. https://www.proquest.com/scholarly-journals/prevalence-adverse-childhood-experiences-ace/docview/1681541057/se-2.

[40] Underwood, Lee A., and Aryssa Washington. "Mental Illness and Juvenile Offenders." *International Journal of Environmental Research and Public Health* 13, no. 2 (February 18, 2016): 228. https://doi.org/10.3390/ijerph13020228.

[41] OJJDP, Suicidal Thoughts and Behaviors Among Detained Youth, Karen M. Abram, Jeanne Y. Choe, Jason J. Washburn, Linda A. Teplin, Devon C. King, Mina K. Dulcan, and Elena D. Bassett, Juvenile Justice Bulletin (Washington, DC, July 2014), https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/243891.pdf.

[42] Modrowski, Crosby A., Diana C. Bennett, Shannon D. Chaplo, and Patricia K. Kerig. "Screening for PTSD among Detained Adolescents: Implications of the Changes in the DSM–5." Psychological Trauma: Theory, Research, Practice, and Policy 9, no. 1 (January 1, 2017): 10–17. https://doi.org/10.1037/tra0000156.

mental health and SUD treatment promptly upon diagnosis.[43] Building trust and helping youth understand the importance of acknowledging and accepting help for mental health and SUD needs as a part of overall health care are critical.

CMS encourages states to expand availability and utilization of peer support services after release from incarceration to support youth reentering the community. Using peer recovery coaches who are in recovery from mental health needs and SUDs may be helpful for youth leaving incarceration.[44] As discussed in State Medicaid Director letter (SMD) 07-011, issued on August 15, 2007, Medicaid peer support providers should have lived experience, demonstrate the ability to support the recovery of others, and complete some training and certification, but those training and certification requirements are to be defined by the state.[45] Peer supporters must also be supervised by a competent mental health professional. State Medicaid programs have broad discretion in determining the types of practitioners that may qualify as competent mental health professionals and may determine more experienced peer supporters and other unlicensed providers as competent mental health professionals qualified to supervise peer supporters. Furthermore, states determine the level of supervision required, ranging from direct oversight to periodic care consultation. CMS has advised states that individuals supervising peers may include SUD treatment specialists, including licensed SUD counselors, as well as unlicensed mental health and SUD professionals. In addition, supervisors of peers may include peers with more experience and training on the provision of peer support services.[46]

Because of both physical and mental risk associated with their age and developmental stage, continuity of care is particularly important for youth.[47] Health records from correctional settings are often not transferred to community providers, which can hinder the continuity of care and lead to confusion for youth and their parents, guardians, or caregivers. Gaps in the continuity of health care can worsen the emotional and logistical challenges of reentry.[48] Linkages to care for youth who move between the correctional system and the community are essential for continuity of care and treatment, particularly for youth with mental health needs and SUDs. These linkages are especially important for youth who are part of both the juvenile justice and foster care systems who may have additional challenges due to transitions to new foster homes within the community.

---

[43] Kim, B., Gilman, A., Thompson, N., & De Leon, J. (2021). Statewide Trends of Trauma History, Suicidality, and Mental Health Among Youth Entering the Juvenile Justice System. *Journal of Adolescent Health*, *68*(2), 300–307. https://doi.org/10.1016/j.jadohealth.2020.05.044.

[44] Ray, Bradley, Dennis K. Watson, Huiping Xu, Michelle P. Salyers, Grant Victor, Emily Sightes, Katie Bailey, Lisa A. Taylor, and Na Bo. "Peer Recovery Services for Persons Returning from Prison: Pilot Randomized Clinical Trial Investigation of SUPPORT." Journal of Substance Abuse Treatment 126 (July 1, 2021): 108339. https://doi.org/10.1016/j.jsat.2021.108339.

[45] See SMDL 07-011: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf.

[46] See Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services: https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.

[47] Mears, Daniel P., and Jeremy Travis. "Youth Development and Reentry." Youth Violence and Juvenile Justice 2, no. 1 (January 1, 2004): 3–20. https://doi.org/10.1177/1541204003260044.

[48] Barnert, Elizabeth S., Ava Sun, Laura S. Abrams, and Paul J. Chung. "Physical Health, Medical Care Access, and Medical Insurance Coverage of Youth Returning Home After Incarceration: A Systematic Review." Journal of Correctional Health Care 26, no. 2 (April 1, 2020): 113–28. https://doi.org/10.1177/1078345820915908.

Children in Foster Care

There is significant overlap between youth in foster care and those involved in the juvenile justice system, sometimes referred to as "crossover," "dually-involved," "dually-adjudicated," or "dual-system" youth.[49] Depending on how broadly multi-system involvement is defined, it is possible that as high as 50 percent of youth referred to the juvenile justice system are also involved with the foster care system.[50]

Certain types of traumas also may be correlated with an increased risk of involvement in the juvenile justice system for youth in foster care. While youth in foster care who experience violence in schools and communities have a higher risk of involvement in the juvenile justice system, research does not indicate that greater total trauma contributed to a higher probability of youth in foster care involvement in the juvenile justice system.[51]

Sharing data between child welfare and juvenile justice systems is critically important to coordinating care for dual-system youth.[52] For example, the Crossover Youth Practice Model aims to strengthen collaborations between child welfare and juvenile justice system professionals by providing early, coordinated, and individualized services to youth. Evidence shows it can reduce dual-system youth recidivism.[53] Finally, the provision of behavioral health and social services, such as housing or mentorship programs, are associated with an increased likelihood that dual-system youth can successfully transition back to school, work, and the community.[54]

Medicaid and CHIP Eligibility and Enrollment

SUPPORT Act Requirements Overview

Section 1001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT for Patients and Communities Act,

[49] Center for Juvenile Justice Reform. "Crossover Youth Practice Model - Center for Juvenile Justice Reform," February 23, 2021. https://cjjr.georgetown.edu/our-work/crossover-youth-practice-model/.

[50] National Council of Juvenile and Family Court Judges (NCJFCJ). "When Systems Collaborate: How Three Jurisdictions Improved Their Handling of Dual-Status Cases - NCJFCJ." NCJFCJ, November 1, 2019. https://www.ncjfcj.org/publications/when-systems-collaborate-how-three-jurisdictions-improved-their-handling-of-dual-status-cases-2/.

[51] National Institute of Justice, *Examining the Relationship Between Childhood Trauma and Involvement in the Justice System*, Phelan Wyrick and Kadee Atkinson, NIJ Journal issue number 283 (Washington, DC, April 29, 2021), https://nij.ojp.gov/topics/articles/examining-relationship-between-childhood-trauma-and-involvement-justice-system.

[52] OJJDP, *Intersection of Juvenile Justice and Child Welfare Systems*, Development Services Group, Inc., Literature review (Washington, DC, May 2021), https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/Intersection-Juvenile-Justice-Child-Welfare-Systems.

[53] Id.

[54] Chuang, Emmeline, and Rebecca G. Wells. "The Role of Inter-Agency Collaboration in Facilitating Receipt of Behavioral Health Services for Youth Involved with Child Welfare and Juvenile Justice." Children and Youth Services Review 32, no. 12 (December 1, 2010): 1814–22. https://doi.org/10.1016/j.childyouth.2010.08.002.

herein referred to as "the SUPPORT Act," (Pub. L. 115-271)), signed into law on October 24, 2018, amended section 1902(a) of the Act to prohibit states from terminating Medicaid eligibility due to incarceration for "eligible juveniles." Eligible juveniles are defined as an individual who is under 21 years of age who was determined eligible for any Medicaid eligibility group, or an individual determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution.[55] To facilitate this requirement, the SUPPORT Act allows states to place the individual in a suspended eligibility or suspended benefits status.[56] States are also required to process Medicaid applications submitted by, or on behalf of, eligible juveniles while the juvenile is incarcerated, and must redetermine the eligibility of certain eligible juveniles prior to their release from public institutions. As discussed later in this SHO in the section titled "Changes to CHIP Eligibility Policy Under Section 5121 of the CAA, 2023," similar requirements are now applicable to CHIP as a result of section 5121 of the CAA, 2023. Although the redetermination requirements for eligible juveniles are not new to Medicaid, we further describe the interaction between these requirements and mandatory CE for children in both Medicaid and CHIP.

With the SUPPORT Act changes to the Medicaid statute that preclude termination of Medicaid eligibility for eligible juveniles, states can more quickly "turn on" eligibility from suspended status, which should help Medicaid-eligible juveniles have prompter access to needed health care services upon release. Suspension was associated with a small improvement in Medicaid continuity of care for justice-involved youth in a 2019 study, prior to implementation of section 1001 of the SUPPORT Act, as gaps in coverage likely affect juveniles' access to physical, mental health, and SUD care.[57]

Similarly, changes to CHIP eligibility under section 5121 of the CAA, 2023 that align closely with the Medicaid SUPPORT Act requirements should help ensure children transitioning back into the community do not have gaps in their CHIP coverage that could delay necessary care due to eligibility changes associated with their previous incarceration.

Eligibility and Enrollment

Incarceration does not preclude an inmate from being determined Medicaid-eligible, and section 1902(a)(84)(C) of the Act contemplates that some individuals may apply for Medicaid while incarcerated and thereby may become eligible juveniles as defined in section 1902(nn) of the Act. The state Medicaid agency must accept Medicaid applications from, or on behalf of,

[55] For additional information on the requirements of Section 1001 of the SUPPORT Act, please see SMDL 21-002: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[56] For more details on eligibility and benefits suspension approaches, please see pages 5-6 of SMDL 21-002 available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[57] Anderson, Valerie R., Fangqian Ouyang, Wanzhu Tu, Marc B. Rosenman, Sarah E. Wiehe, and Matthew C. Aalsma. "Medicaid Coverage and Continuity for Juvenile Justice–Involved Youth." Journal of Correctional Health Care 25, no. 1 (January 1, 2019): 45–54. https://doi.org/10.1177/1078345818820043.

inmates of public institutions at any time during their incarceration and process these applications promptly, in accordance with 42 C.F.R. § 435.912, which describes federal requirements for timely determination of eligibility.

If an individual is determined eligible for Medicaid while incarcerated and the individual otherwise satisfies the definition of an eligible juvenile, the state must treat this individual as it would an eligible juvenile who was enrolled in Medicaid at the time of incarceration and place the individual in a suspended eligibility or benefits status.

As discussed earlier in this SHO, there is significant overlap between youth in foster care and those involved in the juvenile justice system. Since former foster care youth are Medicaid eligible until age 26, this guidance could impact young adults in adult jails and prisons. Identifying this population may require individual surveys of young people, as the data is not regularly collected by corrections staff. To facilitate the mandatory implementation of section 5121 of the CAA, 2023, which requires coverage of certain services, states should conduct pre-release outreach well in advance of the 30-day pre-release period, along with making eligibility and enrollment support available to all incarcerated youth in both juvenile and adult facilities. State Medicaid agencies will need to determine a mechanism to identify former foster care youth, and then assess their Medicaid coverage status, notifying the adult facility of their eligibility as applicable. Outreach and support will provide an opportunity for all interested individuals to apply for Medicaid coverage or to renew their eligibility, if needed, and to receive application assistance.

To ensure individuals are able to access the services for which coverage is required under section 1902(a)(84)(D) of the Act in the pre-release period and continue receiving covered services upon release, states should work with their correctional facility partners to establish procedures to start the application process, and assist incarcerated youth who are not already enrolled in Medicaid with applying for Medicaid upon incarceration and during the period of incarceration, with a goal of application submission no later than 90 days before the individual's expected date of release to allow for application processing time. In some instances, a parent or guardian may not be available to sign and submit an application on behalf of a minor child who is incarcerated. Each state has its own laws and requirements for who may sign a document on a minor's behalf. To facilitate the application process, 42 C.F.R. § 435.907(a) allows someone "acting responsibly" to sign and submit an application on behalf of a minor who is incarcerated, which could include an adult who is not the minor's parent or legal guardian but who is providing assistance to or taking care of the minor.[58]

[58] Per 42 C.F.R. § 435.907: "(a) Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility[.]"

These actions will also facilitate states' optional implementation of section 5122 of the CAA, 2023, as eligible juveniles could be incarcerated pending disposition of charges for indeterminate lengths of time.

Mandatory Requirements of Section 5121 of the CAA, 2023

As noted previously, section 5121 of the CAA, 2023 creates a new mandate in Medicaid for states, effective January 1, 2025, by amending section 1902(a)(84) of the Act (42 U.S.C. 1396a) to require states to provide specific screening and diagnostic services and targeted case management (including referrals) in the 30 days prior to release from incarceration, and targeted case management (including referrals) for at least 30 days post release for eligible juveniles post adjudication. In instances where that is not possible, the statute also allows that such screening and diagnostic services may be provided not later than one week, or as soon as practicable, after release from the public institution. Section 5121 also amends subdivision (A) following the last numbered paragraph of section 1905(a) of the Act to allow for payment for such services with respect to an eligible juvenile during a 30-day period prior to release from incarceration. Accordingly, the statutory Medicaid inmate payment exclusion language has been modified to allow for payment for these services for eligible juveniles under certain circumstances, as specified in the amendments made by section 5121 of the CAA, 2023.

Section 5121 of the CAA, 2023 includes two provisions that impact the eligibility of children in carceral settings under CHIP. First, section 5121 of the CAA, 2023 applies generally similar pre-release case management, screening, and diagnostic services and timeframe requirements described above for Medicaid to children in carceral settings under CHIP. There will be differences across states that have implemented a separate CHIP based on the screening and diagnostic services they make available under their CHIP state plans, because unlike Medicaid, EPSDT is not required in separate CHIP, as discussed below.

Second, section 5121 of the CAA, 2023 amended title XXI of the Act to require that "[s]tate[s] shall not terminate eligibility for child health assistance under the State child health plan for a targeted low-income child because the child is an inmate of a public institution, but may suspend coverage during the period the child is such an inmate." This change aligned CHIP with existing Medicaid requirements as implemented by the SUPPORT Act that are applicable to eligible juveniles. This requirement is discussed later in this SHO under the section titled "Additional Eligibility Changes for CHIP Under Section 5121 of the CAA, 2023."

Eligible Juveniles

For purposes of section 1902(a)(84) of the Act, section 1902(nn) of the Act defines "eligible juvenile" as an individual who is under 21 years of age determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory eligibility group for former foster care children), who was determined eligible for Medicaid before becoming an inmate of a public institution or who is determined eligible for Medicaid

while an inmate of a public institution. Individuals described in the mandatory eligibility group for former foster care children, implemented at 42 C.F.R. § 435.150, include individuals under age 26 who meet the criteria for the group upon attaining either age 18 or such higher age (up to 21) as the state or tribe has elected for termination of federal foster care assistance under title IV-E of the Act. This was described further in SMD 21-002, issued on January 19, 2021.[59] Thus, "eligible juvenile" in the statute also includes former foster care children between 18 and 26 years old.

As noted, under section 2110(b)(2)(A) of the Act, children who are in carceral settings generally are ineligible for CHIP due to their incarcerated status. Section 5121 of the CAA, 2023, added new paragraph (b)(7) to section 2110 of the Act to create an exception to this general eligibility exclusion for incarcerated children who are within 30 days of release for purposes of complying with the new coverage requirement at section 2102(d)(2) of the Act, as added by section 5121 of the CAA, 2023. This exception enables otherwise-eligible children to receive the mandatory case management, including referrals, and screening and diagnostic services during the 30 days prior to their release, as discussed below.

Section 1902(a)(84)(D) of the Act, as added by section 5121 of the CAA, 2023, only applies to eligible juveniles who are being held "post adjudication" as inmates of a public institution. This is because that subparagraph refers specifically to eligible juveniles who are within 30 days of the date on which they are scheduled to be released from a public institution "following adjudication." Adjudication is the court process that determines if an individual committed the act for which they are charged.[60] Accordingly, we interpret section 1902(a)(84)(D) of the Act to apply where the court process has determined that the eligible juvenile committed the charged act and the court ordered the eligible juvenile held as an inmate of a public institution as part of the disposition of the charges.

Carceral Settings

Section 5121 of the CAA, 2023, does not specify the types of carceral facilities where an eligible juvenile in either Medicaid or CHIP who is an inmate of a public institution would receive the specified services. Therefore, CMS interprets the statute to apply to all types of carceral facilities where an eligible juvenile post adjudication may be confined as an inmate of a public institution. This would include state prisons, local jails, tribal jails and prisons, and all juvenile detention and youth correctional facilities. At this time, this does not include federal prisons. CMS will provide further guidance at a later date on the applicability of section 5121 of the CAA, 2023 on federal prisons.

[59] SMD 21-002, Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act). https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[60] The Office of Juvenile Justice and Delinquency Prevention (OJJDP). A juvenile adjudication is not the equivalent of a conviction in adult criminal court. For more information, please refer to the *OJJDP Statistical Briefing Book Glossary* at: https://www.ojjdp.gov/ojstatbb/glossary.html#:~:text=Adjudication%20%2D%20Adjudication%20is%20the%20court,conviction%20in%20adult%20criminal%20court.

Screening and Diagnostic Services

Medicaid

Section 1902(a)(84)(D) of the Act requires, in the 30 days prior to release (or not later than one week, or as soon as practicable, after release), in coordination with the public institution, provision of any screening or diagnostic service (including a behavioral health screening or diagnostic service) which meets reasonable standards of medical and dental practice, as determined by the state. This element of the statute is independent of the reference to Medicaid EPSDT requirements and allows flexibility for the state to develop additional standards for medical and dental screening and diagnostic services to be furnished to the post-adjudication eligible juvenile population during the statutory pre- and post-release period. For example, a state may develop standards that require additional screenings or screenings at increased intervals that a state deems appropriate for eligible juveniles during the statutory pre- and post-release period that are in addition to EPSDT screening services. However, because states have already established standards for EPSDT medical and dental screening and diagnostic services, states may utilize these standards rather than developing additional standards. For populations that do not typically receive EPSDT benefits, such as those 21 years of age and older, states will need to implement policies based on reasonable standards of medical and dental practice to ensure provision of screening and diagnostic services to the post-adjudication eligible juvenile population 21 years of age and older during the statutory pre- and post-release period.

In addition to these state-determined screenings and diagnostic services, section 1902(a)(84)(D) of the Act further requires provision of medically necessary EPSDT screening and diagnostic services in accordance with section 1905(r)(1)(A) and section 1905(r)(5) of the Act. Section 1905(r)(1)(A) of the Act defines intervals at which screening services must be provided; subparagraph (B) goes on to define the minimum services included in the screening services for which the intervals are defined in paragraph (A). In particular, we note that the screening services under section 1905(r)(1) of the Act include appropriate immunizations according to age and health history, which must be provided in accordance with the Advisory Committee on Immunization Practices schedule for pediatric vaccines, as specified in section 1905(r)(1)(A)(i) of the Act. Section 1905(r)(5) of the Act requires coverage of diagnostic services when a screening service indicates the need for further evaluation and when such diagnostic services are otherwise medically necessary. Because states must already cover EPSDT screening and diagnostic services, states should cover these services for eligible juveniles under age 21 in the same manner as for youth under age 21 who are not incarcerated. For eligible juveniles ages 21 and older, we interpret section 1902(a)(84)(D) of the Act to require states to cover screening services when they are medically necessary to determine existence of a physical or behavioral health illness or condition as well as diagnostic services when a screening service indicates the need for further evaluation and when such diagnostic services are otherwise medically necessary.

Section 5121 specifically requires coverage of behavioral health screening and diagnostic services for eligible juveniles. We interpret the statutory reference to "a behavioral health

screening or diagnostic service" in section 1902(a)(84)(D) of the Act to refer to screening and diagnostic services under both the state-determined standards and under the EPSDT services delivered in accordance with section 1905(r)(1)(A) and (r)(5) of the Act. This is a particularly significant issue for incarcerated youth given the trauma they experience and high rates of behavioral health conditions, as noted in the background section of this letter. Providing these services to eligible juveniles pre-release will help identify necessary treatment services so that medical and behavioral health appointments can be scheduled prior to release and occur as soon as possible after an eligible juvenile is released.

In certain situations, an eligible juvenile may have been screened and/or received a diagnostic service(s) prior to incarceration, upon entry to the carceral facility, and/or during other points of incarceration prior to 30-days of their scheduled release date. State Medicaid and CHIP programs should establish policies and procedures to determine if such services align with the state's established standards and/or EPSDT requirements for screening and diagnostic services. If the state determines that such services align with and fully satisfy such standards, then the screening and diagnostic services requirements in sections 1902(a)(84)(D) and 2102(d)(2) of the Act may be considered satisfied.

CHIP

Separate CHIPs must provide screening and diagnostic services available under the CHIP state plan (or waiver of such plan) as required under section 2102(d)(2) of the Act. As previously discussed, EPSDT requirements are optional for separate CHIPs. However, if a separate CHIP elects to provide EPSDT services as defined in section 1905(r) under its CHIP state plan, the state must provide all medically necessary screening and diagnostic services consistent with EPSDT requirements in accordance with sections 1905(r)(1)(A) and 1905(r)(5) of the Act as described above for Medicaid.

Case Management[61]

Medicaid

Sections 1905(a)(19) and 1915(g)(2) of the Act define Medicaid case management as services that will assist an individual eligible under the state plan in gaining access to needed medical, social, educational, and other services. Medicaid case management services are referred to as "targeted case management (TCM) services" when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. The flexibility associated with TCM services enables states to target case management services to specific populations and/or to individuals who reside in specified areas.[62]

[61] Carceral facilities employ reentry specialists who work with youth on reentry plans. These reentry specialists may be a good resource for states to coordinate case management services.
[62] 42 C.F.R. § 440.169(b); *see* https://www.medicaid.gov/federal-policy-guidance/downloads/smd011901c.pdf.

Section 5121 of the CAA, 2023 requires states to cover Medicaid TCM services for eligible juveniles, including referrals to the appropriate care and services available in the geographic region of the home or residence of the eligible juvenile (where feasible) under the state plan (or waiver of such plan) in the 30 days prior to release and for at least 30 days following release. CMS interprets this to mean that TCM services, including referrals, as described at 42 C.F.R. § 440.169, include:

- comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services;
- development (and periodic revision) of a specific person-centered care plan based on the information collected through the assessment;
- referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring.

Many states may already have an existing TCM group that includes some or all eligible juveniles. For example, such target groups that states may already have established might include all youth with behavioral health or physical health needs, those who may be involved in the juvenile or adult criminal justice system, or those involved in the foster care system. In other cases, states may need or want to add a specific target group for eligible juveniles to their state plan.

Case managers are expected to assess the needs of eligible juveniles, plan effectively for any Medicaid screening and diagnostic services that the reentering eligible juvenile may receive on a pre-release basis, make necessary referrals, and arrange for any Medicaid and non-Medicaid services that the beneficiary may need post-release (including scheduling initial post-release appointments with providers, as appropriate). Building trust between case managers and eligible juveniles occurs over time and through learning about the incarcerated eligible juvenile's experience prior to and during incarceration, as well as aspirations for and obstacles to the eligible juvenile's future success upon release back into the community.

TCM should be designed to assist eligible juveniles in getting connected to services and providers in the geographic area where the eligible juvenile will be residing upon release, whenever possible. These services are not only for physical and behavioral health needs, but

also for health-related social needs (HRSNs).[63] HRSNs, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, and opportunities for meaningful employment or skill building, can have an impact on health. The person-centered care plan developed as part of the TCM service should address social, educational, and other underlying needs, such as developing safe decision-making skills or building relationships, which can be particularly challenging for youth who were formerly incarcerated as they reenter the community. Case managers should be making referrals for HRSNs, as well as physical and behavioral health services for an eligible juvenile upon release.

TCM may include contacts with individuals who are not directly connected to the Medicaid program but are directly involved in identifying the eligible juveniles' needs and care for the purposes of helping the eligible juvenile access services, identifying needs and supports to assist the eligible juvenile in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible juveniles' needs. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.

In summary, TCM is a critical lynchpin to help connect eligible juveniles to all needed services upon release, including medical, social, and educational services. TCM services, which must continue for at least 30 days post-release, will help ensure that eligible juveniles receive needed services in the geographic area where they will be residing upon return to the community. The case manager should also monitor to ensure that appointments occur and ongoing services, as needed, continue.

If another case manager is involved upon release or for case management after the 30-day post-release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

[63] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute poor health.

CHIP

Section 2102(d)(2) of the Act, as added by section 5121 of the CAA, 2023 specifies that separate CHIPs must provide case management services to the extent they are otherwise available under the CHIP state plan (or waiver of such plan) to children who are within 30 days of release. We note that, although CHIP regulations do not define the term "case management services," we encourage states to provide case management services in CHIP that encompass all the key components of Medicaid case management services as outlined above.

Timeframe for Services

As previously described, section 1902(a)(84)(D) of the Act, as added by section 5121 of the CAA, 2023, only applies to eligible juveniles who are within 30 days of the date on which they are scheduled to be released from a public institution following adjudication. Section 1902(a)(84)(D)(i) requires that screening and diagnostic services must be provided in the 30 days prior to release of the Medicaid-eligible juvenile. When that is not possible, the statute also allows that such screening and diagnostic services may be provided not later than one week or as soon as practicable after release from the public institution. For TCM services, including referrals, section 1902(a)(84)(D)(ii) requires that these services must be provided in the 30 days prior to release and for at least 30 days post release of the Medicaid-eligible juvenile from the public institution.

Section 2102(d)(2) specifies that separate CHIPs must provide covered incarcerated youth who are within 30 days of release, screening, diagnostic, and case management services, including referrals, as covered under the CHIP state plan. It does not explicitly mention the alternative timeframes in section 1902(a)(84)(D) when that timing is not possible ("not later than one week or as soon as practicable after release from the public institution.") However, section 2102(d)(2) of the Act indicates that states "shall provide […] screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan) in the same manner as described in section 1902(a)(84)(D)." CMS interprets this to mean that the same alternative timeframes as those described above for Medicaid covered screening and diagnostic services are also applicable to CHIP, if it is not possible for the state to provide the service prior to a child's release from the carceral facility. However, children are entitled to the full array of CHIP state plan benefits upon release. Therefore, the expectation is that they will continue to receive case management services (if available under the CHIP state plan) upon release.

In certain situations, the scheduled release date of an eligible juvenile may change based on a variety of factors. If such change results in an eligible juvenile no longer being within 30 days of their new scheduled release date, state Medicaid programs should suspend coverage until such time that the eligible juvenile is within 30 days of their new scheduled release date. For CHIP, states may also suspend coverage or continue to provide CHIP state plan services not otherwise covered by the carceral facility until the eligible juvenile is within 30 days of their new

scheduled release date. As previously noted, states must be mindful of and ensure the policies, procedures, and processes developed to support Medicaid and CHIP coverage of pre-release services do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Section 5121 of the CAA, 2023 Internal Operational Plan

Per section 5121 of the CAA, 2023, "…the State shall have in place a plan, and in accordance with such plan, provide for…" the provision of the mandatory services, including limited pre-release services, for eligible juveniles in Medicaid and CHIP. CMS interprets this statutory provision to mean states are required to maintain an internal operational plan to ensure compliance with the coverage requirements of sections 1902(a)(84)(D) and 2102(d)(2) of the Act. The internal operational plan should include:

- actions for establishing an operational system and updating the system as needed on an ongoing basis, to perform functions such as exchanging data with the carceral system;
- procedures for Medicaid and CHIP eligibility, enrollment, applicable notifications, and claims processing;
- processes to ensure the timeliest possible provision of screening and diagnostic services if they are not able to be covered beginning 30 days prior to release;
- policies, procedures, and processes to ensure pre-release services do not effectuate delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems;
- new or updated written staff-level operational policies and procedures where workflows and processes are impacted by the new requirements;
- new or updated provider and beneficiary-level processes, procedures, policies, and systems related to accessing services such as case management, prior authorization, linkages with managed care plans, payment, claims processing, and data analysis, where these are impacted by the new requirements;
- training, education, and outreach actions; and
- integration with current Medicaid and CHIP operations, such as disaster planning and continuity of operations, hearings and appeals, beneficiary notices, record retention, and other operational activities associated with program administration.

States are required to have a plan in place no later than January 1, 2025, but are not required to submit this internal operational plan to CMS, except upon request. However, CMS is available to provide technical assistance to states for the design and implementation of their internal operational plans.

Data-sharing, Confidentiality, Privacy, and Security Considerations

CMS understands data related to carceral status, release and reentry details, Medicaid and CHIP eligibility, and the health care needs and HRSNs of individuals who are incarcerated and returning to the community may reside in fragmented systems, including non-electronic systems. This may present challenges in data sharing for purposes of providing required screenings, diagnostic services, case management services, and collection of data. States should be cognizant of the laws and regulations regarding confidentiality, access, storage, and handling of certain information, including but not limited to: section 1902(a)(7) of the Act, discussed in further detail below; 42 C.F.R. Part 431, Subpart F; 42 C.F.R § 457.1110; 42 C.F.R. Part 2;[64] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, Breach Notification, and Enforcement Rules (the HIPAA Rules) as well as state-level regulatory requirements.[65] These laws and regulations should not be barriers for health care personnel to coordinate patient care among organizations or for audit, monitoring, and/or evaluation activities, but they may require the data to be used and safeguarded in accordance with the applicable rules, and may require patient consent or authorization under certain circumstances.

Section 1902(a)(7) of the Act and implementing regulations in 42 C.F.R. part 431, subpart F, require state Medicaid agencies to provide safeguards that restrict the use or disclosure of information concerning Medicaid applicants and beneficiaries to uses or disclosures that are directly connected with the administration of the Medicaid state plan.[66] The same requirements also apply to separate CHIPs through a cross reference at 42 C.F.R. § 457.1110(b). Any release of information concerning applicants or beneficiaries must be restricted to individuals or agency representatives who are subject to standards of confidentiality that are comparable to those of the Medicaid or CHIP agency under 42 C.F.R. § 431.306(b). Additionally, states are typically required to obtain permission from applicants, beneficiaries, or an applicant's or beneficiary's personal representative before making a disclosure of their data to an outside source under 42 C.F.R. § 431.306(d). An entity, such as enrolled carceral health care provider who is contracted to assist the agency in a purpose directly connected to the administration of the Medicaid or CHIP state plan, such as providing services to beneficiaries, would not be considered an outside source. An entity that is not an enrolled provider or otherwise contracted with the state to assist the agency in a purpose directly connected to the administration of the Medicaid or CHIP state

[64] On February 16, 2024, the Department published a final rule for 42 C.F.R. part 2 ("Part 2"). Entities should be aware of these changes for SUD patient records protected by Part 2: https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html and https://www.samhsa.gov/newsroom/press-announcements/20240208/hhs-finalizes-new-provisions-enhance-intergrated-care-confidentiality-patients-substance-use-conditions.

[65] 45 C.F.R. § Parts 160 and 164. For more information on the HIPAA Rules, see: https://www.hhs.gov/hipaa/for-professionals/index.html. See also https://www.nasmhpd.org/content/tac-assessment-working-paper-2016-compilation-state-behavioral-health-patient-treatment.

[66] Purposes that are directly connected to the Medicaid state plan administration include: establishing eligibility, determining the amount of medical assistance, providing services for recipients, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the state plan, as specified in 42 C.F.R. § 431.302.

plan is considered an outside source and the state agency must obtain permission before disclosing beneficiary information to such an entity under 42 C.F.R. § 431.306(d).

To operationalize data sharing, CMS recommends that state Medicaid and CHIP agencies engage their juvenile and adult justice system agencies early on to establish written data-sharing agreements and processes for obtaining prior permission, as needed, to facilitate information sharing with appropriate information protections and compliance with section 1902(a)(7) of the Act and 42 C.F.R. Part 431, Subpart F; 42 C.F.R. Part 2; the HIPAA Rules; 42 C.F.R. § 457.1110; and any other applicable requirements under federal and state law for data sharing, confidentiality, privacy, and security.

Service Provision and Delivery Methods

The required case management and screening and diagnostic services authorized beginning 30 days prior to the scheduled date of release may be delivered in-person, via telehealth, or using some combination of both modalities to eligible juveniles who are incarcerated.[67] CMS expects Medicaid and CHIP agencies to work with the respective correctional systems and facilities to ensure access to the required services, and to facilitate access into correctional facilities for community health care providers, including case managers, in person and/or via telehealth. State Medicaid and CHIP agencies should also collaborate with correctional entities to ensure the availability of appropriate technology that may be needed for health care services that are delivered via telehealth, as well as procedures to ensure appropriate privacy during telehealth visits, consistent with any applicable federal and state confidentiality, privacy, and security requirements. This privacy is critical in facilitating a trusting relationship between eligible juveniles who are incarcerated and their health care providers during the 30-day period prior to release, and is expected to help ensure better health outcomes upon release.

While provision of "in reach" pre-release services by community-based providers is the preferred approach to build trust with eligible juveniles who are incarcerated and strengthen the connection to the community upon release, CMS recognizes operational complexities with executing this approach, and that many states have provider shortages, some of which are particularly acute in rural areas. States may choose to rely on carceral health care providers for delivery of some or all of the screening, diagnostic and case management services in the 30-day period prior to release.

Providers

States that rely on carceral health care providers to furnish any of the screening and diagnostic services and case management services during the 30-day period prior to release must ensure that these providers comply with Medicaid and CHIP provider participation and enrollment

[67] For more information about meaningful access requirements for individuals with limited English proficiency or with disabilities, please see https://www.hhs.gov/civil-rights/for-individuals/disability/guidance-on-nondiscrimination-in-telehealth/index.html.

requirements. All individual providers, including carceral providers, who will be furnishing, ordering, referring, and rendering services under these provisions must enroll if they are of a provider type that the state recognizes as eligible to enroll in Medicaid and CHIP. For example, individual practitioners who are physicians are required to enroll. In some circumstances, a practitioner or provider may be enrolled individually as a Medicaid provider, and may either bill directly for the services they furnish or, consistent with 42 C.F.R. § 447.10(g), reassign their right to payment to the carceral facility or an agency contracted by the carceral facility to provide Medicaid-covered services.[68]

Managed Care Delivery System

States may choose to utilize either a fee-for service (FFS) or managed care delivery system to provide care to eligible juveniles. If states intend to utilize their managed care plans for delivery of pre-release services to eligible juveniles, they should ensure they have any necessary managed care authority, which may require actions including but not limited to revisions to the Medicaid and CHIP state plans and/or section 1915(b) waivers. Additionally, states may need to amend managed care plan contracts and rate development. CMS is available to provide technical assistance (and we recommend early engagement). In accordance with 42 C.F.R. § 438.3(c)(1)(ii) and 457.1201(c), the final Medicaid and CHIP capitation rates must be based only upon state plan services and cannot include any state-only funded services. Additionally, as this incarcerated population of eligible juveniles receives only screening, diagnostic, and case management services pre-release, and the acuity for this population is likely to vary from that of other traditional beneficiary populations, states should develop capitation rates separately for this incarcerated population and the traditional Medicaid and CHIP populations. Rate development for this population must be distinct from the rate development for the traditional beneficiary populations. The state should also ensure that it has a process in place to capture and utilize distinct base data for this incarcerated population separately from the traditional Medicaid and CHIP populations. States should also work closely with their actuaries to develop Medicaid and CHIP capitation rates appropriately.

Accessibility

States should evaluate their language and disability accessibility policies and procedures to ensure meaningful access to the Medicaid and CHIP programs by individuals with limited English proficiency (LEP). States must also take appropriate steps to ensure communications are as effective for individuals with LEP and/or disabilities as they are for other individuals accessing the Medicaid and CHIP programs. States must provide language accessibility and effective communication for people with LEP and/or disabilities in the Medicaid and CHIP programs under federal Medicaid and CHIP regulations and under section 1557 of the

[68] Separate CHIP programs are subject to the same provider oversight requirements as Medicaid through a cross reference to section 1902(kk) under section 2107(e)(1)(G) of the Act.

Affordable Care Act (ACA), Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, section 504 of the Rehabilitation Act, and their implementing regulations.

Specifically, in accordance with 42 C.F.R. § 435.905(b) and 42 C.F.R. § 457.110(a), Medicaid and CHIP agencies, respectively, are required to provide program information in plain language, timely, and in a manner that is accessible to applicants and beneficiaries with LEP and/or a disability at no cost to the individual, including oral interpretation, written translations, and auxiliary aids and services. Applications, renewal forms, notices, and the fair hearing process must be accessible to individuals with LEP and/or disabilities.[69] In addition, 45 C.F.R. § 92.101 requires that states take reasonable steps to ensure meaningful access to covered services for Medicaid and CHIP programs by individuals with LEP through provision of language services that are free of charge, accurate and timely, and protect the privacy and independence of the individual. Under 45 C.F.R. § 92.102, states are also required to take appropriate steps to ensure the services provided are as effective for individuals with disabilities as they are for other individuals accessing the Medicaid and CHIP programs through the provision of auxiliary aids and services at no cost to the individual.[70],[71]

Additional Eligibility Changes for CHIP Under Section 5121 of the CAA, 2023

CHIP Eligibility Policy for Children Who Become Incarcerated Prior to Section 5121 of the CAA, 2023.

Incarceration status *is* a factor of eligibility in CHIP. Section 2110(b)(2)(A) of the Act excludes a child who is an inmate of a public institution from the definition of a targeted low-income child and therefore children in a carceral setting are generally ineligible for a separate CHIP.[72] However, as described in SHO 23-004, children who become incarcerated remain eligible for CHIP if they are still within their CE period because becoming incarcerated is not a permissible exception to CE.[73] This means that children determined eligible for CHIP at initial application or renewal who later become incarcerated during a CE period, remain eligible for the duration of their CE period. States may not terminate the child's CHIP eligibility during their CE period unless they experience another permissible exception to CE.

Currently, as explained in SHO 23-004, states may elect to either suspend CHIP coverage or provide all CHIP-covered services not otherwise paid for by the carceral setting through the end of the child's CE period. However, if the child remains incarcerated when their CE period ends, states must terminate their CHIP eligibility because they no longer meet the definition of a targeted low-income child.

---

[69] 42 C.F.R. § 435.907(g); 42 C.F.R. § 435.916(g); 42 C.F.R. § 435.917(a); 42 C.F.R. § 435.956(b), 42 C.F.R. § 431.206(e), 42 C.F.R. § 431.205(e).

[70] For more information on these requirements, please see https://www.medicaid.gov/sites/default/files/2023-02/accessibility-unwinding-slides.pdf.

[71] 45 C.F.R. § 92.201-205. Please see https://www.govinfo.gov/content/pkg/FR-2024-05-06/pdf/2024-08711.pdf for more information.

[72] Section 2110(b)(2)(A) of the Act and regulations at 45 C.F.R. § 457.310 define targeted low-income child.

[73] Section 2107(e)(1)(K) of the Act.

Changes to CHIP Eligibility Policy Under Section 5121 of the CAA, 2023

Effective January 1, 2025, section 5121 of the CAA 2023 adds a new section, 2102(d), to the Act. That new section modifies how incarceration impacts a child's CHIP eligibility and specifies the actions states must take during their period of incarceration. The language added at section 2102(d) of the Act is mostly identical to the existing Medicaid requirements at section 1902(a)(84) of the Act for eligible juveniles, as described in the SMD 21-002.[74]

In this SHO, we are aligning our interpretation of section 2102(d) of the Act with our interpretation of section 1902(a)(84) to the extent possible. We discuss these policies, and explain where they are different, below.

Prohibition on Terminating CHIP Eligibility at the End of the CE Period

Section 2102(d)(1)(A) of the Act, as amended by section 5121 of the CAA, 2023 requires that "[s]tate[s] shall not terminate eligibility for child health assistance under the State child health plan for a targeted low-income child because the child is an inmate of a public institution, but may suspend coverage during the period the child is such an inmate."

This means that, effective January 1, 2025, states may no longer terminate otherwise-eligible children from CHIP at renewal if the only reason for the termination is that they are inmates of a public institution. Under this new provision, states will no longer be permitted to terminate a child at the end of their CE period if they are still incarcerated. However, if they are found ineligible for CHIP for another reason after their CE period ends, the state may terminate the child's CHIP eligibility at that time.

Suspension Option During Incarceration

While section 2102(d)(1)(A) of the Act prohibits the termination of children from CHIP solely because they are inmates of public institutions, states will still have the option discussed in SHO 23-004 to either suspend CHIP coverage or continue to provide CHIP state plan services to children who are incarcerated.[75] For states that elect to suspend CHIP coverage for the duration of a child's incarceration, states may implement either a benefits suspension or an eligibility suspension as follows:

- Under a benefits suspension, children who become incarcerated continue to be eligible for CHIP, but coverage is limited to CHIP state plan services not otherwise provided by the carceral facility. When benefits are suspended during a period of incarceration, the state must complete regular annual renewals and redetermine eligibility if the child

[74] SMD 21-002, Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act). https://www.medicaid.gov/sites/default/files/2021-12/smd21002.pdf.

[75] Since CHIP does not have the same FFP exclusion for inmates of a public institution like Medicaid, states can continue to provide CHIP state plan services that are not otherwise provided by the carceral facility as long as the child remains eligible for CHIP while they are incarcerated. If states elect the option to provide CHIP state plan services during a child's incarceration, we note that FFP is not available for services that are otherwise provided by the carceral facility regardless of the child's insurance status.

experiences a change in circumstances during a CE period that is a permissible exception to CE.

- Under an eligibility suspension, the child's CHIP eligibility is not terminated but is effectively paused. When eligibility is suspended, a state may, but is not required to, conduct regular annual renewals. Eligibility can be reinstated if the individual needs covered CHIP state plan services not otherwise provided by the carceral facility. States that elect to suspend eligibility must redetermine the child's eligibility prior to covering CHIP services if it has been 12 months or longer since the child's last determination (i.e., at application or most recent renewal). As discussed in the next section of this SHO, states that elect to suspend eligibility also must redetermine the child's eligibility prior to the child being released from the carceral setting if it has been 12 months or longer since the child's last determination.

CHIP and Medicaid Redetermination Prior to Release

Both sections 2102(d)(1)(B) and 1902(a)(84)(B) of the Act specify that states must complete a redetermination prior to release for eligible juveniles who were found eligible for CHIP or Medicaid "immediately before becoming an inmate of a public institution." Similar to our interpretation of section 1902(a)(84)(B) of the Act for Medicaid in SMD 21-002, we interpret section 2102(d)(1)(B) of the Act to require that states redetermine such children's eligibility for CHIP prior to their release without requiring a new application and restore the child's coverage upon their release from a carceral facility if eligible.

However, the statutory requirements at sections 2102(d)(1)(B) and 1902(a)(84)(B) of the Act do not address how these provisions relate to the requirement added by section 5112 of the CAA, 2023 that states are also now required to provide a 12-month CE period effective January 1, 2024. As discussed in SHO 23-004 and noted earlier, incarceration is not a permissible exception to a child's CE period. Therefore, if a child is released from the carceral setting before their CE period ends, the state is required to reinstate benefits without conducting a redetermination of eligibility, unless the child has experienced a permissible exception to CE, such as turning 19 years old. That said, if the child remains incarcerated after their CE period ends and the state has not completed a redetermination within the past 12 months, the state is required to complete a redetermination of eligibility prior to the child's release. This policy applies to eligible juveniles in Medicaid and CHIP who are under age 19 who are eligible for mandatory CE effective January 1, 2024.

Redeterminations Prior to Release for Eligible Juveniles in Medicaid Who are Not Eligible for CE

However, some eligible juveniles in Medicaid who are age 19 or older will not be eligible for mandatory CE. Prior to CE becoming mandatory on January 1, 2024, states could consider the last redetermination conducted for any eligible juvenile who is enrolled in Medicaid at the time of incarceration, if that redetermination occurred after the time of incarceration and within 12 months of the date of release. For example, Rafe is determined eligible for Medicaid in January,

becomes incarcerated in March, and is released from incarceration in May. Rafe's Medicaid eligibility determination, which was completed pre-incarceration in January, would not fulfill the pre-release redetermination required under section 1902(a)(84)(B) of the Act because the eligibility determination was made before Rafe was incarcerated in March. Therefore, the state would need to redetermine Rafe's eligibility prior to Rafe's release. This existing policy continues to apply to eligible juveniles in Medicaid who are not eligible for CE prior to their release as described in SMD 21-002.

Redeterminations Prior to Release for Eligible Juveniles Who are Eligible for CE

The following examples are applicable to eligible juveniles enrolled in either Medicaid or CHIP who are under age 19 and whose eligibility is being redetermined prior to their release from a carceral setting:

Sam becomes incarcerated in May 2024, and the state implements an eligibility suspension at that time. Sam's current CE period ends on July 31, 2024, but Sam is not released until September 2024. Under an eligibility suspension, the state is not required to complete a renewal of Sam's eligibility at the end of Sam's CE period in July. If the state does not complete an annual renewal in July, it will have been over 12 months since Sam has had a redetermination when Sam is released in September. Therefore, the state must complete a redetermination of eligibility prior to Sam's release without requiring a new application (and reinstate his eligibility if he continues to meet all eligibility requirements).

Under a benefits suspension, the state would be required to complete Sam's annual renewal when Sam's CE period ends and begin a new eligibility and CE period effective August 1, 2024, if Sam meets all eligibility requirements. In this case, Sam's annual renewal will have been completed within the 12 months prior to Sam's release in September 2024, and the state would not be required to conduct another redetermination of Sam's eligibility prior to Sam's release from the carceral facility.

The following example is applicable to eligible juveniles enrolled in either Medicaid or CHIP who are under age 19 and whose eligibility does not need to be redetermined prior to release:

Alex is 17, and their eligibility period is January 1, 2024 through December 31, 2024. Because of Alex's age, they have 12 months of CE, as required by the CAA, 2023. Alex becomes incarcerated in May 2024, and is released on October 1, 2024. Regardless of the whether the state implements an eligibility or benefits suspension, the state does not have to conduct a redetermination prior to his release because Alex is released prior to the end of Alex's current CE period.

Children Determined Eligible for CHIP While Incarcerated and Upon Their Release

Generally, children who apply for CHIP when they already are in a carceral facility are not eligible because of the eligibility exclusion for inmates of a public institution under section 2110(b) of the Act. However, section 5121 of the CAA, 2023 added a new exception to this eligibility exclusion at section 2110(b)(7) of Act that considers children who are within 30 days prior to their release as no longer subject to the eligibility exclusion. This means that children who apply for CHIP coverage within 30 days prior to their release may be found eligible for screening and diagnostic services, referrals, and case management services under the CHIP state plan. Additionally, under section 2102(d)(1)(C) of the Act, states must process any application submitted on behalf of the child and make an eligibility determination for child health assistance upon their release from the institution.

Section 5122 of the CAA, 2023, at State Option

Section 5122 of the CAA, 2023 amended section 1905(a) of the Act, section 1902(a)(84)(A) of the Act and section 2110(b)(7) of the Act to allow states the option to lift the Medicaid inmate payment and CHIP eligibility exclusions and provide coverage of pre-release Medicaid and CHIP services to eligible juveniles who are incarcerated and pending disposition of charges. Section 5122 of the CAA, 2023, works in concert with section 5121 of the CAA, 2023, to provide limited coverage for eligible juveniles post-adjudication and to make available (for electing states) federal matching funds for the full breadth of Medicaid and CHIP benefits while such eligible juveniles are incarcerated pending disposition of charges. States electing the section 5122 of the CAA, 2023, state plan option are required to satisfy all of the requirements outlined in the provision. A state may elect the section 5122 of the CAA, 2023, state plan option for Medicaid, CHIP, or both. States must work closely with both the juvenile and adult justice systems to ensure the availability of Medicaid and CHIP coverage of pre-release services consistent with this provision does not effectuate a delay of an individual's release or lead to increased involvement in the justice systems.

Eligible Juveniles

Like section 5121, section 5122 of the CAA, 2023, applies to eligible juveniles as defined in section 1902(nn)(2) of the Act, including individuals described there who are eligible for CHIP.[76] Section 5122 of the CAA, 2023 only applies to eligible juveniles who are incarcerated

[76] As described above under "Mandatory Requirements of Section 5121 of the CAA," and detailed in SMDL 21-002, section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old). As mentioned above, the term "eligible juveniles" is not used in the amendments to the CHIP statute effectuated by section 5121 of the CAA, 2023. However, under the section 5121 amendments to section 2102(d) of the Act, the same eligibility policies that apply to "eligible juveniles" in Medicaid also apply to targeted low-income children in CHIP.

pending disposition of charges. For purposes of Medicaid and CHIP, CMS interprets "pending disposition of charges" for this purpose to mean that the eligible juvenile has been charged and is an inmate of a public institution while awaiting the outcome of the charges.

Carceral Settings

Like section 5121 of the CAA, 2023, there is nothing in the statute that speaks to limiting the types of carceral facilities. Thus, CMS interprets that, for states electing the option in section 5122 of the CAA, 2023, the statute applies to all types of carceral facilities where an eligible juvenile pending disposition of charges may be confined. This could include any type of state prison, local jail, tribal jail and prisons, and all juvenile detention and youth correctional facilities. At this time, this does not include federal prisons. CMS will provide further guidance at a later date on the applicability of section 5122 of the CAA, 2023 on federal prisons. Thus, a state electing the option would be required to provide to *all* eligible juveniles coverage of Medicaid and CHIP services to which the eligible juvenile would otherwise be entitled if not for incarceration for the duration of the pre-release period pending disposition of charges, regardless of the type of carceral facility in which they are confined.

Medicaid and CHIP Services

A state electing the option in section 5122 of the CAA, 2023, must provide to eligible juveniles *all* mandatory and optional services to which they are otherwise entitled under the Medicaid or CHIP state plan, waiver(s) of such state plan, and/or section 1115 demonstration project(s) during the period pending disposition of charges. During the period when an eligible juvenile is incarcerated and pending disposition of charges, this is essentially a full lifting of the Medicaid inmate payment exclusion and CHIP eligibility exclusion. States cannot choose to provide a limited array of state plan services under this option. For EPSDT-eligible Medicaid beneficiaries under the age of 21, this includes all medically necessary services under EPSDT as specified in section 1905(r) of the Act. If a state elects to provide EPSDT services under their CHIP state plan, the state also would be required to provide EPSDT consistent with section 1905(r) of the Act to CHIP-enrolled children in a carceral facility pending disposition of charges. Services provided while an eligible juvenile is incarcerated and waiting for the final disposition of charges are intended to ensure continuity of coverage and service delivery for eligible juveniles for whom the disposition of charges results in release.

State Plan Submissions for Sections 5121 and 5122 of the CAA, 2023

To comply with the amendments made by section 5121 of the CAA, 2023, states must submit a Medicaid SPA attesting that the state has developed an internal operation plan, and in accordance with such plan, will provide coverage during the statutory pre- and post-release period of screening, diagnostic, and TCM services for eligible juveniles who are within 30 days of release post adjudication. For Medicaid, a state must submit a SPA no later than March 31, 2025, to

have an effective date of no later than January 1, 2025. CMS is developing a SPA template to assist states.

In addition, states may need to submit a SPA(s) to authorize coverage of screening, diagnostic, and/or TCM services depending on the scope of the state's current plan coverage. For example, if a state does not have an existing TCM benefit with an appropriate target group encompassing eligible juveniles, the state will need to add such a TCM target group through a SPA submitted to and approved by CMS with an effective date no later than January 1, 2025.

States that do not have an approved payment methodology for these services must also submit a payment SPA with a submission date no later than March 31, 2025, and an effective date no later than January 1, 2025. As with any SPA submission, CMS expects states to comply with all applicable federal Medicaid SPA requirements.

For CHIP, states must submit their SPA to effectuate coverage of screening, diagnostic, and case management services that are otherwise available under the CHIP state plan for juveniles who are within 30 days of their release. Additionally, states will need to submit a SPA to comply with the additional eligibility changes for incarcerated youth in CHIP as required under section 2102(d)(1). In order to have an effective date of January 1, 2025, states must submit their SPA no later than the end of the state fiscal year in which January 1, 2025, falls.[77],[78] CMS is developing a SPA template for states.

For states that wish to elect the option in section 5122 of the CAA, 2023, states should submit a SPA attesting to CMS that they are also electing coverage for any Medicaid or CHIP state plan services for eligible juveniles pending disposition of charges to which the beneficiary would otherwise be entitled, if not for their incarceration status. CMS is developing a SPA template to assist states.

Conclusion

CMS looks forward to its continued work with states on the implementation of the requirements added by section 5121 of the CAA, 2023, to ensure that eligible juveniles following adjudication of charges have access to case management and the required screening and diagnostic services beginning 30 days prior to release. CMS also encourages states to exercise the option under section 5122 of the CAA, 2023, by providing coverage of pre-release services to improve care transitions for eligible juveniles who are pending disposition of charges and residing in juvenile detention and other carceral facilities. States must be mindful of and ensure the policies,

[77] 42 C.F.R. §§ 457.60 and 457.65.

[78] States with a separate CHIP that only provides coverage under the from conception to the end of pregnancy (FCEP) option are not required to submit a SPA for Sections 5121 or 5122 of the CAA, 2023. Children covered under the FCEP option are not considered incarcerated because they are not the individual who has been adjudicated, and the parent's incarceration status does not impute to the child; therefore, states would continue to provide CHIP state plan services that are not otherwise provided by the carceral facility.

procedures and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. CMS believes that provision of pre-release services to eligible juveniles who are incarcerated may not only improve the health and reentry outcomes of eligible juveniles who are leaving carceral facilities but may also benefit Medicaid, CHIP, and the community at large through improved connections to health care, particularly behavioral health services.

Questions regarding Medicaid state plan requirements and options provided in this guidance may be directed to Kirsten Jensen, Director of the Division of Benefits & Coverage, at kirsten.jensen@cms.hhs.gov. Questions regarding CHIP requirements and options may be directed to Meg Barry, Director, Division of State Coverage Programs, at meg.barry@cms.hhs.gov. Questions regarding an existing or future Reentry Section 1115 Demonstration Opportunity[79] should be directed to the state's CMS Section 1115 Project Officer.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

[79] https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf.