Section 5121 of the Consolidated Appropriations Act:

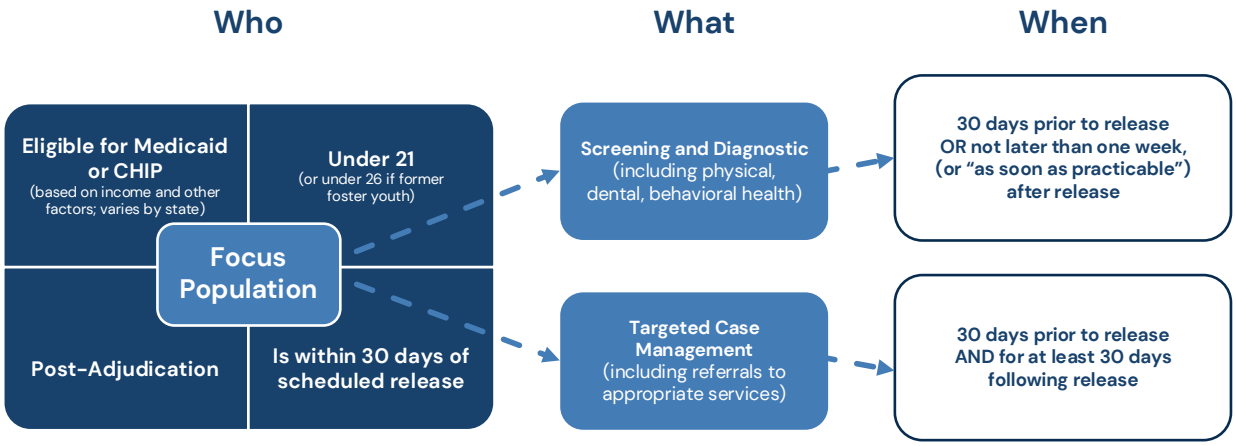
Frequently Asked Questions for Jails

Contents

Q1. What is Section 5121?

Section 5121 refers to a section of the Consolidated Appropriations Act of 2023 that includes requirements for states to provide screening and diagnostic services, including physical, dental, and behavioral health, as well as targeted case management (TCM) for post-adjudicated youth and young adults under the age of 21 or former foster care youth up to age 26. States have the option of providing screening and diagnostic services within 30 days of release or no later than one week after release. TCM must be provided within 30 days of release and for at least 30 days in the community. States have the option of utilizing telehealth for the delivery of TCM during the 30 days prior to release to prevent disruptions to the daily operations of correctional facilities.

New Medicaid and CHIP Policies for Youth Who Are Incarcerated: Required in All States, January 2025



Q2. When do the changes go into effect?

The youth provisions are effective January 1, 2025 (Consolidated Appropriations Act, 2023).

Q3. For Section 5121 of the Consolidated Appropriations Act of 2023, what population will these changes impact?

Per federal law and recent Centers for Medicare & Medicaid Services guidance, changes apply to post-adjudicated youth under age 21 and former foster care youth up to age 26 who are enrolled in or determined eligible for Medicaid or the Children's Health Insurance Program (Tsai, 2024). This population may be incarcerated in youth or adult facilities, including jails, prisons, and tribal facilities.

Key Statistics: Justice Involvement and the Health Needs of Youth

- Primary care use after release correlates to reduced recidivism for youth (Aggarwal & Will, 2023).
- More than 50% of youth in youth correctional facilities meet the criteria for a substance use disorder (Bureau of Justice Statistics, 2023), and approximately 70% have a mental health condition (Youth.gov, n.d.).
- In 2017, individuals, ages 18–24, represented 9.5% of the U.S. population (United States Census Bureau, 2021), yet accounted for 23% of all arrests (Federal Bureau of Investigation, n.d.).
- In 2021, nearly 25,000 youth under age 21 in the United States were confined in juvenile justice detention centers and juvenile long-term secure facilities (Office of Juvenile Justice and Delinquency Prevention, n.d.). Over 2,000 youth under age 18 were confined in adult carceral facilities, including prisons and jails (Zeng et al., 2023).
- Emerging adults, ages 18–25, have the greatest racial disparities of any incarcerated age group. In 2022, Black and Latinx males, ages 18–19, were 11.3 times and 2.8 times, respectively, more likely to be imprisoned compared to their White peers. Black and Latinx males, ages 20–24, were 8 times and 3 times more likely to be imprisoned compared to their White peers, respectively (Carson & Kluckow, 2023).
- 76.5% of individuals, ages 18–24, released from state prison were rearrested within 3 years, the highest recidivism rate of any age group (Alper & Durose, 2018).

Q4. What correctional facilities are subject to these new policies?

New policies apply to:

- State prisons
- Local jails
- Tribal jails and prisons
- Juvenile detention and youth correctional facilities

Q5. What actions/plans are required for implementation? How does it go into effect?

State Medicaid agencies (SMA) must submit state plan amendments (SPA) for the Centers for Medicare & Medicaid Services' (CMS) review and approval by March 31, 2025. Amendments will be retroactive to January 1, 2025. Through the SPAs, states attest that the state has developed an internal operational plan to provide mandatory services for eligible youth and young adults and establish specific service and payment approaches (Tsai, 2024).[1] While SMAs are required to develop operational plans on behalf of their state by January 1, 2025, they are not required to submit the plans to CMS. However, local jails and state correctional agencies should engage with SMAs so corrections' views are included in operational plans. CMS plans to release SPA templates for SMA use.

1 Please see companion *Getting Ready: Key Elements for the Implementation of Section 5121 Youth Requirements in Adult Correctional Facilities* document for more information on operational plan elements.

Q6. Are federal resources available to support implementation?

Yes. In 2025, the Centers for Medicare & Medicaid Services (CMS) will competitively award $106 million in planning grants to state Medicaid and Children's Health Insurance Program (CHIP) agencies. The funding is intended to support states in developing operational capabilities to promote continuity of care for Medicaid and CHIP beneficiaries leaving incarceration. In its notice of funding opportunity, CMS states that "funds may be used for addressing operational barriers and improving systems for continuity of care following incarceration in state-operated prisons, local, tribal, and county jails, and youth correctional or detention facilities" (Grants.gov, 2024).

CMS encourages state Medicaid and CHIP programs to partner with correctional entities, community-based organizations, and others to develop grant project proposals. Correctional administrators should reach out to their state Medicaid agency to inquire about applying for funds. Grant funding can be used by states to implement the new youth continuity of care requirements or other specific activities affecting continuity for reentering Medicaid and CHIP beneficiaries, such as meeting federal requirements to suspend, rather than terminate, Medicaid and CHIP eligibility upon incarceration. The funds can be used to identify and address operational gaps in meeting federal requirements, develop systems to operationalize continuity of care, and establish oversight and monitoring processes. CMS will consider several factors when making awards, including the number of correctional facilities in a state and the state's efforts to establish continuity of care.

CMS will issue cooperative agreements to states in two rounds of awards. The deadline to apply for the first cohort is November 26, 2024. CMS expects to award grants to this cohort by February 15, 2025. The deadline for the second cohort is March 17, 2025, and CMS anticipates awarding grants by July 15, 2025. States may apply for either cohort. Grants will range from $1 to $5 million over 4 years.

Congress authorized grant funds in the Consolidated Appropriations Act of 2024.[2]

Q7. How do the required youth provisions intersect with the Medicaid 1115 Reentry Demonstration Opportunity?

All states, with and without approved Medicaid 1115 Reentry Demonstration Opportunities, must implement the new Medicaid and Children's Health Insurance Program requirements for youth and young adults. In states with approved Medicaid 1115 Reentry Demonstration Opportunities, youth requirements will likely be implemented alongside their broader waiver policies.

2 The notice of funding opportunity is available on this Grants.gov web page.

Q8. Who will make decisions about how these new services are implemented, including screening and diagnostic services and targeted case management?

Correctional administrators should coordinate with state Medicaid agencies (SMA) to develop service implementation approaches. Discussions should focus on issues like:

- How eligibility and other information will be shared
- Which providers will provide the covered services
- How services will be carried out
- How services will be financed
- How service provision will be overseen, including identifying performance measures

Like all other Medicaid services, SMAs will be accountable to the Centers for Medicare & Medicaid Services (CMS) for developing and overseeing services in accordance with federal Medicaid law. SMAs will be responsible for developing operational plans and submitting state plan amendments to CMS. Correctional administrators must work closely with SMAs to develop operational approaches that consider the specific operational realities of corrections, including security, staffing, training, and developing administrative policies and procedures. Other entities, such as the managed care organizations that many SMAs partner with to organize and deliver Medicaid services, may also play a role.

Q9. How will youth in adult correctional facilities be enrolled in Medicaid?

State Medicaid agencies (SMA) will work with correctional administrators to develop processes to support youth applying for Medicaid and Children's Health Insurance Program (CHIP) coverage if they are not already enrolled. In some states, SMAs have trained correctional staff to assist with applications. The Centers for Medicare and Medicaid Services' guidance suggests that applications be submitted 90 days or more prior to release. State Medicaid and CHIP agencies will process applications and make Medicaid and CHIP eligibility determinations.

Q10. Do facilities need a process to suspend benefits for youth enrolled in Medicaid and the Children's Health Insurance Program when they enter custody?

Yes. In partnership with the state Medicaid agency, state and local correctional facilities must suspend Medicaid coverage when a youth or young adult enters custody and reactivate it within the 30-day pre-release window or upon release. Reactivating coverage means that, upon release, youth and young adults will have access to comprehensive benefits, referred to as "full state plan benefits" in Medicaid and the Children's Health Insurance Program (CHIP). A federal law enacted in 2018 required states to suspend Medicaid eligibility for beneficiaries under 21 and former foster care youth up to age 26. The Consolidated Appropriations Act of 2023 extends this requirement to youth enrolled in CHIP.[3]

3 Additionally, the Consolidated Appropriations Act of 2024 requires that the coverage of all Medicaid beneficiaries who are incarcerated be suspended—not terminated. This federal law is effective January 2026, extending the current requirement for youth to all Medicaid beneficiaries.

What is CHIP?

The Children's Health Insurance Program (CHIP) is a state-federal partnership program that provides low-cost coverage with comprehensive benefits for children whose family income is too high for the child to qualify for Medicaid. In some states, CHIP covers pregnant women and children. Like Medicaid, states make decisions about their programs within federal guidelines set by the Centers for Medicare & Medicaid Services (CMS), so state CHIP programs vary (Centers for Medicare & Medicaid Services, 2021).

States can design their CHIP program in one of three ways (Medicaid, n.d.-b):

1. **Separate CHIP programs**: Operate separately from Medicaid. Children covered by CHIP are generally offered benefits that differ from Medicaid benefits. Other programmatic rules may differ as well.
2. **Medicaid expansion CHIP programs**: These programs follow Medicaid policies and are functionally identical to Medicaid. Programs cover CHIP children and are funded by federal CHIP matching funds.
3. **Combination CHIP programs:** States cover some CHIP-eligible children through Medicaid expansions and other children through a separate CHIP program.

Of the 46.5 million children in the United States covered by Medicaid and CHIP in 2022, 2.7 million were enrolled in separate CHIP programs. The remaining 43.7 million were enrolled in Medicaid or a CHIP-funded Medicaid expansion program (Medicaid and CHIP Payment and Access Commission, 2023). As of 2017, 40 states operated combination programs, and two states operated separate CHIP programs (Medicaid and CHIP Payment and Access Commission, 2021). In states with separate CHIP programs, CHIP may be overseen by a state agency separate from the state Medicaid agency.

Youth Provisions: Key Considerations & CHIP Implications:

The youth continuity of care requirements apply to Medicaid beneficiaries and beneficiaries enrolled in separate CHIP programs. States must provide targeted case management (TCM) services to children under 21 for 30 days before and 30 days after their release. Correctional administrators and state CHIP and Medicaid agencies should consider the following in implementing the youth requirements:

- **Eligibility/enrollment**: A child within 30 days of release may apply and be eligible for services. States must also submit applications for full CHIP benefits upon release.
- **Suspension:** Longstanding Medicaid requirements dictate that the eligibility of youth and young adults be suspended rather than terminated when individuals are incarcerated. For the first time, these requirements are being extended to CHIP, effective January 1, 2025. Previously, federal law required coverage of CHIP beneficiaries to be terminated upon incarceration.
- **Screening & diagnostic services:** In separate CHIP programs, established screening and diagnosis requirements may differ from those of Medicaid. Aligning CHIP and Medicaid screening and diagnosis policies may ease implementation and reduce administrative burden on facilities.
- **TCM:** Unlike Medicaid, CHIP does not have a specific definition of TCM. CMS encourages states to align with Medicaid's TCM definition.

Youth Provisions: Impact of Medicaid and CHIP Continuous Eligibility Requirements (Tsai, 2024)

Continuous eligibility is designed to promote access to health care for youth, even if the child's family experiences a change in circumstances, such as an unexpected income increase. In 2024, people aged 19 and younger are guaranteed 12 months of continuous coverage once they are determined eligible for and enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Like the new youth requirements, the new continuous eligibility requirement was established by the Consolidated Appropriations Act of 2023.

This 12-month coverage guarantee applies whether or not an individual is incarcerated. As a result, youth and young adults younger than 19 who are incarcerated are unlikely to experience interruptions or gaps in Medicaid and CHIP coverage; the few who do will qualify for one of the narrow exceptions to the guarantee of continuous coverage. This should make it easier for correctional facilities to provide the new case management, screening, and diagnostic services required, as few Medicaid and CHIP beneficiaries will lose coverage during the 30-day pre-release period.

The continuous eligibility requirement interacts with new federal requirements that mandate CHIP youth and young adults' coverage be suspended rather than terminated. **Correctional administrators and state Medicaid and CHIP agencies have options for operationalizing coverage suspension requirements.** They can implement a *benefits* or an *eligibility* suspension. Decisions about which option to apply should be made by state Medicaid and CHIP agencies in consultation with correctional administrators.

- **CHIP suspension options.** In CHIP, during a benefits suspension, the child remains eligible, and the state can, only for the duration of the continuous eligibility period, provide all CHIP-covered services not otherwise paid for by the correctional facility. Under a CHIP eligibility suspension, the child's CHIP eligibility is paused, and CHIP does not cover services, other than the case management, screening, and diagnostic services required during the 30 days before release.
- **Medicaid suspension options.** The Medicaid eligibility suspension policy differs slightly from the CHIP eligibility suspension policy. Under a benefits suspension in Medicaid, an individual's Medicaid benefits are paused, except for inpatient hospital stays. Under an eligibility suspension, an individual's eligibility is effectively paused and reactivated upon release or if/when an individual needs inpatient hospital services.

The continuous eligibility policies place specific requirements on Medicaid and CHIP agencies regarding when they can redetermine children's eligibility. If a child covered by Medicaid or CHIP is released from incarceration during the child's 12-month continuous eligibility period, the state must reactivate the individual's benefits without redetermining eligibility. However, if a state and facility elect the benefits suspension option for CHIP enrollees, the state must conduct annual eligibility redeterminations for CHIP enrollees. These annual redeterminations are not required for children in Medicaid or CHIP children whose eligibility, rather than benefits, has been suspended. Finally, for any Medicaid or CHIP child who remains in custody after the end of the continuous eligibility period, the state must redetermine eligibility before the child is released if a redetermination has not been completed in the last 12 months.

Q11. Who is responsible for identifying former foster age youth up to age 26?

State Medicaid agencies (SMA) are responsible for developing a process to identify former foster-age youth, but correctional administrators may consider inquiring about individuals' status during intake. However, administrators should not solely rely on self-reported information. This process will require a high level of cross-agency collaboration among SMAs, correctional administrators, and the foster care system. Please engage your SMA to hear their initial plans for identifying these youth.

Q12. What screening and diagnostic services are required under the new provisions?

New federal law and recent Centers for Medicare & Medicaid Services guidance specify that screening and diagnostic services, including immunizations, must be offered for physical health, behavioral health, and dental services. These services must be delivered 30 days before release, no later than 1 week, *or* as soon as practicable after release. Screening and diagnostic services administered before incarceration, at entry, or more than 30 days before release can satisfy this requirement, but Medicaid will not pay for services rendered outside the 30-day window.

State Medicaid agencies (SMA) will determine the screening and diagnostic services covered. State Medicaid programs set specific screening and diagnostic standards for all people under 21 who meet federal requirements for Medicaid's comprehensive pediatric benefit, known as the Early and Periodic Screening Diagnostic and Treatment program. Correctional facilities will need to work with SMAs in their state to align their screening and diagnostic services and schedules with these existing standards.

State and local correctional leaders must engage in discussions with SMAs on the extent to which the current screening and diagnostic services provided by their facilities comply with state Medicaid requirements. SMAs and correctional facilities can also develop additional standards specific to this population. State Medicaid programs will need to coordinate with correctional facilities to deploy services at appropriate intervals in accordance with state standards.

In separate Children's Health Insurance Programs (CHIP), established screening and diagnostic requirements may differ from those of Medicaid. Aligning CHIP and Medicaid screening and diagnostic policies may ease implementation and reduce the administrative burden on facilities when implementing the youth requirements.

Q13. What is targeted case management?

Targeted case management (TCM) is a care coordination function designed to help connect people to services when needed. The four primary elements of TCM are (1) a comprehensive assessment, (2) the development of a person-centered care plan, (3) referral to appropriate health and other services, and (4) monitoring and follow-up activities (Public Health, 2009a).

Under the youth continuity of care requirements, TCM services must be available 30 days before release *and* at least 30 days after. TCM should include referrals to appropriate care and services in the geographic area where the individual resides (Tsai, 2024).

TCM is an established Medicaid benefit available to many Medicaid beneficiaries who reside in the community (Public Health, 2009a). TCM benefits are offered at state option and vary widely within and across states. In contrast to most other Medicaid benefits, states can offer TCM only to specific subpopulations of beneficiaries or within specific regions of the state. For that reason, states' approaches to TCM vary. Correctional facilities and state Medicaid agencies (SMA) should discuss the following:

- The availability and design of existing TCM benefits
- Who is eligible for TCM
- Whether TCM benefits need to be revised or expanded to include youth and young adults who have been incarcerated
- The extent to which any existing case management services offered in correctional facilities meet Medicaid TCM standards

TCM can connect youth and young adults to social, educational, and health care services and support social and family connections. TCM providers can make connections to Medicaid-covered services and services that Medicaid does not cover (Tsai, 2024).

In its guidance, the Centers for Medicare & Medicaid Services (CMS) notes the importance of trust between case managers and youth who are incarcerated. To assist youth returning to the community, CMS encourages states to incorporate peers with lived experience into their case management approach (Tsai, 2024).

Correctional facilities should work closely with their respective SMAs to ensure that pre- and post-release services are well coordinated and minimize gaps in care upon release.

Targeted Case Management

Targeted case management (TCM) is a care coordination function designed to help connect people to services when they need them. For the first time, the youth continuity of care requirements make this longstanding Medicaid benefit available to youth and young adults before release from corrections facilities. Specifically, TCM (Tsai, 2024):

- Must be provided 30 days before release and at least 30 days after release.
- Allows services to be "targeted" to a specific population or geographic area.

CMS also encourages using peers with lived experience to support youth reentering the community (Tsai, 2024).

TCM includes the following four elements, which are established in the Centers for Medicare & Medicaid Services' (CMS) youth guidance and reflect longstanding federal regulations (Public Health and Welfare, 2024):

1. Comprehensive assessment and periodic reassessment of individuals to determine the need for any medical, educational, social, or other services.
2. Development and periodic revision of a specific, person-centered care plan based on the information collected through the assessment.
3. Referral and related activities, such as scheduling appointments, to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs that are capable of providing services to address identified needs and achieve goals specified in the care plan.

Continued on the following page

4. Monitoring and follow-up activities, including activities and contacts necessary to ensure that the care plan is effectively implemented and adequately addresses the eligible individual's needs. Monitoring activities may require contact with the individual, family members, service providers, or other entities and should be conducted as frequently as necessary but at least once annually.

In its youth guidance, CMS describes TCM as a "critical lynchpin to help connect eligible juveniles to all needed services upon release, including medical, social, and educational services" (Tsai, 2024, p. 17). Correctional facilities can refer to the CMS guidance for additional context about TCM.

Q14. How does the guidance address warm handoffs for individuals transitioning to the community?

Under the new requirements, case management services must be provided before and after release, as noted above. State Medicaid agencies and correctional facilities will determine whether the same or different case managers will provide pre- and post-release care. If different case managers (CM) deliver services before and after release or even during the post-release period after the 30-day mandatory period, the state must ensure a "warm handoff" between the CMs. The warm handoff should include a meeting of the pre-release CM, the post-release CM, and the impacted youth to discuss the individual service plan and next steps. Strong communication across state agencies, local agencies, and community providers will be needed to facilitate access to individuals during incarceration.

Q15. What options are available for delivering these new services?

Youth continuity of care services can be delivered by the correctional health care staff, through in-reach from community providers, or a hybrid of the two. The Centers for Medicare & Medicaid Services guidance cites a preference for service delivery from community providers as they can strengthen connections to post-release community services. Screening, diagnostic, and case management services may be delivered in person or through telehealth.

Q16. Are all correctional facilities required to enroll as Medicaid providers?

To provide Medicaid-covered services, providers must meet Medicaid provider participation and enrollment requirements. Enrolling as a Medicaid provider is a specific process established by state Medicaid agencies. The process includes having a national provider identifier number, providing proof of licensure, a background check, federal database checks, and periodic renewals (Public Health, 2009b).

Correctional administrators may enroll as Medicaid providers but are not required to unless they provide Medicaid-covered services. Correctional administrators can instead turn to existing service providers, such as individual or group practitioners, community providers, such as community health centers or hospitals, or other contracted healthcare providers. Correctional administrators must require contracted health care providers to enroll as Medicaid providers if they plan to provide any mandatory covered services under the youth provisions.

A practitioner enrolled individually as a Medicaid provider can bill directly for services delivered. Additionally, the individually enrolled provider could reassign their right to payment to the correctional facility or an organization contracted to provide services behind the wall.

Q17. What should be considered regarding data sharing and systems when implementing the youth provisions?

States and facilities must establish systems that can share data with state Medicaid offices and community partners.

- **State Medicaid offices:** Eligibility, enrollment, and suspension status and billing claims information
- **Community partners:** Clinical information for coordination of care at reentry

The Centers for Medicare & Medicaid Services (CMS) guidance highlights the importance of data sharing across systems to facilitate effective care coordination while recognizing the possible challenges related to data collection, systems capacity, and legal considerations. CMS guidance acknowledges that various federal data laws and regulations may apply to the new youth requirements (e.g., section 1902(a)(7) of the Act; 42 Code of Federal Regulations [CFR] Part 431, Subpart F; 42 CFR § 457.1110; 42 CFR Part 2; the Health Insurance Portability and Accountability Act [HIPAA]).

CMS recommends strong cross-agency collaboration to establish appropriate data-sharing agreements that consider all the requirements under federal law, including HIPAA, 42 CFR Part 2, and state law. Correctional administrators are encouraged to engage with their state-level partners early to draft the necessary information-sharing agreements.

Q18. Do facilities need to hold an individual in custody until the required services are delivered?

No. The Centers for Medicare & Medicaid Services guidance stresses the importance of ensuring that implementing these provisions does not delay an individual's release from a correctional facility or increase criminal justice system involvement.

Q19. Will facilities be responsible for ensuring any post-release services (case management, screening, diagnosis, and referrals) are delivered?

Although coordination of pre- and post-release services is important, correctional facilities will not be expected to oversee the delivery of services once an individual is out of their custody. Community providers and Medicaid-managed care organizations, which operate under the direction of state Medicaid programs, will be responsible for post-release services. In specific cases where correctional providers offer post-release case management, they may be authorized to provide this service, subject to the guidance of the state Medicaid agency.

Q20. As a jail, what are the potential next steps?

Jails are expected to comply with the youth provisions. First, contact your state sheriffs' association and your state Medicaid agency (SMA). Both entities should be able to identify next steps for your facility. As SMAs develop their respective operational plans this fall, sheriffs', jail administrators', and jailors' perspectives will be critical to develop realistic plans that comply with statute requirements and the Centers for Medicare & Medicaid Services' guidance. For example, certain facilities are deputizing staff/program coordinators to prepare for January 1, 2025. Please see companion documents for operational checklists and key elements to guide your implementation efforts.

As jails contemplate funding and staffing needs for sustainable implementation, jail administrators should engage with their county commissioners and boards to highlight their preparations and challenges.

Q21. What key terms should jails be aware of?

Please see below for key terms and a relevant glossary.

1. **Medicaid:** The nation's public health coverage program that serves people who have low incomes (Centers for Medicare & Medicaid Services, n.d.-a). As of June 2024, Medicaid covered more than 79 million adults, children, seniors, and people with disabilities (Centers for Medicare & Medicaid Services, n.d.-c). Medicaid operates as a state-federal partnership. States determine policies regarding eligibility, benefits, payment, and other areas within federal guidelines and above federal minimums.
2. **Centers For Medicare & Medicaid Services (CMS):** CMS is the federal agency responsible for Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace, among other responsibilities. It is part of the U.S. Department of Health and Human Services (Kaiser Commission on Medicaid and Uninsured, n.d.).
3. **Medicaid Section 1115 Demonstration Opportunity:** Medicaid 1115 demonstrations, also known as "Medicaid waivers," are a feature of the Medicaid program through which states may, with federal approval, depart from some provisions of federal law in operating their Medicaid programs. By law, these demonstrations are experimental, pilot, or demonstration projects proposed by states and reviewed and approved by CMS (Medicaid, n.d.-a). Demonstrations must promote the objectives of the Medicaid program. "Section 1115" refers to the section of Medicaid's authorizing law, the Social Security Act, establishing CMS' demonstration waiver authority (Kaiser Commission on Medicaid and Uninsured, n.d.).
4. **State plan amendment (SPA):** Each state has a federally approved state plan that governs its Medicaid and Children's Health Insurance Programs and enables the state to obtain federal Medicaid matching payments for the services it provides. When states change their Medicaid programs, they submit a SPA for CMS' review and approval (Kaiser Commission on Medicaid and Uninsured, n.d.).
5. **Managed care organization (MCO):** State Medicaid agencies may contract with Medicaid managed care organizations (generally, health insurers) to organize and deliver services to Medicaid beneficiaries. In most states, MCOs play a major role in Medicaid service delivery, covering most Medicaid beneficiaries for a wide range of services (Centers for Medicare & Medicaid Services, n.d.-a).

6. **Eligibility:** Medicaid has specific policies that determine who is eligible to enroll in Medicaid coverage. There are several components of Medicaid eligibility requirements, such as income and state residency. Medicaid eligibility policies vary by state, as states set eligibility policies within federal guidelines and above federal minimum standards. States are responsible for processing applications for Medicaid coverage and making eligibility determinations (Centers for Medicare & Medicaid Services, n.d.-a).
7. **Inmate exclusion:** Since 1965, federal Medicaid law has generally prohibited using Medicaid funds to pay for the health care of "inmates of a public institution," including post-adjudicated individuals and those held awaiting trial (Tsai, 2024).
8. **Post-adjudication:** Adjudication is the court process determining if an individual committed the act for which they are charged. For purposes of determining who is eligible for the new youth services, CMS defines adjudication "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" (Tsai, 2024, p. 13).
9. **Pending disposition of charges:** CMS interprets "pending disposition of charges" as an eligible juvenile who has been charged and is an inmate of a public institution while awaiting the outcome of the charges (Tsai, 2024).
10. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. EPSDT is designed to promote the health and development of children and adolescents by ensuring that children and adolescents receive appropriate preventative, dental, mental health, and specialty services. It includes periodic screenings to identify health and behavioral health conditions and follow-up services to correct or ameliorate a condition identified during a screening (Medicaid, n.d.-c).

Helpful Resources

- 104th Congress: Health Insurance Portability and Accountability Act of 1996 (public law)
- Centers for Medicare & Medicaid Services: *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* (publication)
- Medicaid.gov: About Section 1115 Demonstrations (web page)
- Medicaid.gov: Early and Periodic Screening, Diagnostic, and Treatment (web page)
- U.S. Department of Health and Human Services: Fact Sheet 42 CFR Part 2 Final Rule (web page)

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