

Medicaid Access for Youth Aging Out of Foster Care



APHSA

American Public Human Services Association



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About APHSA

The American Public Human Services Association (APHSA), founded in 1930, is a nonprofit, bipartisan organization of state and local human service agencies and individuals who work in or are interested in public human service programs. Our mission is to develop and promote policies and practices that improve the health and well-being of families, children, and adults. We educate

Congress, the media, and the general public on social policies and practices and help state and local public human service agencies achieve their desired outcomes in Temporary Assistance for Needy Families, child care, child support, Medicaid, food stamps, child welfare, and other program areas and issues that affect families, the elderly, and people who are economically disadvantaged.

About the Authors

Sonali Patel, MSW

Ms. Patel is a senior policy associate in the Policy and Government Affairs Department of APHSA. Ms. Patel has over ten years of combined professional experience in family health research and child welfare policy. At APHSA, Ms. Patel primarily focuses on issues pertaining to child welfare policy and works closely with the National Association of Public Child Welfare Administrators (NAPCWA), an APHSA affiliate organization.

Martha A. Roherty

Ms. Roherty is the Director of the National Association of State Medicaid Directors and the Center for Workers with Disabilities. Ms. Roherty and her staff are responsible for educating Congress, the Administration, other state executive branch organizations, advocacy groups, and the general public on administrative and health policy issues of special concern to the state officials administering the Medicaid and State Children's Health Insurance Programs (SCHIP). Ms. Roherty furnishes technical assistance to state Medicaid, SCHIP, and disability program staff.



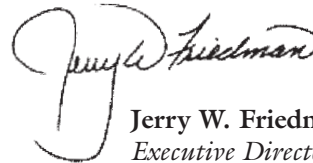
Acknowledgements

APHSA is pleased to release this report on providing Medicaid services to youth who have aged out of foster care. This report was a joint project of two of our affiliate organizations, the National Association of State Medicaid Directors (NASMD) and the National Association of Public Child Welfare Administrators (NAPCWA).

We would like to thank the state officials who completed the comprehensive survey instrument and who responded to our numerous follow-up questions. Due to the complex nature of this issue, we recognize that this survey required the coordination of multiple state agencies and we appreciate the time and effort that was devoted to each state's response. We also extend appreciation to the Medicaid Eligibility Technical Advisory Group and its full state membership for their work on this project.

We are especially grateful for the leadership of Nancy Atkins, chair of NASMD, Richard Anderson, president of NAPCWA, and MaryBeth McCaffrey, chair of the Eligibility Technical Advisory Group.

The Jim Casey Youth Opportunities Initiative funded this important project, and we would like to especially thank Gary Stangler for his vision for this work. I would also like to extend my appreciation to Elaine Ryan for her guidance and leadership on this project. Sonali Patel was the lead staff person for this report, Gregorio Hunt assisted with the numerous follow-up questions, and Martha Roherty provided direction on the Medicaid section of the report.



Jerry W. Friedman
Executive Director
APHSA



**JIM CASEY YOUTH OPPORTUNITIES INITIATIVE***Helping youth in foster care make successful transitions to adulthood*

January 4, 2007

Dear Colleagues:

A useful standard for gauging what supports we should provide for youth aging out of our foster care systems is: what would we do for our own kids? Would we tell our own 18-year-old that we would help her stay in high school, but not pay for a visit to the doctor? For a number of us, the answer is quite easy, since our employer-based health insurance allows us to cover our dependents until they are 23. Yet for most youth leaving foster care, not having health insurance is one more by-product of not having the support of a family that most of us take for granted. I expect that none of us would make our child choose between education and health care. In fact, we try to teach our children how important it is to stay healthy in order to succeed in school or at work.

In 1999, Congress gave the states an opportunity to extend Medicaid to young people 18-21 exiting from foster care. The bad news is that most states have not done so: only 17 have exercised this option. The good news is that several states have very recently joined that group, and several more are proposing to do so. And with additional opportunities under the Deficit Reduction Act, and possibly in the context of Congressional deliberations on reauthorization of the State Children's Health Insurance Program, perhaps more states will act.

I commend the American Public Human Services Association for the excellent work to produce this important publication, and the leadership of the National Association of State Medicaid Directors and the National Association of Public Child Welfare Administrators for bringing this issue to the forefront. I have long believed that the leadership of state human services administrators is the key to innovation and improving the outcomes for our children and families.

It is my sincere hope that this publication will be useful to those state leaders, and contribute to their efforts to improve the life outcomes for these youth.

Sincerely,

A handwritten signature in black ink, appearing to read "Gary Stangler". The signature is fluid and cursive.

Gary Stangler
Executive Director

GS:bjt



Executive Summary

The Foster Care Independence Act of 1999 (P.L. 106-169) and the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) have provided unique opportunities for states to extend Medicaid coverage for youth who have aged out of foster care. This report is intended to provide state child welfare and Medicaid officials and state legislatures with data on how these legislative changes are being and can be used to cover youth that continue to need support after leaving state custody. APHSA, in conjunction with the National Association of State Medicaid Directors (NASMD), and the National Association of Public Child Welfare Administrators (NAPCWA), surveyed states on several key areas to develop this report. This report covers the following:

- Current Medicaid programs that are being used to cover foster youth who have aged out of the system.
- Cost estimates associated with providing this coverage.
- How the newly enacted DRA can be used to create a program to cover these youth.

The survey was compiled and analyzed during Fall 2006. The report is based on responses from a combination of state officials including: state Medicaid directors, state child welfare directors, and state eligibility workers. Key findings include:

Finding 1. Over 40 percent of the states have taken the Chafee option to extend Medicaid or have plans to do so.

Since the enactment of P.L. 106-169, 17 states have extended their Medicaid programs using this provision to cover these youth. Five states reported that they had plans to request the Chafee option in the next legislative session.

Finding 2. Extending Medicaid using the Chafee option is affordable.

According to the states that responded to this question, the Per Member Per Month (PMPM) costs for this program are less than \$350.

Finding 3. States provide coverage under other state plan categories or waivers.

While 22 states reported providing coverage to these youth under the Chafee option or plans to do so, the remaining 28 states and the District of Columbia reported using other methods to extend coverage. These alternative methods of coverage include the medically needy category, 1115 waivers, State Children's Health Insurance Program (SCHIP), and general assistance based on income and resources.

Finding 4. States may be able to use the newly enacted DRA benefits flexibility option to create a program for these youth.

Since enactment of the DRA, four states have enacted benefit flexibility options for various populations of their Medicaid programs. States could consider using this new flexibility to design a benefit package for youth who have aged out of foster care.



Medicaid Access for Youth Aging Out of Foster Care

Introduction

APHSA conducted a survey in October 2006 to assess how states provide continuity of health care coverage to youth who have aged out of foster care, defined as former foster youth who reached their eighteenth birthday while in state custody. Based on survey results and follow-up with each state, this report includes background on older foster youth, information on how states currently provide Medicaid coverage to former foster youth, and a new option states can use to extend Medicaid coverage.

Background

Foster Youth Transitioning to Adulthood

As of fiscal year (FY) 2005, there were 104,710 youth aged 16 and older in foster care. This group of foster youth represents about 20 percent of the total foster care population, while 9 percent (24,407) aged out of foster care that year.¹ Unlike their younger counterparts, older foster care youth are more likely to stay in group home settings and have multiple foster care placements, and are less likely to be reunified with their biological families. In federal FY 2000, about one-fourth of youth ages 16-18 had been in care for at least five years, while 51 percent of foster youth over 19 had been in care for at least five years.²

¹ U.S. Department of Health and Human Services, Administration for Children and Families, *The AFCARS Report #13 (Preliminary Estimates for FY 2005)*.

² Analysis of data from the National Data Archives on Children Abused and Neglected. *Revised data for federal FY 2000*. As cited in: *Demographics of Children in Foster Care*. (2003). Briefing paper by the Pew Commission on Children in Foster Care.

Young people in out-of-home care face considerable challenges in making the transition from state care to adulthood as they struggle with the lack of ongoing familial support, both emotionally and financially, while assuming increasing levels of independence and responsibility. While states are focusing more attention on ensuring these youth have the supports they need once they leave the care of the child welfare system—permanent connections, educational opportunities, employment options, and adequate housing—this report focuses on the options states have taken and are looking to take to provide ongoing access to health and mental health services.

Health Care Needs of Foster Youth Transitioning Out of Care

Researchers have been studying and reporting on the high prevalence of health and mental health problems plaguing children in foster care for several decades. Many children entering foster care exhibit chronic health, developmental, and psychiatric disorders.³ The poor health status of many of these children is rooted in exposure to negative environments, including adverse prenatal conditions, the effects of which can linger well into adulthood. Based on these histories which put these youth at high risk for problems and the added trauma from being separated from their families, the health and mental health care needs of youth in foster care can be different than youth not in care.

In a recent study focusing on Illinois foster youth who aged out of care, one-third of the youth were identified by caseworkers as having one or more spe-

³ Simms, M., Dubowitz, H., Szilagyi, M.A. Health Care Needs of Children in the Foster Care System. *Pediatrics*. 2000;106:909-918.

cial mental health, medical, pregnancy and parenting, substance abuse, or developmental need that significantly interfered with their ability to live independently. Fourteen percent of the youth were reportedly suffering from a mental health disorder, 9 percent were dealing with substance abuse issues, and 13 percent had either a developmental disability or were dealing with special medical needs.⁴

Youth aging out of foster care need additional

behavioral health care. In one study, children in foster care were twice as likely as non-foster care children to use behavioral health services.⁵ Based on a recent review of various research studies,⁶ findings on the mental health status of youth in foster care have been reported as outlined in Table 1.

It is abundantly clear that adequate health, mental health, and other support services are necessary to facilitate a successful transition to adulthood.

TABLE 1 Study Findings on Mental Health Status of Youth in Foster Care

| STUDY | FINDINGS |
|--|--|
| Adoption and Foster Care Reporting and Analysis System (AFCARS), 2003 | 80% of youth in foster care have received services for mental health issues during placement. |
| Pecora, P.J., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., and Holmes, K.E. (2003). <i>Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study</i> . Seattle, WA: Casey Family Programs. | 54% have a mental health diagnosis after leaving care (n=659). |
| Courtney, M.E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., and Bost, N. (2005). <i>Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at age 19</i> . Chicago, IL: Chapin Hall Center for Children, University of Chicago. | 12% and 10% had a lifetime diagnosis of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder, respectively (n=321). |
| Needell, B., Cuccaro-Alamin, S., Brookhart, A., Jackman, W., and Shlonsky, A. (2002). <i>Youth Emancipating from Foster Care in California: Findings Using Linked Administrative Data</i> . Berkeley, CA: Center for Social Services Research. | 62% had received mental health services prior to emancipation (n=10,228). |

⁴ Leathers, Sonya J. and Testa, Mark F., "Foster Youth Emancipating from Care: Caseworkers' Reports on Needs and Services", *Child Welfare*, May/June 2006, 85, 3, p. 478.

⁵ Becker, Marion, Jordan, Neil, and Larsen, Rebecca, "Behavioral Health Services Use and Costs Among Children in Foster Care", *Child Welfare*, May/June 2006, 85, 3, p. 638.

⁶ Lenz-Rashid, S. (2006). *Emancipating from Foster Care in the Bay Area: What Types of Programs and Services are Available for Youth Aging Out of the Foster Care System*. San Francisco, CA: Bay Area Social Services Consortium.

Methods Used to Cover Former Foster Care Youth Utilizing the Medicaid Program

States provide health care for children and youth who are in foster care through Medicaid. Foster children who are eligible for federal funds are categorically eligible for Medicaid and states have taken on the responsibility of providing Medicaid coverage for the remaining children in out-of-home care who do not qualify for federal funding. Recognizing the unique challenges faced by youth who are exiting foster care, both the federal government and state governments have enacted programs designed to provide a bridge between their Medicaid coverage as children and their coverage as young adults. States have used various ways to extend Medicaid coverage for this population. Some states use an option, referenced in this report as the Chafee option, that was enacted through the Foster Care Independence Act of 1999 and includes a provision to allow states to extend Medicaid eligibility to youth ages 18 to 21 who have aged out of foster care. Alternatively, states may also extend Medicaid coverage for youth who have aged out of care by other means using state general funds or other Medicaid options to provide coverage.

The Chafee option to extend Medicaid coverage is the most widely recognized Medicaid option to cover these youth, but an equal number of states have also used their existing state plans to extend coverage. Several states have utilized their 1115 waiver under the Medicaid program to extend care. Some states also offer former foster youth the opportunity to qualify for the additional benefits if they remain in care or in an educational setting. Additionally, several states indicated that they have proposed or will soon be proposing expansions of their Medicaid programs for youth aging out of foster care.

This report provides details about the coverage options that states currently utilize to provide health care to youth who have aged out of foster care. The report also outlines the possibility of developing customized benefit packages targeted towards meeting the health care needs of former foster youth based on a provision in the DRA.

Chafee Option to Extend Medicaid Coverage

On December 14, 1999, the Foster Care Independence Act was signed into law. The legislation included an option for states to extend Medicaid coverage to foster youth up to age 21. The law was enacted as part of a larger foster care reform package designed to ensure the safety and protection of one of our most vulnerable populations. The eligibility category for this population can be found under section 1905(w)(1) of the Social Security Act as described in Table 2.

As highlighted in Figure 1, 44 percent of the states have taken the Chafee option to extend Medicaid or have plans to do so. Seventeen states reported in our survey that they have acted to extend Medicaid coverage to youth aging out of foster care using this option, and five states reported that they have plans to extend this option during the next legislative session. Figure 2 outlines how the remaining states provide coverage.

Cost of Coverage under the Chafee Option

APHSA's survey also included questions asking states to provide cost data on covering youth who aged out of foster care through the Chafee option. To provide comparable cost information, states were asked to provide data based on Per Member Per Month (PMPM) costs (Table 3) as well as quarterly or annual costs and the number of youth for whom those costs were expended during that period of time. Several states indicated their programs were just beginning and they did not yet have the cost data to report. The following is information from states that were able to provide some of the cost data for covering youth who had aged out of foster care under the Chafee option to extend Medicaid.

The cost data that were reported has variations based on the type of programs offered. The states who responded reported that the costs associated with providing this coverage varied from a low in California of approximately \$110 PMPM in a managed care setting to a high cost of \$350 PMPM in South Carolina. The cost data received indicates that extending Medicaid using the Chafee option is affordable given that the PMPM costs for this eligibility group have been \$350 or less in all five states that responded.

TABLE 2 Changes to Title XIX in the Foster Care Independence Act of 1999, (Public Law No. 106-169)

§1902. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(ii) at the option of the State, any group or groups of individuals described in section 1905(a) of this title (or, in the case of individuals described in section 1905(a)(i) of this title, any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1) of this title), or who are with- in any reasonable categories of such adolescents specified by the State.

§1905. Definitions

(w) Independent foster care adolescent

(1) For purposes of this subchapter, the term “independent foster care adolescent” means an individual—

- (A) who is under 21 years of age;
- (B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and
- (C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by the State under paragraph (1)(c) may not be less than the corresponding levels applied by the State under section 1931(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter before the date the individuals attained 18 years of age.

CALIFORNIA

California provides service for youth aging out of foster care in both managed care settings and fee-for-service settings. In 2005, three-quarters of the youth eligible for the program were in fee-for-service programs and a quarter of their total population were receiving services through a managed care program. The managed care PMPM cost for 2005, the most recent data available, was \$102.64, and the additional dental option per month was \$8.52 under the managed care setting for a total of \$111.16. In the fee-for-service environment, the costs are higher, averaging \$138 PMPM. However, when California adds the additional costs of providing services as required

under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, the average PMPM costs increase to \$231 per month. California’s program averages just under 5,000 youth aging out of foster care per month.

FLORIDA

Medicaid services for children that age out of foster care were first funded beginning in state FY 2006. The following information is based on enrollment and expenditures for the four-month period of July through October 2006. Total expenditures were \$1,060,694, which included a total of 5,346 youth and PMPM costs of \$198.41.

IOWA

In the fourth quarter of federal FY year 2006, Iowa’s average PMPM cost was \$306.57. The total cost of coverage for 80 youth during that quarter was \$45,300.

SOUTH CAROLINA

South Carolina reports that the total cost of extending coverage to youth aging out of foster care is \$2,969,339 per year. The state reports having just under 950 individuals eligible for the program and just over 700 being served. The average PMPM cost for its program is \$350.

TEXAS

In state FY 2005, approximately 1,315 youth who had aged out of foster care received acute medical care services, which accounted for an annual cost of approximately \$2.5 million. The average acute medical PMPM cost was \$227.85, which includes all individuals who received acute medical services in state FY 2005, not just youth who had aged out of foster care.

Medicaid State Plan Amendments and State Statutes

Excerpts from the state statutes or Medicaid state plan amendments that were used by several of these states to enact the Chafee option are included in Appendix A. Please note that for any state that has applied an income or resource test under the Chafee option, the standards or methodologies used cannot be more restrictive than those used for the state’s low-income families with children eligible under Section 1931 of the Social Security Act.

Other Ways States Provide Medicaid for Youth Who Have Aged Out

In addition to the Chafee option, survey results indicated that states use several other programs to provide health care coverage for youth as they age out of foster care. All 50 states and the District of Columbia provided information on how they currently provide Medicaid coverage or plan to provide coverage to this population. While 22 states reported providing cov-

erage to former foster youth under the Chafee option or plans to do so, the remaining 28 states and the District of Columbia reported using other methods to extend coverage. Figure 2 indicates coverage options, other than the Chafee option, that states use for youth who have aged out of foster care and is based on the detailed descriptions in Table 5.

Coverage through Current State Plan Categories

Some of the states reported that they are placing the youth in Medicaid eligibility categories currently allowable under their state plan amendment. These states reported that the youth do not necessarily qualify for Medicaid solely on the basis of their status as youth who have aged out of foster care, but rather on other factors as well. Most states reported that the youth would need to remain below a certain income threshold to qualify for Medicaid under their state plan. Some states reported that the youth aging out of foster care could remain eligible for foster care under the state plan option if they were full-time students and under age 21. In addition to the states that currently offer Medicaid coverage through their state plan, expanding coverage to youth who have aged out of foster care was noted for the upcoming legislative sessions in several survey responses.

Under the state plan, another option that states reported is the use of the medically needy program. This program allows states to extend Medicaid eligibility to qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to “spend down” to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that state’s Medicaid plan. States may also allow youth to establish eligibility as medically needy by paying monthly premiums to the state in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

TABLE 4

Iowa's Experience with Extending Medicaid Coverage for Foster Youth Aging Out of Care: The Medicaid for Independent Young Adults (MIYA) Program

How was Iowa able to get the extension?

The director of the Iowa Department of Human Services (DHS) made it clear from the beginning of his tenure in 2002 that older youth leaving foster care were a priority. DHS submitted proposed legislation to this effect for several years. The state was finally successful in 2006 with passage of not only extended Medicaid for youth leaving state-paid foster care at age 18 (up to their 21st birthday), but also received additional state funds to provide a monthly stipend to youth leaving state-paid foster care, up to the age of 21, who are working or attending an education/training program on a full-time basis. The monthly stipend component, known as PAL (Preparation for Adult Living), will be rolled into Iowa's current Chafee-funded aftercare program (which supports youth via a case management component, where each youth has a self-sufficiency plan with goals specific to that youth to achieve self-sufficiency—primarily around housing, educational and employment goals—in addition, youth are able to access a vendor payment component relating to goals within their plans—the maximum allocated to each youth is \$1200 per 12 month period). Iowa's aftercare program is contracted out to a network of providers, ensuring youth are served on a statewide basis.

Who in the state actively supported this extension?

Key legislators on the Health and Human Services committee, the Iowa Foster and Adoption Parents Association, the Iowa Coalition for Providers, current/former foster youth, and the media. It was critical to include youth input throughout the process, including youth helping to design the program and promote the program to legislators and community stakeholders.

What does the state do to let foster youth know that this option is available?

Extensive education of DHS personnel overall as well as judges, providers, foster and adoptive parents, and the media.

How many youth in Iowa access this option every year?

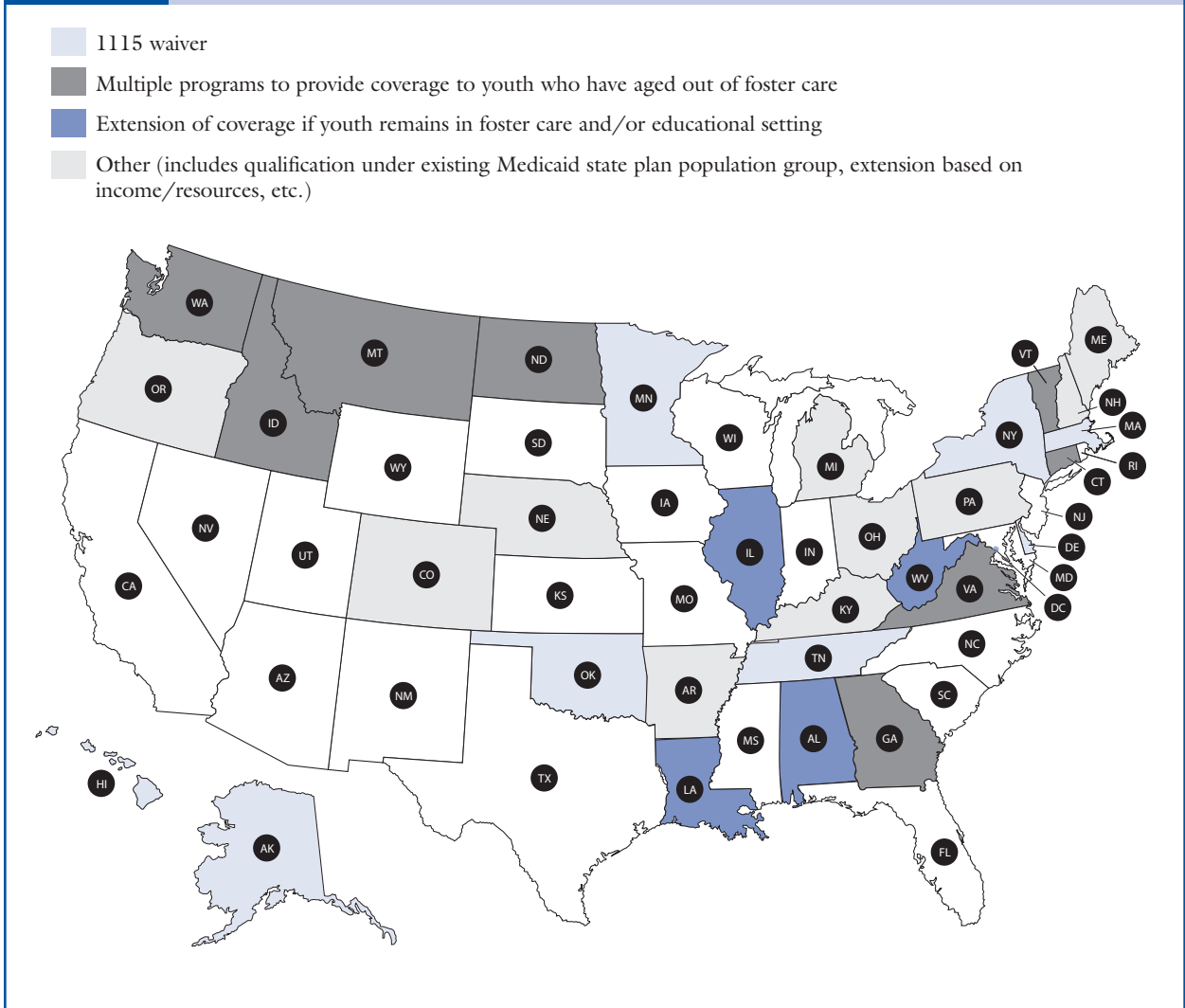
Since the inception of the aftercare program in April 2002, there have been over 600 youth who have participated; approximately 150 youth per year have accessed the aftercare program. The PAL/extended Medicaid program was just implemented in July 2006. It is expected that the vast majority of eligible youth will access the Medicaid option. Youth do not have to be enrolled in the aftercare program to access the continued Medicaid coverage. The PAL component (monthly stipend) has been rolled into the overall current aftercare program. Given the state funding appropriated specifically for PAL, it is expected that at any given time, a maximum of 100 youth can be served.

Coverage through 1115 Waiver Demonstration Projects

The 1115 waiver demonstration program affords states the opportunity to provide care to a unique population category under a waiver. Eight states reported using the 1115 waiver as a method to expand Medicaid coverage to youth aging out of fos-

ter care. The 1115 allows states to waive standard Medicaid requirements such as freedom of choice of provider, comparability of services, and statewide access. This waiver program is designed to allow states to test new ideas and initiatives that normally would not be possible under the Medicaid statute. The waiver also allows states to expand eligibility to

FIGURE 2 Map of Medicaid Coverage Other than the Chafee Option



populations that usually are not covered under Medicaid and provide services that are typically not provided by Medicaid programs.

- A waiver of choice of provider allows states to set restrictions on the type or number of providers to which a beneficiary has access.
- A waiver of statewideness allows states to provide services to a specific geographic area or region.

- A waiver of comparability allows states to provide differing levels of services in amount, duration, and/or scope.

The coverage options of all 50 states and the District of Columbia, which include the Chafee option, other state plan categories, and 1115 waivers, are described in Table 5. It is interesting to note that most states report utilizing multiple methods to cover youth aging out of foster care to ensure coverage.

TABLE 5

Descriptions of How States Provide Medicaid Coverage to Former Foster Youth

| STATE | COVERAGE DESCRIPTION |
|---|--|
| Alabama | <ul style="list-style-type: none"> ■ A state plan category exists for foster youth who remain in state custody to retain Medicaid eligibility. ■ Youth are allowed to remain in custody until age 21. |
| Alaska | <ul style="list-style-type: none"> ■ Denali KidCare: Using an 1115 Waiver, Alaska developed a program called Denali KidCare. The program is designed to ensure that children and teens of both working and non-working families can have the health insurance they need. There is no cost for eligible children, teens, and pregnant women. However, youth who are 18 years old may be required to share a limited amount of the cost for some services. This program is available to youth for a 12-month period, but the youth need to reapply every six months. The program is designed to assist beneficiaries whose income exceeds 150 percent of the federal poverty level (FPL), but does not exceed 175 percent of FPL. ■ Native Health Care Program: Another program that Alaska uses to provide Medicaid to youth who age out is the Native Health Care Program. The majority of Alaska's youth in foster care are Alaska Natives and have access to health care through this program. |
| Arizona <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ The Chafee option program for these youth is known as the Youth Adult Transitional Insurance (YATI) program. ■ All youth who meet the residency and citizenship requirements are pre-enrolled into a Medicaid health plan of their choosing the month they turn 18. ■ The state has a streamlined referral process that allows youth to choose their health care plan and provider for physical and dental health services. ■ All youth are required to undergo an annual review of their eligibility similar to other enrollees in the program. ■ This coverage group is available for these young adults until their 21st birthday. |
| Arkansas | <ul style="list-style-type: none"> ■ If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|--|
| <p>California <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth who age out of foster care in California are transitioned into the extended Medi-Cal program on their 18th birthday and will continue until age 21 without requiring the foster care youth or foster care parent to complete an application. ■ There are no income or resource requirements for this group. ■ Redetermination is limited to verification of any remaining factors that affect eligibility, for example, residency. Each foster youth is requested to provide information on change of residency, whenever appropriate. |
| <p>Colorado</p> | <ul style="list-style-type: none"> ■ Youth who age out of foster care may be eligible to continue to receive Medicaid coverage based on eligibility using their income and resources as requirements. ■ If an individual is ineligible for Medicaid, eligibility for Colorado’s Health Initiative Plan (CHIP) will be determined. CHIP is a public health insurance program for adults ages 19 and over who do not have health insurance—either on their own or through their employer—but have income or resources that are too high to qualify for Medicaid. |
| <p>Connecticut</p> | <ul style="list-style-type: none"> ■ These youth may qualify, just as any other individual, under the medical component of the State-Administered General Assistance (SAGA) program, which is a 100 percent state-funded program. Individuals who are 18 years of age or older and do not qualify for Connecticut’s HUSKY A or Medicaid programs may qualify for SAGA. The individual must be a U.S. citizen or have permanent resident status, have assets under \$1000, and have automobile equity below \$4,500. The individual’s income must be below the “medically needy” income limit. ■ Connecticut is also conducting a pilot program under which 100 youth who have aged out of foster care with both a significant behavioral and physical diagnosis continue to receive Medicaid benefits through SAGA without income or asset requirements. |
| <p>Delaware</p> | <ul style="list-style-type: none"> ■ Medicaid benefits are available to these youth through programs that are available to any individual who qualifies. Youth who have income at or below 100 percent of the FPL are covered through age 18. ■ Delaware also provides coverage through the state’s 1115 demonstration waiver to uninsured youth age 19 and up who have family income at or below 100 percent of FPL. The youth can call an 800 number to obtain an application, which they then need to mail in to begin the application process. |

TABLE 5

Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|---|
| District of Columbia | <ul style="list-style-type: none"> ■ A state plan category exists for foster youth who remain in state custody to retain Medicaid eligibility until the month of their 21st birthday. |
| Florida <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who exit foster care at age 18 are eligible for Medicaid services until age 20. ■ Youth who exit foster care and are receiving Road to Independence scholarship benefits are eligible for Medicaid up to age 21. ■ Youth are automatically enrolled in the program. |
| Georgia | <ul style="list-style-type: none"> ■ Georgia receives Chafee funds for the Independent Living Program and Educational and Training Vouchers for youth aging out of foster care. ■ Some youth in the Independent Living Program receive assistance with medical expenses, but it is limited to \$500 annually. ■ Some youth remain in foster care past age 18 and continue to receive Medicaid (42 CFR 435.222, 435.308). ■ It is also possible for some youth who are no longer in foster care to meet the criteria for another Medicaid category of assistance (e.g., pregnancy, SSI, etc.). |
| Hawaii | <ul style="list-style-type: none"> ■ The Hawaii QUEST 1115 Demonstration program includes coverage for single, able-bodied individuals over age 18. The state is using this program to qualify former foster care recipients for Medicaid. Hawaii QUEST is a Medicaid managed care program that provides medical and mental health services for eligible residents. Dental services are provided on a fee-for-service basis. ■ Former foster youth must meet an asset and income test to qualify for this program. |
| Idaho | <ul style="list-style-type: none"> ■ Foster youth are eligible to receive Medicaid until age 19 under Title XIX whether they exit or stay in continued care. After age 19, these youth, just like the general population, may still qualify for Medicaid if they fall under the TANF, SSI or disability criteria. They would apply through the Department of Health and Welfare's self-reliance unit. |
| Illinois | <ul style="list-style-type: none"> ■ Youth who remain in state custody continue to be eligible for Medicaid coverage until age 21. ■ If the youth's case does close at age 18, the youth maintains Medicaid eligibility until age 19 as a result of Illinois' policy of granting 12 months of continuous eligibility for children. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|--|---|
| Indiana <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who exited foster care at age 18 are eligible for Medicaid services through age 21. ■ The youth’s case manager must submit a form to Medicaid indicating the youth’s continuing eligibility for Medicaid due to aging out of foster care. ■ The youth must then sign an application to continue their connection to Medicaid. ■ Youth who aged out of foster care without maintaining their Medicaid eligibility may apply at the Department of Family Resources office in the county of their residence. |
| Iowa <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who exited foster care at age 18 and have countable income under 200 percent of FPL are eligible for Medicaid services through age 21. ■ An automatic redetermination is completed when the youth ages out of foster care. Annual reviews/redeterminations are required for ongoing eligibility. |
| Kansas <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who are age 18 or older when exiting foster care qualify under the program and are eligible for Medicaid services up through the month of their 21st birthday. ■ Youth are enrolled with the assistance of their social worker when exiting foster care. A special application form has been created for use with youth existing foster care. ■ Youth may apply at any SRS office in Kansas and are not obligated to receive any other services to be eligible for the medical card program. ■ The full Medicaid benefit package is available to the youth enrolled under this Medicaid group. |
| Kentucky | <ul style="list-style-type: none"> ■ Youth who age out of foster care at 18 have a reduced benefit medical card until their 19th birthday. ■ Kentucky is covering medical expenses for aged-out youth with Chafee room and board contracts up to their 21st birthday, Education Training Voucher funding up to their 23rd birthday, and the new state Foster Youth Transition Assistance funding that will soon be available to aged-out youth up to their 24th birthday. |



TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|--|---|
| Louisiana | <ul style="list-style-type: none"> ■ Medicaid can be extended to these youth through the Young Adult Program. This program allows those who turn 18 to continue to receive Medicaid if they sign a contract agreeing to enroll in a vocational or educational program. ■ As long as the youth are making satisfactory progress in the vocational or educational program, they will remain in the Young Adult Program until they reach age 21. |
| Maine | <ul style="list-style-type: none"> ■ Youth aging out of the foster care system can reapply for MaineCare as a “family of one.” ■ Youth are declared eligible for services based solely on income and the federal poverty guidelines. Since youth rarely have enough income to put them over the income limit, most qualify for Medicaid. |
| Maryland | <ul style="list-style-type: none"> ■ The state plans to pursue the Chafee option in the near future. |
| Massachusetts <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ The MassHealth program provides comprehensive health insurance or help in paying for private health insurance to over one million Massachusetts children, families, seniors, and people with disabilities. MassHealth includes Massachusetts’ Medicaid program, which is implemented in part through an 1115 demonstration project, as well as the State Children’s Health Insurance Program (SCHIP). ■ Massachusetts has enacted the Chafee option and is in the process of extending MassHealth coverage to independent foster care adolescents under that option. These are youth who were in the care or custody of the Department of Social Services on their 18th birthday. Independent foster care adolescents would be covered until their 21st birthday. The state does not intend to impose an income or asset test on this population. ■ Currently, many of these youth already may qualify for MassHealth. For example, MassHealth already covers children in families with income up to 300 percent of FPL up to their 19th birthday, either directly or through premium assistance. ■ Through the 1115 demonstration project, Massachusetts provides subsidized health plan coverage to many low-income families as well as to individuals without children. Individuals with special health care needs may also qualify for other MassHealth coverage types, some of which have no income limit but require cost sharing. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|--|--|
| Michigan | <ul style="list-style-type: none"> ■ If the former foster youth meets the eligibility criteria for an existing population group, they will qualify for the Medicaid program. |
| Minnesota | <ul style="list-style-type: none"> ■ Minnesota allows youth aging out of foster care to remain covered for Medicaid in three ways: <ul style="list-style-type: none"> ■ There are two options, based on the youth’s age, allowed through the Medicaid state plan. <ol style="list-style-type: none"> (1) youth, including those who aged out of foster care, can maintain their standard Medicaid coverage through age 18 if their net income is at or below 150 percent of FPL. (2) youth, including those who aged out of foster care, can maintain their standard Medicaid coverage if they are age 19 to 21 and have a net income at or below 100 percent of FPL. ■ Under a third option, youth can be covered using the state’s 1115 waiver program, MinnesotaCare. <ul style="list-style-type: none"> • Youth would be entitled to be covered up to age 21 if they have a net income up to 275 percent of FPL, but would be required to pay a premium on a sliding scale. • Youth apply for the program by filing an application in their county of residence or at the state MinnesotaCare office. • Youth in the MinnesotaCare program do pay sliding fee premiums based on family income, but those with income at or below 150 percent of FPL pay premiums of \$4 per month. Youth whose income exceeds the application income standard may be eligible by incurring medical expenses equal to the amount their income exceeds the income standard. • Minnesota provides broad health coverage for these youth enrolled in Medicaid or MinnesotaCare including physician office visits, inpatient and out-patient hospital care, dental care, prescription drugs, some over-the-counter drugs, dental care, vision care, mental health care, and EPSDT care. |
| Mississippi <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services to age 21 without regard to their income or resources. ■ Cases are referred to the state Medicaid agency by the Department of Human Services, which manages the foster care programs; therefore, youth do not need to apply for continuing coverage. ■ Eligibility for Medicaid is continued until the former foster care youth reaches age 21. ■ These youth are eligible for the full range of Medicaid services. |



TABLE 5

Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|----------|--|
| Missouri | <ul style="list-style-type: none"> ■ The state plans to pursue the Chafee option in the near future. |
| Montana | <ul style="list-style-type: none"> ■ These youth may be eligible for a few different programs until age 19 if they meet the criteria: <ul style="list-style-type: none"> • The Family Medicaid program: Montana’s 1931 program. It covers children and their parents or one specified caretaker relative. Eligibility depends on household size where income limits range from about 30 percent of FPL for large families up to about 36 percent of FPL for families of four or fewer. The resource limit is \$3,000. For this program, the youth are required to live with a specified caretaker relative. • The Child-Age 6 to 19 program: the income limit is 100 percent of FPL, and the resource limit is \$15,000. • The Child-Medically Needy program: the income limit is the same as Family Medicaid, but the child cannot be living with a parent or specified relative. The state uses this program for youth who do not qualify for other coverage and who are not living with a parent/specified caretaker relative. The resource limit for this program is \$3,000. • Eligibility for these programs depends on the youth’s living circumstances, income, and resources. Each of these programs covers an individual through the month of their 19th birthday, and coverage is for all Medicaid payable services that are medically necessary. To apply, the youth (or the youth’s guardian) would need to complete an application, bring/mail it to an Office of Public Assistance, and provide all information necessary to determine eligibility. |
| Nebraska | <ul style="list-style-type: none"> ■ These youth can access these services under the “former ward” program. ■ Medicaid coverage is provided up to age 21 for youth who were wards of the state through a court action or relinquishment, are successfully participating in school, and fall within the medically needy income and resource limits. ■ Youth apply for the program through their case manager, and the income maintenance worker completes the enrollment. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|--|
| <p>Nevada <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible and will be given the opportunity to apply through their state or county Family Service worker when they are exiting foster care. ■ Youth who choose not to apply at that time, but later decide they need assistance, can apply at any time prior to their 21st birthday. ■ These individuals are required to keep their address updated with the state agency. ■ There are no income or resource requirements for this group. ■ Young adults who age out of foster care in another state may also apply for benefits in Nevada. These individuals will need to provide proof they aged out of foster care at age 18 in addition to providing proof they meet the other eligibility requirements. |
| <p>New Hampshire</p> | <ul style="list-style-type: none"> ■ Many of these youth are eligible for the Aid to the Permanently and Totally Disabled Program (APTD). Through APTD, qualified youth can receive Medicaid coverage until age 19. ■ Older youth participating in Aftercare Services have access to a limited amount of Chafee funds for their medical needs. |
| <p>New Jersey <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to income or resources. ■ Enrolled youth are required to keep their address updated with the state agency. ■ Currently, foster youth can apply for this coverage via a toll-free phone number. The state is working to implement an automatic enrollment process. |
| <p>New Mexico</p> | <ul style="list-style-type: none"> ■ The state has submitted a state plan amendment to include the Chafee option, which is currently being reviewed by CMS. |



TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|----------------|---|
| New York | <ul style="list-style-type: none"> ■ The child welfare agency makes a referral when a youth ages out of foster care to have eligibility determined for the Medicaid program, the Family Health Plus program, and the Family Planning Benefit program. <ul style="list-style-type: none"> • Medicaid program: for youth who age out of foster care to continue to receive Medicaid coverage, eligibility must be redetermined based on income and resource requirements. • Family Health Plus: if an individual is ineligible for Medicaid, eligibility for Family Health Plus will be determined. Family Health Plus is a public health insurance program for adults between the ages of 19 and 64 who do not have health insurance—either on their own or through their employers—but have income or resources too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State and are United States citizens or fall under one of many immigration categories. Youth who age out of foster care who qualify under one of those categories may be eligible for Family Health Plus. • Family Planning Benefit: if the former foster care youth is not eligible for Family Health Plus, eligibility for the Family Planning Benefit Program will be determined. The Family Planning Benefit Program provides Medicaid eligibility to men and to women of child-bearing age who are not eligible for Medicaid and who meet income guidelines. Recipients qualify for comprehensive family planning services through the Family Planning Benefit Program, which is provided through an 1115 demonstration waiver. ■ There is a 12-month renewal for all three programs. Both the Medicaid Program and the Family Health Plus Program provide comprehensive coverage, including prevention, primary care, hospitalization, prescriptions, and other services. The Family Health Plus Program is available through managed care organizations. The Family Planning Benefit Program includes all FDA-approved birth control methods, devices, and supplies; comprehensive reproductive health history and physical/ gynecological examination; male and female sterilization; pregnancy testing and counseling; and preconception counseling. |
| North Carolina | <ul style="list-style-type: none"> ■ The state plans to bring the Chafee option before the next legislative session. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|--------------|--|
| North Dakota | <ul style="list-style-type: none"> ■ Youth who age out of foster care are enrolled into other existing Medicaid categories, and the coverage can continue up to age 21. ■ The youth do not need to complete a new application for Medicaid because the individual’s continued eligibility is established through the redetermination process. ■ Earned income for full-time and part-time students who have aged out of foster care, up to age 21, is considered as follows: <ul style="list-style-type: none"> • Full-time students’ earned income is disregarded. • Part-time students’ earned income is disregarded if the youth is working less than 100 hours per month. • Assets are disregarded unless the youth is eligible under a disability category. ■ Individuals who are age 18 and whose income is less than 100 percent of FPL are eligible for full Medicaid benefits. Individuals with higher income, and those ages 19 and 20, may be eligible under the Medically Needy Group, and are subject to a spend-down. Recipient liability (spend-down) begins when the individual’s net adjusted income exceeds \$530 per month (includes a \$30 work/training allowance). Individuals who are age 18 and have income between 100 and 140 percent of FPL may opt to have coverage under SCHIP. |
| Ohio | <ul style="list-style-type: none"> ■ Youth who emancipate from care may request independent living services from a Public Children Services agency. In addition to income eligibility requirements set by the Medicaid agency, youth accessing independent living services after emancipation may be eligible for Medicaid if they are in an appropriate independent living arrangement.* ■ Emancipated youth who do not access independent living services can qualify for Medicaid if they meet the general Medicaid eligibility requirements. <p><i>* An independent living arrangement is defined in the Ohio Administrative Rules as a domicile of the person’s own choosing that is used by the individual for his principal place of residence. The shelter may be fixed or mobile and located on land or water. Examples of an independent living arrangement include a house, apartment, mobile home, motor home or houseboats, rooming house, or room and boarding home.</i></p> |

TABLE 5

Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|---|
| Oklahoma <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Oklahoma extends Medicaid to youth aging out of foster care through an 1115 Waiver program called SoonerCare and the state plan based on the Chafee option. ■ Youth who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) on their 18th birthday and living in an out-of-home placement are eligible for Medicaid services until their 21st birthday. ■ SoonerCare eligibility is determined by OKDHS. ■ An application for SoonerCare can be made at, or mailed to, one of the OKDHS county offices. Reapplication is required every 12 months. ■ To qualify, the youth's monthly countable income must be equal to or less than 185 percent of FPL. |
| Oregon | <ul style="list-style-type: none"> ■ Foster youth have been designated as a special population under Oregon's State Plan and can continue their medical coverage if they apply and qualify for the Oregon Health Plan (OHP). ■ To qualify, application must be made during the same month that the youth's final substitute care placement is terminated. Youth who qualify must continue to reapply every six months. ■ There is no maximum age limit for participation in the program, but there is an income requirement. ■ Youth who have an income at or below 100 percent of FPL qualify for the program without a premium requirement. Youth whose income is above 10 percent of FPL must pay a small premium (ranging from \$9 to \$20 per month). ■ These youth receive the OHP standard benefit package. |
| Pennsylvania | <ul style="list-style-type: none"> ■ If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|---|
| <p>Rhode Island <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth can remain in foster care up to age 21, which allows them to retain Medicaid eligibility. ■ For those youth who age out of care and attend college, the state also offers coverage under the Chafee option. <ul style="list-style-type: none"> • If youth, under the Chafee option, exceed the age of 21, the Rhode Island Department of Children, Youth and Families (DCYF) covers their medical expenses until graduation or until they reach the age of 25, whichever comes first. The DCYF generally purchases coverage through the college or university and provides state-sponsored wrap-around medical coverage on a fee-for-service basis. ■ Rhode Island currently does not have a program to extend Medicaid coverage for youth who do not remain in care and do not attend college. |
| <p>South Carolina <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to their income or resources. ■ Cases are referred to the state Medicaid agency by the Department of Social Services, which manages the foster care program; therefore, youth do not need to apply for coverage. ■ Typically, these youth are already in an established foster care case, and their coverage is protected from ages 18 to 21. ■ These youth are eligible for the full range of Medicaid services. |
| <p>South Dakota <i>(Chafee Option Enacted)</i></p> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services through age 21. ■ When the youth ages out of the state system, the office of Medicaid eligibility automatically enrolls the youth into the special program covered under the state plan. |

TABLE 5

Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|---|
| Tennessee | <ul style="list-style-type: none"> ■ Former foster youth may be eligible for an open Medicaid category, such as the Poverty Level Income Standard category, if they are under 19 and have an income below the FPL. ■ Youth who are over age 19 and under age 21 may be able to qualify in the Medically Needy category. There is no set income level for Medically Needy individuals, but they must meet a spend-down threshold (i.e., they have enough unpaid medical bills that can be spent down to a state-established level). ■ These youth may also be eligible for the state’s 1115 waiver if they apply soon after their Medicaid coverage as a foster care child ends. To be eligible for the 1115 waiver, they must be under age 19, lack access to insurance, and have incomes under 200 percent of FPL. Youth who have a medical condition that renders them uninsurable can be eligible at any income level if they are under 19 and lack access to insurance. Eligibility in the 1115 waiver ends when the individual turns 19. ■ These young adults may also qualify under a newly approved demonstration population of non-pregnant adults aged 21 and older who meet criteria similar to those of the Medically Needy program. The state hopes to add this new demonstration group in the near future. To apply for any of these options, these youth can contact the Department of Human Services in the county in which they live. |
| Texas <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who were in foster care prior to turning age 18, and who are not otherwise eligible for medical assistance, are eligible for Medicaid services up to age 21 through the Chafee option. ■ Eligibility is based on an income level at or below 400 percent of FPL, resources at or below \$10,000, and an exemption for one vehicle. ■ Under this option, youth receive the full range of Medicaid benefits. ■ Youth are automatically enrolled when they turn age 18 and are required to undergo a recertification every 12 months, which can be completed via mail or phone. |
| Utah <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21. ■ When youth are no longer in state custody, they are considered for all Medicaid programs. If the “aging out” program is the only option, the child welfare agency verifies the youth was in foster care at age 18. ■ The youth must continue to be a resident of the state, must meet citizenship criteria, and must complete application and subsequent certification to qualify under the Chafee option. |

TABLE 5 Descriptions of How States Provide Medicaid Coverage to Former Foster Youth (Continued)

| STATE | COVERAGE DESCRIPTION |
|---|--|
| Vermont | <ul style="list-style-type: none"> ■ If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program. |
| Virginia | <ul style="list-style-type: none"> ■ Medicaid benefits are available to these youth through programs that are available to any individual who qualifies. ■ Individuals with income at or below 133 percent of FPL are covered up to age 19. ■ Eligibility in other Medicaid-covered groups will be evaluated through the redetermination process at the time the youth ages out of foster care; no new application is needed. |
| Washington | <ul style="list-style-type: none"> ■ Youth who age out of foster care can receive coverage through other existing Medicaid categories if they qualify. ■ Youth can apply at the local community services office and be assigned to a managed care plan or to the State Children’s Medicaid program and receive coverage up to age 19. |
| West Virginia | <ul style="list-style-type: none"> ■ West Virginia continues Medicaid coverage for foster children who remain in foster care and attend school up to the age of 21. ■ Former foster children who exit foster care upon their 18th birthday are eligible to receive assistance for payment of medical care through the Chafee Foster Care Independence program. ■ Foster children exiting foster care may also receive continuing Medicaid coverage for up to 12 months after exiting from care. |
| Wisconsin | <ul style="list-style-type: none"> ■ A request has been made to extend the Chafee option in the Department of Health and Family Services 2007-2009 Biennial Budget Request. |
| Wyoming <i>(Chafee Option Enacted)</i> | <ul style="list-style-type: none"> ■ Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to their income or resources. ■ Youth can apply through the eligibility worker in each area of the state. |

Despite the challenges outlined and ongoing efforts to address them, states continue to look for new ways to ensure access to health care for these vulnerable youth. The DRA contains a pro-

vision that will provide states the opportunity to develop customized benefits packages targeted toward meeting the health care needs of former foster youth.

New Medicaid Option

The Deficit Reduction Act of 2005

New Benchmark Benefit Packages under the DRA

On February 8, 2006, President Bush signed the DRA into law. Included in the DRA is new flexibility for states to redesign their benefit packages. Beginning on March 31, 2006, states may amend their state plan to provide alternative benefit packages to beneficiaries without regard to comparability, statewideness, freedom of choice, or certain other traditional Medicaid requirements. This new provision could be used by states to provide coverage to foster care youth aging out of the system.

The state must meet the following conditions to use this option:

- They must be able to demonstrate that prior to February 8, 2006, the state had an eligibility category covering these youth. The state may do this in one of two ways:
 1. If the state covered the population under the Chafee option prior to February 8, 2006, the state can design a targeted benchmark benefit package for that population.
 2. If the state did not cover the 1905(w)(1) group, it can still implement benchmark benefit coverage for this group (taking advantage of the “notwithstanding comparability” provision) for individuals in other eligibility groups who have aged out of foster care. Eligibility groups that former foster care recipients might be eligible for include SSI, the section 1931 group, or the groups for low-income pregnant women.

Individuals who would be eligible under the benchmark benefit package must “opt in” to the program. The state would need to inform the youth aging out of the system that they are eligible for a new Medicaid program, but the state would have to inform the individuals that enrollment is voluntary and that they may opt out at any time. Even foster youth ages 18 and 19 who are currently in their state’s regular Medicaid program could be switched to the new alternative benefit package if the state were to use the “opt in” approach. The state must also advise the youth of the differences in the traditional Medicaid program and the alternative benefit package.

If the state can satisfactorily show that it covered this population in some fashion, it can proceed to the second step in designing the benefit package.

Under the DRA benefits flexibility, a state may choose either to use benchmark equivalent coverage options or benchmark equivalent coverage. The benchmark coverage is described as any of the following:

- **Federal Employee Health Benefits (FEHB)-equivalent Health Insurance Coverage**—The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under Section 8903(l) of Title 5, United States Code (U.S.C.).
- **State Employee Coverage**—A health benefits coverage plan that is offered and generally available to state employees within the state involved. (The state must submit a copy of its employee benefits plan package.)
- **Coverage Offered through a Health Maintenance Organization (HMO)**—The health insurance plan that is offered by an HMO and that has the largest insured commercial, non-Medicaid enrollment of such plans within the state involved.
- **HHS secretary-approved Coverage**—Any other health benefits coverage that the secretary determines provides appropriate coverage for the population served.⁷

The benchmark-equivalent option allows the state to create another plan other than those listed above, but the plans must have the same actuarial value as one of the benchmark plans. The benchmark-equivalent plans must include coverage for the following categories of services:

- Inpatient and outpatient services
- Physicians’ surgical and medical services
- Laboratory and x-ray services
- Well-baby and well-child care, including age-appropriate immunizations
- Other appropriate preventive services as designated by the secretary

⁷ Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, State Medicaid Director Letter, SMDL #06-008, March 31, 2006 (see Appendix B).

If the state benchmark-equivalent package includes coverage for prescription drugs, mental health services, vision services, and hearing services, then the actuarial value of the coverage for each of these categories of services must be at least 75 percent of the value of the coverage in each of the categories.

Additional important provisions for this population include that the state must provide wrap-around services to cover EPSDT services for youth under age 19. Appendix B is the SMD letter 06-008 dated March 31, 2006, which outlines the parameters that states must utilize when redesigning their benefits. Appendix C is the alternative benefits preprint that states must utilize to explain who will receive coverage, the services that will be offered, and how those services will be implemented.

To date, four states have created benefit package redesigns using the new flexibility in the DRA: Idaho, Kentucky, West Virginia, and Kansas. None of the redesigns were specifically designed for foster youth aging out of care; however, some of the provisions could be utilized in these specific states. Perhaps more importantly, these states can provide a road map for the other states who are considering a redesign of their Medicaid system.

Idaho's recent revamping of its Medicaid program includes a basic benchmark plan for low-income children and working-age adults. Former foster youth could be eligible for this program. The program will provide EPSDT services for youth up to 21 years of age. The new plan places heavy emphasis on preventive services. Each recipient entering the program will receive a health risk assessment. The recipient will complete the assessment as well as the physician and together they will decide on the appropriate follow-up services for the recipient. The new plan includes an enhanced primary care case management model, which focuses on providing one point of contact for all services for the recipient. The benefit package also includes enhanced mental health coverage, additional vision care, and transportation as well as other community support services. There is a sliding scale premium to participate in the program for those families with incomes above 133 percent of the FPL. In addition, the newly created benefit package includes health savings accounts for each recipient. The HSA can be used to pay cost sharing payments and for preventive services.

Kansas' redesign was limited to one specific eligibility group—the working disabled. The Kansas program allows individuals with disabilities who are working to maintain their Medicaid coverage with

incomes up to 300 percent of the FPL. The program also allows assets of up to \$15,000 and allows for the working disabled to maintain retirement accounts. The new benefit package allowed Kansas to target the “Working Healthy” participants for an enhanced benefit package. The state hopes these enhancements will encourage additional individuals to seek employment. The plan offers beneficiaries Medicaid benefits, health care assessment when they join the program, personal assistance services, independent living counseling, and assistive services.

The Kentucky Medicaid redesign divides the state's Medicaid population into four new categories. Under Global Choices, there is an emphasis placed on disease management. Similar to Idaho's new plan, the Kentucky model also places a strong emphasis on integrating the care for the beneficiaries to improve the coordination among mental health, substance abuse, and physical health. There is also a sliding scale premium and cost sharing for the Kentucky Global Choices program; however, preventive services are exempted from cost sharing. Kentucky also offers a health savings account called “Get Healthy Benefits.” Under the Kentucky program, individuals will be allowed to use the account to have a limited allowance for dental care, purchase glasses, attend nutrition counseling, or purchase smoking cessation products. An additional method that can be used under the new Kentucky benefits package is the new program that allows the state to pay the premium for individuals who are low income but have access to health insurance through their employer. If a former foster youth does have access to health insurance through his or her employer, the state could pay the premium for the individual.

West Virginia's new “Mountain Health Choices” program streamlined 29 eligibility categories into four. The eligibility criteria did not change; rather, the groupings of those eligible were simplified. The benefit packages are tailored to the needs of each population group. There is a care coordination component similar to the plans in Kentucky and Idaho. The care manager will ensure that members receive the screenings and treatment for chronic conditions. West Virginia's program also requires the member to sign a member agreement. Once signed, the member will be entitled to an enhanced benefit package including the health rewards accounts. If the member chooses not to sign the member agreement, he or she is then enrolled in the regular West Virginia Medicaid program without the enhancements.



All four states were able to target their program to specific populations and offer an expanded or specialized level of care for that group. States interested in providing similar benefits to youth who have aged out of care could use these states as models. Due to the special nature of the care needed for former foster youth, some additional options for states to consider adding to a targeted benefits package could be:

- An enhanced behavioral health component;
- A health savings account;
- Additional substance abuse counseling services;
- A care coordination model;
- A medical home;
- Additional independent living counseling; and
- Assistive services.

Under the DRA, states could target those youth aging out of foster care only in a particular region of the state, or they could offer the program statewide. States interested in pursuing this option can submit a benchmark benefit pre-print to CMS (see Appendix C).

Challenges and Opportunities

This report demonstrates that the vast majority of states have programs currently in place that youth who are aging out of foster care may utilize to receive Medicaid benefits. The report also describes some of the limitations of those services for the youth, for example, that in order to qualify the youth must remain in an educational setting.

There are several challenges to providing these services to youth who are aging out of care. The first challenge is that states indicated that youth often find

the Medicaid forms to be daunting, do not want to enroll due to continued linkage with the child welfare system, or realize after they have aged out of care that they are in need of ongoing health care services. States have attempted to address some of these issues by streamlining and simplifying the Medicaid application process, sometimes making enrollment for these youth automatic for at least one year after aging out of care; and developing mechanisms to allow youth to enroll after they have aged out of care under less restrictive criteria. States have also created ways to reach out to youth as they are transitioning, and sometimes after they have transitioned, to inform them of the availability of the option.

An additional challenge is that, as with all programs with low numbers of eligible individuals, frequent training of eligibility workers is necessary to reacquaint them with the requirements and the benefits of the program. Many of the survey respondents reported that it was the individual eligibility worker who took the challenge to find a way to cover the individual aging out of foster care that made the system work. Those states moving towards an electronic eligibility system with a series of questions that lead to various eligibility categories will eventually lessen the need for the training. However, in the short run, frequent repeat training is necessary.

A significant challenge facing those wishing to implement these programs is the fear of implementing a program with high costs. However, as demonstrated in this report, using the traditional Chafee option to extend coverage to youth aging out of foster care does not necessarily lead to high PMPM costs.

This report demonstrates numerous opportunities to provide this vulnerable population with continued access to Medicaid services, including the potential opportunity to use the additional flexibilities afforded under the DRA to offer a different benefit package to youth.

APPENDIX A: Medicaid State Plan Amendments and State Statutes

| APPENDIX A | Medicaid State Plan Amendments and State Statutes |
|-------------------|---|
| Arizona | <p>ARIZONA REVISED STATUTE.</p> <p>§ 36-2901. Definitions</p> <p>In this article, unless the context otherwise requires:</p> <p>6. “Eligible person” means any person who is:</p> <p>(a) Any of the following:</p> <p style="padding-left: 40px;">(iii) Under twenty-one years of age and who was in the custody of the department of economic security pursuant to title 8, chapter 5 or 10 when the person became eighteen years of age.</p> |
| California | <p>Cal Wel & Inst Code §14005.28 (2006)</p> <p>§14005.28. Extension of Medi-Cal benefits to independent foster care adolescents</p> <p>(a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall exercise its option under Section 1902(a)(10)(A)(XV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(XV)) to extend Medi-Cal benefits to independent foster care adolescents, as defined in Section 1905(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396d(v)(1)).</p> <p>(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and if the state plan amendment described in subdivision (a) is approved by the federal Health Care Financing Administration, the department may implement subdivision (a) without taking any regulatory action and by means of all-county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.</p> <p>(c) The department shall implement subdivision (a) on October 1, 2000, but only if, and to the extent that, the department has obtained all necessary federal approvals.</p> |

APPENDIX A

Medicaid State Plan Amendments and State Statutes (Continued)

Florida

Florida Statute §409.903

- (4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption. This category includes a young adult who is eligible to receive services under s. 409.1451(5), until the young adult reaches 20 years of age, without regard to any income, resource, or categorical eligibility test that is otherwise required. This category also includes a person who as a child was eligible under Title IV-E of the Social Security Act for foster care or the state-provided foster care and who is a participant in the Road-to-Independence Program.

Mississippi

Miss. Code Ann. § 43-13-115

§ 43-13-115. Persons entitled to receive Medicaid

- (23) Children certified by the Mississippi Department of Human Services for whom the state and county departments of human services have custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.

Nevada

State Plan Amendment, July 2005, Section 2.2, Attachment A, Item 21, page 23c

- B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A) (ii)(XV) of the Act and 1905(w)(1) of the Act
- X 21. All “Independent foster care adolescents” (as defined in §1905(w)(1) of the Social Security Act)
- a) Reasonable classifications of individuals described in (21) above, as follows:
 - 1) Individuals under the age of
 ___ 19
 ___ 20
 - 2) Individuals to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.
 - 3) Other (please describe): _____

APPENDIX A

Medicaid State Plan Amendments and State Statutes (Continued)

Nevada
(Continued)

- b) Financial requirements
 - 1) Income test
 - There is no income test for this group.
 - The income test for this group is _____
 - 2) Resource test
 - There is no income test for this group.
 - The income test for this group is _____

New Jersey

TITLE 30. INSTITUTIONS AND AGENCIES
SUBTITLE 1A. DIVISION OF FAMILY DEVELOPMENT
CHAPTER 4D. MEDICAL ASSISTANCE PROGRAM

§ 30:4D-3. Definitions

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L. 1968, c. 413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in resource family care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds

Oklahoma

CHAPTER 70. OKLAHOMA CHILDREN'S CODE
ARTICLE IV. DEPARTMENT OF HUMAN SERVICES
PART 1. POWERS AND DUTIES

10 Okl. St. § 7004-1.6

§ 7004-1.6. Independent Living Act—Short title—Purpose

- A. This section and Section 3230 of Title 70 of the Oklahoma Statutes shall be known and may be cited as the "Independent Living Act".
- B. The purpose of the Independent Living Act shall be:
 - 1. To ensure that eligible individuals who have been or are in the foster care program of the Department of Human Services due to abuse or neglect receive the protection and support necessary to allow the individuals to become self reliant and productive citizens through the provision requisite services that include, but are not limited to, housing, medical coverage and education; and

APPENDIX A

Medicaid State Plan Amendments and State Statutes (Continued)

Oklahoma
(Continued)

2. To break the cycle of abuse and neglect that obligates the state to assume custody of children.
- C. Individuals eligible for services pursuant to the Independent Living Act include any individual up to twenty-one (21) years of age who has been in the custody of the Department of Human Services or a federally recognized Indian tribe due to abuse or neglect for any nine (9) of the twenty-four (24) months after the individual's sixteenth birthday and before the individual's eighteenth birthday.
- D. Individuals who are eligible for services pursuant to the Independent Living Act and who are between eighteen (18) and twenty-one (21) years of age shall be eligible, when funds become available, for Medicaid coverage, provided such individuals were also in the custody of the Department of Human Services or a federally recognized Indian tribe on the date they reached eighteen (18) years of age. The Legislature directs the Oklahoma Health Care Authority to submit a State Medicaid Plan Amendment to the federal Health Care Financing Administration to provide medical coverage for such individuals to become effective fiscal year 2003.

South Carolina

State Plan Amendment, July 2000, Section 2.2, Attachment A, Item 23, page 23d

- B. Optional Groups Other Than the Medically Needy
1902(a)(10)(A)(ii)(XV)
- X 23. Children who are in foster care under the responsibility of the Act the state on their 18th birthday may be eligible for Medicaid until their 21st birthday without regard to their income and resources.

South Dakota

State Plan Amendment, July 2003, Section 2.2, Attachment A, Item 21, page 23c

- B. Optional Groups Other Than the Medically Needy
1902(a)(10)(A) (ii)(XV) of the Act
- X 21. Children who are in foster care under the responsibility of the state on their 18th birthday pursuant to § 1902(a)(10)(A)(ii)(XV) of the Social Security Act.

APPENDIX A

Medicaid State Plan Amendments and State Statutes (Continued)

South Dakota
(Continued)

- a. The State will provide coverage for these children until the age of:
 - 19 years old
 - 20 years old
 - 21 years old
- b. The State will *not* apply an income test for these children.
- c. The State will *not* apply a resource test for these children.

Texas

**HUMAN RESOURCES CODE
TITLE 2. DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES
SUBTITLE C. ASSISTANCE PROGRAMS
CHAPTER 32. MEDICAL ASSISTANCE PROGRAM
SUBCHAPTER B. ADMINISTRATIVE PROVISIONS**

Tex. Hum. Res. Code § 32.0247

§ 32.0247. Medical Assistance for Certain Persons Making Transition From Foster Care to Independent Living

- A. In this section, “independent foster care adolescent” has the meaning assigned by 1905(w)(1), as amended.
- B. The department shall provide medical assistance, in accordance with department rules, to an independent foster care adolescent who:
 - 1. is not otherwise eligible for medical assistance; and
 - 2. is not covered by a health benefits plan offering adequate benefits, as determined by the Health and Human Services Commission.
- C. The department shall by rule establish a specific set of income, assets, or resources allowable for recipients under this section. The income level shall not be less than 200 percent or more than 400 percent of the federal poverty level. Allowable asset or resource levels shall not be less than:
 - 1. the levels allowed for individuals who are in foster care; and
 - 2. the levels allowed for a person under 19 years of age who is eligible for the medical assistance program.
- D. In setting allowable income, asset, or resource levels, the department shall exclude:
 - 1. any financial benefit used for the purpose of educational or vocational training, such as scholarships, student loans, or grants;
 - 2. any financial benefit used for the purpose of housing; and

APPENDIX A

Medicaid State Plan Amendments and State Statutes (Continued)

Texas
(Continued)

3. any grants or subsidies obtained as a result of the Foster Care Independence Act of 1999 (Pub. L. No. 106-169).
- E. The Department of Protective and Regulatory Services shall certify the income, assets, or resources of each individual on the date the individual exits substitute care. An individual qualifying for medical assistance as established by this section shall remain eligible for 12 calendar months after certification and after each recertification.
- F. The recertification process for individuals who are eligible for medical assistance under this section shall include the option of recertifying by mail or phone.

Utah

**State Plan Amendment, July 2006, Section 2.2,
Attachment A, Item 24, page 23c**

- B. Optional Coverage Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XVII)
- X 24. Individuals who are age 18 but not yet 21 if they turn 18 while in the foster care custody of the Division of Child and Family Services, or if they turn 18 while in the foster care custody of the Department of Human Services and the Division of Child and Family Services is the primary case manager. Medicaid also covers individuals who are age 18 but not yet 21 if they turn 18 while in the foster care custody of a federally recognized Indian tribe.

See Supplement 1 to Attachment 2.2-A for eligibility criteria.

Wyoming

**State Plan Amendment, July 2000, Section 2.2,
Attachment A, Item 24, page 23d**

- D. Optional Groups Other Than the Medically Needy
1902(a)(10)(A) (ii)(XV) of the Act
- X 24. Children who are in foster care under the responsibility of the state on their 18th birthday pursuant to § 1902(a)(10)(A)(ii)(XV) of the Social Security Act.
- X a. The State will provide coverage for these children until the age of:
- ___ 19 years old
- ___ 20 years old
- X 21 years old
- X b. The State will *not* apply an income test for these children.
- X c. The State will *not* apply a resource test for these children.

APPENDIX B: SMD letter 06-008 dated March 31, 2006

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

March 31, 2006

SMDL #06-008

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005, Public Law Number 109-171. Section 6044, State Flexibility in Benefit Packages, adds a new section 1937 to the Social Security Act (the Act). Under section 1937, States have the option to amend their State plan to provide alternative benefit packages to beneficiaries, without regard to comparability, statewideness, freedom of choice, or certain other traditional Medicaid requirements. These benchmark plans may be familiar to you because they are the same benchmark plans that are currently in place in the State Children's Health Insurance Program. This provision is effective March 31, 2006. A State plan amendment (SPA) preprint is enclosed with this letter to assist you in submitting an amendment.

Beneficiaries Subject to the Provision

Under section 1937 of the Act, the State may require that medical assistance to individuals, within one or more groups of individuals specified by the State, be provided through enrollment in benchmark coverage or benchmark-equivalent coverage. A State may only require that individuals obtain benefits by enrolling in such coverage if they are a "full benefit eligible" in an eligibility category established under the State plan on or before February 8, 2006, and are not within exempted categories under the statute. Full benefit eligible individuals are individuals who would otherwise be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan, but do not include individuals determined eligible by the State for medical assistance under section 1902(a)(10)(C) of the Act, or by reason of section 1902(f), or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care (medically needy and spend-down populations). Generally, these individuals are healthy adults and healthy children on Medicaid.

Individuals under age 19 who are covered under the State plan under section 1902(a)(10)(A) of the Act must receive wrap-around benefits to the benchmark, or benchmark-equivalent plan, consisting of early and periodic screening, diagnostic, and treatment (EPSDT) services defined in section 1905(r). Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit. The State plan must include a description of how wrap-around benefits or additional services will be provided to ensure that these beneficiaries receive full EPSDT services. In accordance with section 1905(r), EPSDT services must be medically necessary services.

The following are categories of individuals who may not be required to enroll in an alternate benefit plan:

1. The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).
2. The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).
3. The individual is entitled to benefits under any part of title XVIII.
4. The individual is terminally ill and is receiving benefits for hospice care under title XIX.
5. The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
6. The individual is medically frail or otherwise an individual with special medical needs (as designated by the Secretary). For purposes of this section, the Secretary designated individuals with special needs to include those groups defined by Federal regulations at 42 CFR 438.50(d)(1) and (3) of the managed care regulations (i.e., dual eligibles and certain children under 19 who are eligible for SSI; eligible under section 1902(e)(3) (TEFRA children); in foster care or other out of home placement; receiving foster care or adoption assistance; or, receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as defined by the State in terms of either program participation or special health care needs).
7. The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).
8. The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
9. The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after welfare reform effective date defined in section 1931(i)). This provision relates to those individuals who qualify for Medicaid solely on the basis of qualification under the State's TANF rules (i.e., the State links Medicaid eligibility to TANF eligibility).

10. The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa). This provision relates to those individuals who are eligible for Medicaid based on the breast or cervical cancer eligibility provisions.

11. The individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII).

12. The individual is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

There may be instances in which an exempted individual may benefit from enrolling in an alternative benefit package. States are permitted to offer them such a package but may not require them to enroll in one. For example, in some States the State employee benchmark coverage may be more generous than the State Medicaid plan. Secretary-approved coverage may offer the opportunity for disabled individuals to obtain integrated coverage for acute care and community-based long-term care. (See discussion of alternative benefit options below.)

In any case in which a State offers an individual the option to enroll in an alternative benefit package, the State must inform the individuals that such enrollment is voluntary and that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan. The State must inform the individual of the benefits available under the alternative benefit package and provide a comparison of how they differ from the benefits available under the regular Medicaid program. The State must document in the individual's eligibility file that the individual was informed in accordance with this paragraph and voluntarily chose to enroll in the alternative benefit package.

Benchmark Benefit Coverage

Benchmark coverage is described as any one of the following:

Federal Employees Health Benefit Plan (FEHBP – Equivalent Health Insurance Coverage). The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in and offered to Federal employees under 5 U.S.C. 8903(1).

State Employee Coverage. A health benefits plan that is offered and generally available to State employees in the State involved.

Health Maintenance Organization (HMO) plan. A health insurance plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

Secretary Approved Coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage. States wishing to opt for Secretarial approved coverage should submit a full description of the proposed coverage and include a benefit by benefit comparison of the proposed plan to one or more of the three Benchmark plans specified above as well as a full description of the population that would be receiving the coverage.

A State may select one or more benchmark coverage plan options. The State may also specify the benchmark plan for any specific beneficiary. For example, one beneficiary may be enrolled in the FEHBP and another may be enrolled into State Employee Coverage at the option of the State.

Benchmark-Equivalent Benefit Coverage

If a State designs or selects a benchmark plan other than those specified above the State must comply with the following conditions:

1. The benchmark-equivalent benefit package has an aggregate actuarial value, as determined in an actuarial report discussed below, that is at least equivalent to the actuarial value of one of the Benchmark Benefit Packages described above.
2. Benchmark-equivalent coverage must include coverage for the following categories of services: 1) Inpatient and outpatient hospital services; 2) Physicians' surgical and medical services; 3) Laboratory and x-ray services; 4) Well-baby and well-child care, including age-appropriate immunizations; and 5) Other appropriate preventive services, as designated by the Secretary. At this time, the Secretary has not designated any other preventive services.
3. If the benchmark coverage package used by the State as a basis for comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes the following four categories of services: prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for such category of service in the benchmark plan used for comparison by the State. If the benchmark coverage package does not cover one of the four categories of services mentioned above, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.
4. If the State chooses to provide benchmark-equivalent coverage, the State must submit, as part of its SPA, an actuarial report. The actuarial report must contain an actuarial opinion that the health benefits coverage meets the actuarial requirements described in paragraphs 1-3 above. The actuarial report must be prepared by an individual who is a member of

the American Academy of Actuaries: a) using generally accepted actuarial principles and methodologies; b) using a standardized set of utilization and price factors; c) using a standardized population that is representative of the population involved; and d) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. The actuary preparing the opinion must select and specify the standardized set of factors and population to be used in (b) and (c) above. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State’s result.

Employer Sponsored Insurance Health Plans

Use of benchmark or benchmark-equivalent benefit coverage is at the discretion of the State and may be used in conjunction with employer sponsored health plans as a coverage option for individuals with access to private health insurance. For example, if an individual has access to employer sponsored coverage and that coverage is determined by the State to be benchmark equivalent, a State may, at its option, provide premium payments on behalf of the beneficiary to purchase the employer coverage. The premium payments would be considered medical assistance and the State could require the beneficiary to enroll in the group health plan.

Payment of Premiums

Payments of premiums for benchmark or benchmark-equivalent coverage shall be treated as payments for medical assistance.

Option to Provide Additional Wrap-Around Services

If the State opts to provide additional wrap around services to the benchmark or benchmark-equivalent plans, the State plan must describe the populations covered and the procedures for assuring those services.

Coverage of Rural Health Clinic and FQHC Services

If a State provides benchmark or benchmark-equivalent coverage to individuals, it must assure that the individual has access, through such coverage or otherwise, to rural health clinic services and FQHC services as defined in subparagraphs (B) and (C) of section 1905(a)(2). Payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act.

Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.



Page 6 – State Medicaid Director

Compliance with the Law

States will be required to continue to comply with all other provisions of the Act in the administration of the State plan under this title.

Submission Procedures

As previously mentioned, this provision is effective March 31, 2006. State plans submitted by June 30, 2006, may be approved retroactively to the first day of the quarter (i.e., April 1, 2006) and would be subject to the traditional State plan review process. Please submit your SPA electronically in a “pdf” file format to your regional office in order to implement these provisions.

The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children’s Health Program Group, who may be reached at (410) 786-5647. If you have any additional questions, please let us know.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosure

Page 7 – State Medicaid Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Senior Director, Access Policy
Association of State and Territorial Health Officials

Christie Raniszweski Herrera
Director, Health and Human Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments



APPENDIX C: Benchmark benefits preprint

SECTION 3.1-C.

**ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE**

1937(a) The State elects to provide alternative benefits under Section
1937(b) 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006 will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals protected from such a requirement.

List the population(s) subject to mandatory alternative coverage:

Children aged out of foster care; ages 18-24. _____

B. Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

Children aged out of foster care; ages 18-24. _____

Describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

Provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform the individual of this information.

___ Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Please provide a global chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

B. Description of the Benefits

___ The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. ___ Benchmark Benefits

- a. ___ **FEHBP-equivalent Health Insurance Coverage**—The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under Section 8903(1) of Title 5, United States Codes
- b. ___ **State Employee Coverage**—A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State’s employee benefits plan package.
- c. ___ **Coverage Offered Through a Health Maintenance Organization (HMO)**—The health insurance plan that is offered by an HMO (as defined in Section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO’s benefit package.
- d. X **Secretary-approved Coverage**—Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State’s plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

___ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: _____.

- a. The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: a) has been prepared by an individual who is a member of the American Academy of Actuaries; b) using generally accepted actuarial principles and methodologies; c) using a standardized set of utilization and price factors; d) using a standardized population that is representative of the population being served; applies the same principles and factors in comparing the value of different coverage (or categories of services); and takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage and the amounts of cost sharing applicable to such coverage. Attach a copy of the report.
- b. The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.
- c. The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.
1. **Inclusion of Basic Services**—This coverage includes benefits for items and services within the following categories of basic services:
(Check all that apply).
- Inpatient and outpatient hospital services;
 - Physicians' surgical and medical services;
 - Laboratory and x-ray services;
 - Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
 - Other appropriate preventive services, as designated by the Secretary.
 - Clinic services (including health center services) and other ambulatory health care services.
 - Federally qualified health care services
 - Rural health clinic services
 - Prescription drugs
 - Over-the-counter medications
 - Prenatal care and pre-pregnancy family services and supplies
 - Inpatient Mental Health Services not to exceed 30 days in a calendar year
 - Outpatient mental health services furnished in a state-operated facility and including community-based services

- Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
- Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
- Nursing care services including home visits for private duty nursing not to exceed 30 days per calendar year
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
- Outpatient substance abuse treatment services
- Case management services
- Care coordination services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
- Premiums for private health care insurance coverage
- Medical transportation
- Enabling services (such as transportation, translation, and outreach services)
- Any other health care services or items specified by the Secretary and not included under this section

2. Additional benefits for voluntary opt-in populations:

- Home and community-based health care services
- Nursing care services including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

- a. The State assures that wrap-around or additional benefits will be provided to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).
- b. The State has elected to also provide wrap-around or additional benefits to ensure that the following care and services.

Attach a list of all wrap-around or additional benefits as well as a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

Service Delivery System

Check all that apply.

1. The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
 2. The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above except that it will be operated with a primary care case management system consistent with section 1915(b)(1).
- The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.
- Alternative benefits provided through premium assistance for benchmark equivalent in employer-sponsored coverage.
- Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

Additional Assurances

- a. The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise to Rural Health Clinics (RHCs) services and Federally Qualified Health Centers (FQHCs) services as defined in subparagraphs (B) and (C) of Section 1905(a)(2).
 - b. The State assures that payment for RHC and FQHC services is made in accordance with the requirements of Section 1902(bb).
- E. Cost Effectiveness of Plans
- Benchmark or benchmark equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.
- F. Compliance with the Law
- The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.
- G. Implementation Date
- The State will implement this State Plan amendment on (date).

APPENDIX D: Contact information for state* and federal Medicaid agencies

Alabama

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624 (36104 FedEx)
Commercial: (334) 242-5600

Alaska

Division of Medical Assistance
Department of Health and Social Services
P.O. Box 110601
Juneau, AK 99811
Commercial: (907) 465-1617

Arizona

Arizona Health Care Cost
Containment System (AHCCCS)
801 East Jefferson
Phoenix, AZ 85034
Commercial: (602) 417-4711

Arkansas

Division of Medical Services
Department of Health and Human Services
P.O. Box 1437, Slot S401
700 Main Street
Little Rock, AR 72203
Commercial: (501) 682-8740

California

Medical Care Services
Department of Health Services
1501 Capitol Avenue, 6th Floor
MS 4000
Sacramento, CA 95814
Commercial: (916) 440-7800

Connecticut

Medical Care Administration
Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Commercial: (860) 424-5116

Colorado

Medical Assistance Office
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818
Commercial: (303) 866-5929

Delaware

Division of Medicaid and Medical Assistance
Department of Health and Social Services
P.O. Box 906, Lewis Building
New Castle, DE 19720
Commercial: (302) 255-9627

Washington, D.C.

Medical Assistance Administration
Department of Health
825 North Capitol Street NE
Suite 5135
Washington, D.C. 20002
Commercial: (202) 442-5988

Florida

Agency for Health Care Administration
2727 Mahan Drive
Fort Knox Building 3, Room 2417
Tallahassee, FL 32308
Commercial: (850) 413-9660

Georgia

Medical Assistance Plans
Department of Community Health
Two Peachtree Street, Suite 3733
Atlanta, GA 30303
Commercial: (404) 657-1502

Hawaii

Med-Quest Division
Department of Human Services
PO Box 700190
Fed. Ex (601 Kamokila Blvd. Room 518
Kapolei, HI 96707)
Kapolei, HI 96709-0190
Commercial: (808) 692-8050

**Idaho**

Department of Health and Welfare
Division of Medicaid
3232 Elder Street
Boise, ID 83705
Commercial: (208) 334-5747

Illinois

Medical Programs
Illinois Department of Public Aid
201 S. Grand Avenue, East, 3rd Floor
Springfield, IL 62763-0001
Commercial: (217) 782-2570

Indiana

Medicaid Policy and Planning
Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204-2739
Commercial: (317) 233-4690

Iowa

Iowa Medicaid Enterprise
Department of Human Services
100 Army Post Road
Des Moines, IA 50315
Commercial: (515) 725-1123

Kansas

Kansas Medical Assistance Programs
Kansas Division of Health Planning and Finance
900 SW Jackson Avenue, Suite 900
Topeka, KS 66612
Commercial: (785) 296-3981

Kentucky

Department for Medicaid Services
275 East Main Street, 6 West A
Frankfort, KY 40621
Commercial: (502) 564-4321

Louisiana

Bureau of Health Services Financing
Department of Health and Hospitals
1201 Capitol Access Road
P.O. Box 91030
Baton Rouge, LA 70821-9030
Commercial: (225) 342-3891

Maine

Office of MaineCare Services
Bureau of Medical Services
Department of Health & Human Services
#11 Statehouse Station
442 Civic Center Drive
Augusta, ME 04333-0011
Commercial: (207) 287-2093

Maryland

Health Care Financing
Department of Health and Mental Hygiene
201 West Preston Street
Room 525
Baltimore, MD 21201
Commercial: (410) 767-4073

Massachusetts

Office of Medicaid
1 Ashburton Place, 11th Floor
Room 1109
Boston, MA 02108
Commercial: (617) 573-1770

Michigan

Medical Services Administration
Michigan Department of Community Health
Capitol Commons Center, 7th Floor
400 S. Pine Street
Lansing, MI 48909
Commercial: (517) 241-7882

Minnesota

Department of Human Services
P.O. Box 64998
St. Paul, MN 55164-0998
Commercial: (651) 431-2914

Mississippi

Division of Medicaid
239 North Lamar Street
Suite 801
Robert E. Lee Building
Jackson, MS 39201-1325
Commercial: (601) 359-9562

Missouri

Division of Medical Services
 Department of Social Services
 615 Howerton Court (zip code 65109)
 P.O. Box 6500
 Jefferson City, MO 65102
 Commercial: (573) 751-6922

Montana

Department of Public Health & Human Services
 P.O. Box 4210
 111 N. Sanders
 Helena, MT 59604
 Commercial: (406) 444-4084

Nebraska

Health and Human Services Finance and Support
 Medicaid Division
 P.O. Box 95026
 301 Centennial Mall South, 5th Floor
 Lincoln, NE 68509-5026
 Commercial: (402) 471-9567

Nevada

Division of Health Care Financing and Policy
 1100 E. Williams
 Suite 101
 Carson City, NV 89710
 Commercial: (775) 684-3677

New Hampshire

Health Policy and Medicaid
 Office of Commissioner
 129 Pleasant Street
 Concord, NH 03301-6521
 Commercial: (603) 271-5254

New Jersey

Department of Human Services
 Division of Medical Assistant and Health Services
 7 Quakerbridge Plaza
 P.O. Box 712
 Trenton, NJ 08625-0712
 Commercial: (609) 588-2600

New Mexico

Medical Assistance Division
 Department of Human Services
 P.O. Box 2348
 Santa Fe, NM 87504-2348
 Commercial: (505) 827-3106

New York

Office of Medicaid Management
 New York State Department of Health
 Empire State Plaza
 Room 1466, Corning Tower Building
 Albany, NY 12237
 Commercial: (518) 474-3018

North Carolina

Health Policy and Medical Assistance
 Division of Medical Assistance
 Department of Health & Human Services
 1985 Umstead Drive, 2501 Mail Service Center
 Raleigh, NC 27699-2501
 Commercial: (919) 855-4100

North Dakota

Division of Medical Services
 ND Department of Human Services
 600 E. Boulevard Avenue, Dept. 325
 Bismarck, ND 58505-0250
 Commercial: (701) 328-1603

Ohio

Ohio Health Plans
 Department of Job & Family Services
 30 East Broad Street, 31st Floor
 Columbus, OH 43215-3414
 Commercial: (614) 466-4443

Oklahoma

Oklahoma Health Care Authority
 4545 N. Lincoln Boulevard, Suite 124
 Oklahoma City, OK 73105
 Commercial: (405) 522-7365
 Fax Number: (405) 530-3202

Oregon

DHS-Office of Medical Assistance Programs
 Office of Medical Assistance Programs
 500 Summer Street, NE E49
 Salem, OR 97301-1079
 Commercial: (503) 945-5772

Pennsylvania

Medical Assistance Programs
 Department of Public Welfare
 Health and Welfare Building, RM 515
 Commonwealth Avenue & Forster Street
 P.O. Box 2675
 Harrisburg, PA 17105
 Commercial: (717) 787-1870



Rhode Island

Division of Health Care Quality
 Department of Human Services
 600 New London Avenue
 Cranston, RI 02920
 Commercial: (401) 462-3575

South Carolina

Department of Health & Human Services
 P.O. Box 8206
 1801 Main Street
 Columbia, SC 29202-8206
 Commercial: (803) 898-2504

South Dakota

Medical Services
 Department of Social Services
 Kneip Building
 700 Governors Drive
 Pierre, SD 57501-2291
 Commercial: (605) 773-3495

Tennessee

Bureau of TennCare
 301 Great Circle Road
 Nashville, TN 37243
 Commercial: (615) 507-6443

Texas

Texas Health and Human Services Commission
 1100 West 49th Street
 Mail Code H100
 P.O. Box 85200
 Austin, TX 78708 (78751 FedEx)
 Commercial: (512) 491-1867

Utah

Division of Health Care Financing
 Department of Health
 P.O. Box 143101
 Salt Lake City, UT 84114-3101
 Commercial: (801) 538-6406

Vermont

Office of Health Access
 Department of Social Welfare
 Agency of Human Services
 312 Hurricane Lane, Suite 201
 Williston, VT 05495
 Commercial: (802) 879-5901

Virginia

Department of Medical Assistance Services
 600 East Broad Street
 Suite 1300
 Richmond, VA 23219
 Commercial: (804) 786-8099

Washington

Health and Recovery Services Administration
 P.O. Box 45507
 Olympia, WA 98504-5507
 Commercial: (360) 725-1867

West Virginia

Bureau for Medical Services
 Department of Health & Human Resources
 350 Capitol Street
 Room 251
 Charleston, WV 25301-3706
 Commercial: (304) 558-1700

Wisconsin

Division of Health Care Financing
 Department Of Health and Family Services
 1 West Wilson Street
 Room 350
 PO Box 309
 Madison, WI 53701-0309
 Commercial: (608) 266-8922

Wyoming

Office of Health Care Financing
 Wyoming Department of Health
 6101 Yellowstone Road, Suite 210
 Cheyenne, WY 82009
 Commercial: (307) 777-7531

* A listing of current Medicaid Directors for each state can be found at www.nasmd.org.

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services
 Central Office**
 7500 Security Boulevard
 Baltimore, MD 21244
 Phone: (877) 267-2323

Centers for Medicare and Medicaid Services

Regional Office
 Region 1
 JFK Federal Building, Room 2325
 Boston, MA 02203
 Phone: (617) 565-1188
 Fax: (617) 565-1339

Centers for Medicare and Medicaid Services

Regional Office
 Region 2
 26 Federal Plaza, 38th Floor
 New York, NY 10278
 Phone: (212) 616-2205
 Fax: (212) 264-6189

Centers for Medicare and Medicaid Services

Regional Office
 Region 3
 Public Ledger Building, Suite 216
 Philadelphia, PA 19106
 Phone: (215) 861-4140
 Fax: (215) 861-4140

Centers for Medicare and Medicaid Services

Regional Office
 Region 4
 Atlanta Federal Center
 61 Forsyth Street, S.W., Suite 4T20
 Atlanta, GA 30303-8909
 Phone: (404) 562-7500
 Fax: (404) 562-7162

Centers for Medicare and Medicaid Services

Regional Office
 Region 5
 233 North Michigan Avenue, Suite 600
 Chicago, IL 60601
 Phone: (312) 886-6432
 Fax: (312) 353-0252

Centers for Medicare and Medicaid Services

Regional Office
 Region 6
 1301 Young Street, Suite 714
 Dallas, TX 75202
 Phone: (214) 767-6423
 Fax: (214) 767-6400

Centers for Medicare and Medicaid Services

Regional Office
 Region 7
 Richard Bolling Federal Building, Room 235
 601 East 12th Street
 Kansas City, MO 64106
 Phone: (816) 426-5233
 Fax: (816) 426-3548

Centers for Medicare and Medicaid Services

Regional Office
 Region 8
 Colorado State Bank Building
 1600 Broadway, Suite 700
 Denver, CO 80202
 Phone: (303) 844-2111
 Fax: (303) 844-6374

Centers for Medicare and Medicaid Services

Regional Office
 Region 9
 75 Hawthorne Street, Suite 408
 San Francisco, CA 94105
 Phone: (415) 744-3501
 Fax: (415) 744-3517

Centers for Medicare and Medicaid Services

Regional Office
 Region 10
 2201 Sixth Avenue, MS-40
 Seattle, WA 98121
 Phone: (206) 615-2306
 Fax: (206) 615-2027

** For information about the State Plan Amendment option outlined in this report, contact the Children and Families Division of the CMS Central Office.