Direct Cash Transfers and Medicaid

Considerations for addressing benefit eligibility and access

By Liz Buck[1] and Stefanie Arbutina[2] | November 2022

For youth and young adults 18 to 24 years old experiencing homelessness, health insurance coverage—typically through Medicaid—is critical. During this important developmental period, youth and young adults experiencing homelessness often struggle to meet basic needs like food and shelter. As a result, they are at higher risk for further victimization, trauma, and high-risk behaviors (like increased substance use or survival sex) that can lead to poor health (Kull et al., 2022). The social inequities, adverse experiences, and financial strains that youth and young adults face prior to homelessness and during homelessness can lead to an increased risk of mental health, substance use disorders, and physical health issues, having wide-ranging negative consequences (Silva et al., 2016). Indigenous people, people of color (BIPOC), and lesbian, gay, bisexual, queer, transgender or gender nonconforming (LGBTQ+) youth have a higher risk of experiencing homelessness and have higher risk of involvement in the child welfare and the juvenile justice systems relative to their white, heterosexual, cisgender peers (Morton et al., 2017).

Direct cash transfers (DCTs) for youth and young adults experiencing homelessness offer promise for providing a pathway out of homelessness to stability and thriving. Direct cash transfers can positively impact a range of health and social outcomes for low-income individuals and households (Loeser et al., 2021). By design, direct cash transfers also provide a direct antidote and policy response to structural racism. Putting cash in the hands of youth who have been marginalized empowers them to make their own decisions, which aligns with principles of racial equity and justice (Point Source Youth, n.d.). To achieve systemic and sustainable solutions, though, jurisdictions must navigate designing cash transfer programs to ensure that access to other public benefits, including Medicaid, are not jeopardized by youths' increased income. This paper provides a summary of Medicaid eligibility for young people, describes the potential implications of direct cash transfers to Medicaid benefits, and outlines how state and local agencies can address risks to Medicaid benefits when implementing cash transfer programs.

[1] Liz Buck is a senior program officer at the Center for Health Care Strategies.

[2] Stefanie Arbutina is a senior program officer at the Center for Health Care Strategies.

It is important to understand the critical role Medicaid plays in providing health care coverage for young people experiencing homelessness and how housing instability and homelessness create significant challenges to accessing needed health care.

HIGHLIGHTS:

- Direct cash transfers (DCTs) for youth and young adults experiencing homelessness offer promise in providing a pathway out of homelessness to stability and thriving.
- DCTs hold little risk to Medicaid eligibility for young people enrolled in Medicaid—particularly for those who have their Medicaid eligibility determined under Modified Adjusted Gross Income (MAGI)—when designed as gifts.
- DCTs, however, can undermine Medicaid coverage, particularly for individuals who are exempt from MAGI-based income counting rules, including those who are blind or disabled.
- Jurisdictions considering implementing direct cash transfers should understand the implications for different eligibility categories under Medicaid and take precautions to ensure that individuals do not lose Medicaid coverage due to participation in a direct cash transfer program.
- This paper describes why jurisdictions are considering DCTs for young people experiencing homelessness, potential implications to Medicaid eligibility for participation in DCT programs, health access barriers for young people experiencing homelessness, and policy and practice changes to address risks to Medicaid eligibility and improve access to health care.

MEDICAID PRIMER

In order to identify the impact of DCTs on Medicaid eligibility, it is important to understand the critical role Medicaid plays in providing health care coverage for young people experiencing homelessness and how housing instability and homelessness create significant challenges to accessing needed health care. This section discusses both health insurance coverage issues related to Medicaid and broader issues related to health care access and equity.

Medicaid—a joint federal and state-funded health insurance program for low-income and disabled individuals—is the single largest source of health care coverage in the United States (Centers for Medicare and Medicaid Services, Eligibility, n.d.). Each state administers its own Medicaid program in conjunction with the federal Centers for Medicare & Medicaid Services (CMS). Since each state administers its own Medicaid program, eligibility, coverage, and services vary between states.

States are required to provide Medicaid coverage to certain groups, including low-income families, people with disabilities, and qualifying children and pregnant individuals (Centers for Medicare and Medicaid Services, List of Eligibility Groups, n.d.). In addition to these populations, children and youth receiving Title IV-E foster care, guardianship, or adoption assistance payments are automatically eligible for Medicaid (Centers for Medicare and Medicaid Services,

Implementation Guide, n.d.). Beyond the mandatory populations, state Medicaid programs have the option to cover other populations.

MEDICAID ELIGIBILITY: COVERED GROUPS AND METHODOLOGIES

Under the Medicaid program, youth who are at risk of homelessness or experience homelessness may fall into one or more eligibility categories. Some categories depend on income while others relate to an individual's clinical or functional status.

INCOME-BASED ELIGIBILITY

Most individuals are determined to be eligible for Medicaid based on Modified Adjusted Gross Income (MAGI). MAGI includes Adjusted Gross Income (Internal Revenue Service, Adjusted Gross Income, n.d.), plus any untaxed foreign income, nontaxable Social Security benefits, and tax-exempt interest (Centers for Medicare and Medicaid Services, Modified Adjusted Gross Income, n.d.). The MAGI calculation does not include Supplemental Security Income (SSI) or gift income but does include Social Security Disability Income (SSDI; Centers for Medicare and Medicaid Services, What to include as income?, n.d.). The MAGI calculation includes a 5% income disregard, and it does not include an asset test (Centers for Medicare and Medicaid Services, Eligibility, n.d.). Since gift income is excluded from the MAGI calculation, youth and young adults whose eligibility is determined through MAGI will not risk benefit loss if they participate in a direct cash transfer program. It is critical that jurisdictions understand how participants in direct cash transfer programs are eligible for Medicaid to determine potential risk to Medicaid benefits, since income-based eligibility and other eligibility based on clinical or functional status have different determinations.

For children (defined in Medicaid as being under 19 years of age) who do not reside with their parents (for example, unaccompanied homeless youth or young people living with grandparents), a child's MAGI-based income is counted in determining the child's eligibility regardless of whether the child's income meets the tax filing threshold (Centers for Medicare and Medicaid Services, 2020).

Federal regulations require that MAGI-based Medicaid eligibility be recertified annually.[3] There is no time limit for how long individuals can receive Medicaid benefits, provided they continue to meet eligibility criteria. States are required to recertify Medicaid eligibility for program participants on at least an annual basis.

ELIGIBILITY BASED ON DISABILITY

Over 10 million people qualify for Medicaid due to a disability. The disability pathway for Medicaid eligibility includes individuals who have disabling conditions, including those with physical conditions (such as traumatic brain injury), intellectual or developmental disabilities (for example, autism), and serious behavioral disorders or mental illness (for example, schizophrenia or bipolar disorder). People with disabilities may be eligible for Medicaid through this pathway, but they may also be eligible through other pathways, including income eligibility or being medically needy (Medicaid and CHIP Payment and Access Commission, People with Disabilities, n.d.).

In most states, people enrolled in Supplemental Security Income (SSI) are a mandatory population and therefore automatically enrolled in state Medicaid programs. Nearly all Medicaid programs use the same definition of disability that SSI uses (Medicaid and CHIP Payment and Access Commission, People with Disabilities, n.d.). For SSI determination, income

[3] Periodic renewal of Medicaid Eligibility, 42 C.F.R. §435.916.

includes both earned and unearned income, and parental or spousal income when the applicant resides in the same home. Income also includes "in-kind income," or food or shelter provided for free or less than the market value.

The authors found that individuals who have Medicaid due to their disability may be at risk of losing their benefits if they are participating in a DCT program, because unearned income (including gift income) is included in SSI determination. (See more information on SSI in a companion paper that examines potential impact for DCT programs written by the National Center for Children in Poverty.)

Additional information related to key legislative changes that impact Medicaid eligibility for subpopulations that are at risk of homelessness is included in Appendix A.

OTHER NON-MAGI ELIGIBILITY GROUPS

YOUTH IN OR FORMERLY IN FOSTER CARE

Youth who receive Title IV-E Foster Care, Guardianship, or Adoption Assistance funds are categorically eligible for Medicaid until age 21, regardless of household income. Youth or young adults in foster care are also eligible, even if they remain in the legal custody of their parents (Child Welfare Information Gateway and Children's Bureau, 2022).

Youth who have aged out of foster care are eligible for Medicaid until age 26, regardless of income. Currently, they must have been enrolled in Medicaid at the time they "aged out" of foster care and reside in the state in which they aged out. States have the option to provide Medicaid to youth who reached independence in other states, but not all have done so. Pursuant to the SUPPORT for Families and Communities Act of 2018, starting in 2023, states will be required to provide Medicaid coverage to youth formerly in foster care to age 26, regardless of the state in which they aged out (Purington, 2018).

We do not see a risk to Medicaid eligibility under a DCT since this is a categorical eligibility that is not calculated based on income.

OTHER GROUPS OF INTEREST

IMMIGRANTS AND REFUGEES

Legal permanent residents may be eligible for Medicaid after 5 years of residency, depending on their state of residence. Certain groups of immigrants, including refugees and asylees, are generally eligible when entering the country and are not included under a 5-year requirement. States may also choose to provide coverage to immigrant and refugee children and pregnant individuals during the 5-year waiting period (Medicaid and CHIP Payment and Access Commission, Non-citizens, n.d.). Undocumented immigrants are generally not permitted to enroll in federally funded Medicaid; however, they may be eligible for emergency medical assistance to address a specific medical need (Medicaid and CHIP Payment and Access Commission, Non-citizens, n.d.). Many states cover undocumented immigrants with state funds.

HEALTH CARE ACCESS AND UTILIZATION FOR YOUNG PEOPLE

The experience of homelessness and experiences that lead to homelessness can make it more difficult to focus on health care needs, secure transportation to office-based services, access mental health services, or trust health care providers.

Homelessness for young people is wide reaching but traditionally undercounted and hidden (Morton et al., 2017). The most comprehensive analysis of youth homelessness found that one in 10 American young adults ages 18–25 and at least one in 30 adolescents ages 13–17 experience some form of homelessness in a year (Morton et al., 2017).

Young people who are homeless or at risk of being homeless have a greater need for health care services. However, being homeless makes it harder to access health care. For example, the experience of homelessness and experiences that lead to homelessness (including familial rejection or being kicked out of the home) can make it more difficult to focus on health care needs, secure transportation to office-based services, access mental health services, or trust health care providers. Recertifying Medicaid eligibility, which may require documentation or identification, can also be challenging for youth experiencing homelessness. While there are examples of strong partnerships between health care providers, youth housing providers, and homeless service systems that bridge health access issues, there is a need to expand and scale these partnerships nationally to meet the overall need (National LGBTQIA+ Health Education Center, 2020).

Below are specific subpopulations that represent youth and young adults who are experiencing homelessness, along with Medicaid eligibility considerations.

LGBTQ, BLACK, AND HISPANIC YOUTH

LGBTQ, Black, and Hispanic youth are disproportionately represented in the homeless population. LGBTQ youth have a 120% higher risk of reporting homelessness compared to non-LGBTQ youth. Black youth have an 83% higher risk of experiencing homelessness compared to white youth. Hispanic youth have a 33% higher risk of reporting homelessness compared to white youth (Morton et al., 2017). Structural racism, including racism within the homeless service system, contributes to the higher rates of homelessness among Black and Hispanic youth. In an analysis of the homeless service systems in eight cities, Black young adults aged 18 to 24 were 69% more likely to reenter homelessness than their white counterparts (Olivet et al., 2021).

SINGLE YOUNG ADULTS EXPERIENCING HOMELESSNESS

In a single year, nearly one in 10 young adults ages 18–25 experience some form of homelessness (Morton et al., 2017). The Affordable Care Act expanded Medicaid eligibility for this population. For example, through MAGI calculations, if an individual is at least 19 years old, earns less than 133% of the federal poverty level (FPL) annually, and lives in a state that has expanded Medicaid to adults, then they are eligible for Medicaid (Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, n.d.). In 2022, $18,075 is 133% of the FPL for a single individual (American Council on Aging, 2022). If an individual in this age category has been found disabled, they would also qualify for Medicaid, regardless of the state's expansion. Those who live in states that have not expanded Medicaid and are not disabled may be ineligible unless they fall into another MAGI category.

UNACCOMPANIED MINORS EXPERIENCING HOMELESSNESS

In a single year, one in 30 adolescents between the ages of 13 and 17 experience some form of homelessness (Morton et al., 2017). Many unaccompanied minors in this category are eligible for Medicaid due to income thresholds. For example, youth under age 19 and those earning less than 133% of the FPL annually may be eligible (many states cover children under 19 at higher income levels under Medicaid or CHIP; Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, n.d.).

CURRENT OR FORMER FOSTER CARE YOUTH/YOUNG ADULTS

As a population, current or former foster youth have an increased risk of homelessness. Insights from surveys of youth across 22 counties found that nearly one-third of youth experiencing homelessness had prior experience in foster care (Morton et al., 2017). Despite this, there are low rates of Medicaid enrollment for former foster care youth. One common barrier to enrollment of former foster care youth is the lack of outreach services and the youths' subsequent lack of awareness of Medicaid eligibility (Bullinger & Meinhofer, 2021). The estimated rate of uninsurance for former foster care youth at age 19 is between 16 and 53% (CMS All State SOTA Call, 2017). For context, looking at 2019 data, the uninsurance rate of people ages 19–26 is 15.6% (Conway, 2020).

PREGNANT AND PARENTING YOUTH AND YOUNG ADULTS

Unmarried parenting youth have a 200% higher risk of experiencing homelessness compared to other youth (Morton et al., 2017). Pregnant women at or below 133% of the federal poverty level are a mandatory Medicaid eligibility group. States are required to extend eligibility for 60 days postpartum and now have the option to extend coverage postpartum for up to 12 months (Medicaid and CHIP Payment and Access Commission, Pregnant Women, n.d.).

DIRECT CASH TRANSFERS, MEDICAID, AND HEALTH CARE ACCESS FOR YOUNG PEOPLE

If eligibility is calculated under MAGI and if the direct cash transfer is administered as a gift, there is generally a low risk of Medicaid benefit loss for participants in direct cash transfer programs for youth and young adults. There is a higher risk of benefit loss for people who are eligible under Medicaid due to a disability, a non-MAGI calculation. This section outlines the impact of direct cash transfers on Medicaid benefits and health access, as well as considerations for reducing the risk to benefit loss and policy/practice recommendations to improve connections to health care for young people at risk of or experiencing homelessness.

ADMINISTERING DIRECT CASH TRANSFERS AS GIFTS

If administered as a gift, direct cash transfers should not be included in MAGI calculations for Medicaid eligibility. The Internal Revenue Service (IRS) defines a gift as "property (including money) or the use of or income from property (given) without expecting to receive something of at least equal value in return" (Internal Revenue Service, Gift Tax, n.d.). A MAGI determination is reflective of modified adjusted income under the IRS, so the IRS definition of a gift applies to MAGI as well. Gift limitations tend to apply to the giver (either an individual or organization) and not the recipient.

For beneficiaries with eligibility linked to SSI eligibility, gift income may be included in the non-MAGI calculation. However, in states with the same eligibility rules for SSI and Medicaid, Medicaid can continue when income exceeds the threshold to get SSI. In those circumstances, the individual needs to have been eligible for SSI for at least 1 month, still be disabled, and must "meet all other eligibility rules and have gross earned income insufficient to replace SSI, Medicaid and any publicly funded attendant care" (Social Security Administration, n.d.).

If these criteria are not met, or if the state has different rules, individuals should explore whether they can obtain coverage through a MAGI group. As Medicaid eligibility is based on monthly income or disability status, none of the items discussed below (apart from household status) appear to impact a young person's ability to access that benefit.

Overall, we found that people whose Medicaid eligibility is based on income and calculated under MAGI or who are in a categorical group including youth in or formerly in foster care have little risk of losing their benefits if receiving a DCT as a gift. We found that individuals who receive Medicaid through a disability would be most at risk for benefit loss under a DCT program.

Some jurisdictions are also considering using the IRS' general welfare exclusion as a mechanism for direct cash transfers.

DISBURSEMENT

The amount and frequency of disbursement of benefits (for example, lump sum, monthly regularized payments, or a combination) appear to be of low risk to Medicaid eligibility as calculated through MAGI. The risk is low because eligibility is based on monthly income and gift income is not included in the calculation.

However, if a young person is eligible for Medicaid under a disability status not calculated under MAGI, eligibility may be impacted by amount and frequency of disbursement, as monthly income and source (government or nonprofit) are both considered for eligibility purposes.

SOURCE OF FUNDING

The source of funding (whether public, private, or a combination of these sources) does not impact MAGI-based eligibility but may impact disability-based non-MAGI eligibility.

When considering the funding source and parameters of the program, jurisdictions should consider structuring the arrangement so that entities that provide the direct cash transfer do not expect anything of equal or greater value in return. This will ensure that the cash transfer maintains its status as a gift.

HOUSEHOLD STATUS

A difference in recipient household composition can affect eligibility for Medicaid, as eligibility income thresholds for both MAGI and non-MAGI populations vary based on the number of people in the household. Generally, as household size increases, the income threshold increases.

CONDITIONS

There may be a risk to Medicaid eligibility related to conditional direct cash transfers. For example, requirements (such as mandatory participation in services) may change the nature of the direct cash transfer as a gift, since a requirement creates a dynamic that a certain behavior/outcome is expected.

Requiring services for interventions related to housing is counter to Housing First principles. These principles provide an evidence-based approach that lessens barriers to housing access and does not place treatment or service requirements as a condition for housing (U.S. Department of Housing and Urban Development, n.d.). For jurisdictions that are developing these programs, unconditional cash transfers appear to pose little risk for a young person to lose Medicaid coverage when compared to a conditional transfer; however, the considerations discussed above must be addressed.

EVALUATION

If participation in research is not mandatory, there is low risk that a research/evaluative component to the program will impact Medicaid eligibility.

CONSIDERATIONS FOR ENSURING MEDICAID BENEFITS WITH DCTS

The three key approaches that may mitigate the risk of benefit loss are the use of income disregard waivers, pursuing a legislative approach, and establishing a Hold Harmless fund.

While the risk of losing Medicaid benefits is low for most categories of young adults who receive direct cash transfers, there are three key approaches that may mitigate the risk of benefit loss. For each of these approaches, it is important to consider the feasibility, effectiveness, and state and local policy environment in which it will be employed.

USE INCOME DISREGARD WAIVERS

An entity implementing DCTs could request that the income of program recipients be disregarded (not included) in benefit eligibility determinations. This would require completing such a request letter indicating the reason for the request, the specific population, benefits included, and the applicable time-period for which income should be disregarded.

In some cases, however, requesting that income be disregarded may prove ineffective for protecting Medicaid eligibility. As stated previously, the MAGI calculation used for income-based eligibility includes a 5% income disregard. As such, it does not permit other state or population-specific income disregards (Centers for Medicare and Medicaid Services, Eligibility, n.d.). For jurisdictions that have attempted to use income disregards to mitigate against benefit loss, they have been requested of cities or other smaller units of government. As Medicaid is a joint federal-state program, a request would not be granted without approval from the Centers for Medicare and Medicaid Services. It is critically important to work with relevant state agencies (including the state Medicaid agency) to explore potential feasibility and support of direct cash transfer programs as well as providing guidance and training materials for frontline workers interacting with people receiving direct cash transfers.

States can make changes to Medicaid program requirements and services using State Plan Amendments, which require CMS approval. Medicaid agencies may consider the use of a State Plan Amendment (Centers for Medicare and Medicaid Services, Medicaid State Plan Amendments, n.d.) in lieu of an income disregard to waive gift income for participants with non-MAGI eligibility based on disability.

PURSUE A LEGISLATIVE APPROACH

Another way to reduce the risk of Medicaid loss is to pursue state legislation exempting DCT beneficiaries from Medicaid income requirements. This change would require CMS approval for MAGI populations. The political environment in each state can also have significant impacts on the likelihood of a bill's passage and subsequent enactment, so passage of legislation will depend on the political priorities of state legislators.

ESTABLISH A HOLD HARMLESS FUND

An entity can opt to establish a Hold Harmless Fund, which is a fund that is set up to offset the cost of benefits lost due to a DCT. If a program participant loses Medicaid coverage because of the DCT, money from a Hold Harmless Fund could be used to purchase health insurance through the Health Insurance Marketplace operated by the Department of Health and Human Services or through a state marketplace. Depending on income and state of residence, individuals purchasing insurance through the Marketplace may be eligible for subsidies to reduce out-of-pocket costs. Hold Harmless Funds may also be used to cover the cost of individual health care services, such as dental exams and cleaning, without the use of insurance.

Potential uncertainties or barriers involving the use of Hold Harmless Funds to cover health insurance and health services largely involve the variability in cost. Insurance premiums differ based on state of residence and income level. Out-of-pocket medical expenses, like copays, visits, procedures not covered by insurance, and prescription medications, can vary widely and may be much higher than what a Hold Harmless Fund can cover. While other benefits could be more easily covered under a Hold Harmless Fund, the volatility and unpredictability of health care costs would not act as a replacement or solution for Medicaid coverage losses. Moreover, as we find that there is greater risk to benefit loss for those who are Medicaid-eligible due to disability, we also believe this pathway to be insufficient to cover the range of health care needs for individuals with disabilities.

ADDITIONAL POLICY AND PRACTICE RECOMMENDATIONS

In addition to preserving existing Medicaid benefits, entities implementing DCT programs with youth and young adults experiencing homelessness may also consider opportunities to increase and maintain Medicaid enrollment, while improving overall access and utilization of health care services. We offer the following recommendations to achieve this:

DEVELOP GIFT INCOME GUIDANCE AT THE FEDERAL AND STATE LEVEL

State and federal Medicaid agencies should consider issuing clear, specific guidance on gift income and its impact on eligibility. This could eliminate confusion for both beneficiaries and entities overseeing DCT programs while highlighting potential limitations related to amount, source, and disbursement method. For example, the New York Medicaid agency developed clarifying guidance related to exemptions for 9/11 funds in relationship to impact on Medicaid eligibility. Similar policy clarifications that cite relevant regulations and guidance documents can provide clear directives to Medicaid beneficiaries or those eligible for Medicaid, state Medicaid staff, and frontline workers. State Medicaid agencies can implement an "Operations Memo" that can be delivered to local county offices for frontline staff. This memo would clarify how workers should proceed with interpreting gifts.

IMPLEMENT YOUTH-SPECIFIC SUPPORTIVE SERVICES

Entities implementing DCTs should ensure that services are low barrier, trauma informed, and voluntary for participants. Peer workers and health navigators models offer promise in connecting this population to services related to the specific barriers and challenges faced by young people experiencing homelessness. Individuals who know the state's eligibility guidelines, as well as enrollment and recertification processes, could be particularly beneficial to young people struggling to navigate the

complexities of applying for and maintaining Medicaid coverage. These staff could also assist with locating and connecting to providers who can meet young people's individual health care needs.

In addition to enrollment and access, peer workers and health navigators can also promote health literacy with young adults. Increasing young adults' personal health literacy, "the ability to find, understand, and use health information and services," can provide them with an understanding of the value of regular health care as well as the tools they need to access services and advocate for themselves (Centers for Disease Control and Prevention, 2022).

EXPAND HEALTH CARE MODELS THAT ARE LOW BARRIER AND INFORMED BY YOUNG ADULTS

To improve young adults' utilization of health care services, entities implementing DCT programs should consider collaborating with health care providers and payers to ensure that services provided are low barrier, culturally competent, and affirming of youth identities. This may involve providing additional guidance, training, and incentives to ensure providers are able to meet the unique needs of all young people.

Entities overseeing DCT programs may consider interviewing potential and past program participants to understand their needs and desires for health care services to ensure the programs are informed by those being served. Engaging young people with lived experience in the design process can promote the development of a comprehensive array of effective, accessible health care and supportive services.

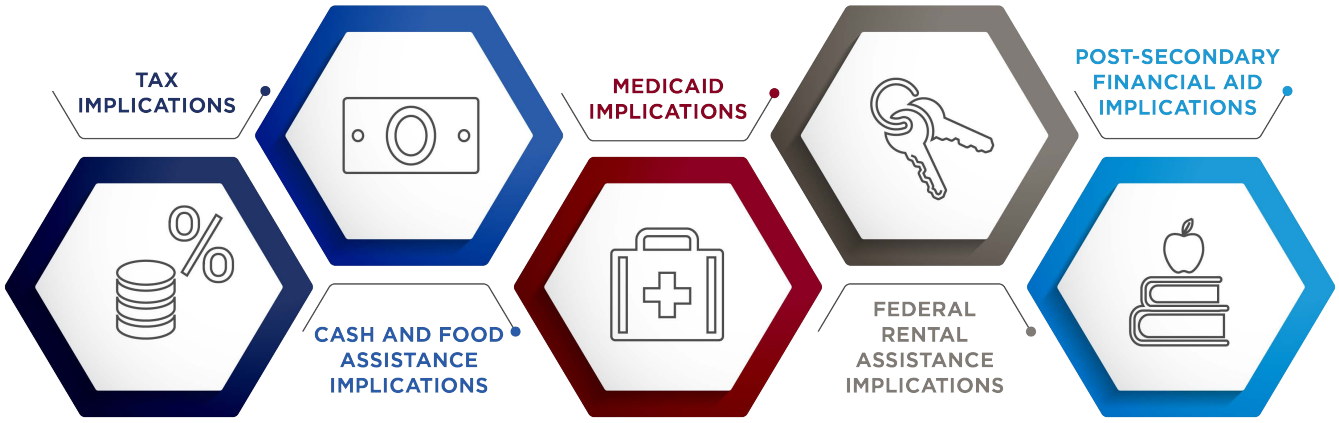
IMPROVE COORDINATION BETWEEN HEALTH CARE ORGANIZATIONS AND HOUSING PROVIDERS

Models of care that most effectively met the needs of young adults require strong collaboration between health care organizations and housing providers (National LGBTQIA+ Health Education Center, 2020). Best practices for these local partnerships include making these services closer and more connected to where young people are located, and include colocating health and housing services, minimizing transportation barriers through bus passes, conducting street outreach, and delivering services through mobile units (National LGBTQIA+ Health Education Center, 2020). Additional support, training, and technical assistance can further the expansion of these partnerships. On a federal level, CMS and the U.S. Department of Housing and Urban Development (HUD) can collaborate to provide additional support and guidance to state Medicaid agencies to encourage these partnerships. HUD can also encourage or require collaboration between Medicaid agencies and health care providers that serve youth in jurisdictions funded under the Youth Homelessness Demonstration Program (YHDP), a HUD-funded initiative that supports local communities in developing coordinated responses to youth homelessness.

CONCLUSION

Direct cash transfers are a promising intervention that have shown the ability to reduce days experiencing homelessness (Foundations for Social Change, 2021), improve savings (Foundations for Social Change, 2021), and improve mental health (West et al., 2021). If direct cash transfers are implemented as gifts, youth face little risk to eligibility for Medicaid benefits if their eligibility is calculated through MAGI. People who are eligible due to disability in a non-MAGI group do have some risk of losing benefits. It will be important for entities administering direct cash transfer programs to understand implications for Medicaid eligibility and mitigate risk of potential benefits loss specifically for people who have disabilities and are eligible under a non-MAGI calculation. Jurisdictions and entities implementing direct cash transfer programs should provide benefit information and advise youth who are eligible for DCTs to determine potential benefit loss and make determinations on whether to participate in the program. State Medicaid agencies can consider state plan benefits as one mechanism to ensure Medicaid eligibility for non-MAGI populations. As Medicaid is a federally funded and state-administered program, state Medicaid agencies and CMS will need to be key partners in the process and CMS will need to approve the state plan amendment. State agencies can play a critical role in providing guidance and directives to state and local organizations on appropriate interpretation of benefits.

The toolkit is comprised of multiple well-researched, vetted, and user-friendly resources that cross the spectrum of taxes and public benefits to provide clear policy analyses and recommendations for state and local jurisdictions to implement and evaluate DCT projects for youth and young adults that maximize their positive outcomes and minimize risks to participants.



APPENDIX A.

OVERVIEW OF RECENT LEGISLATIVE CHANGES THAT IMPACT MEDICAID ELIGIBILITY FOR SUBPOPULATIONS AT HIGH RISK OF HOMELESSNESS

The Patient Protection and Affordable Care Act of 2010 extended Medicaid eligibility to all adults with incomes below 133% of the federal poverty level (FPL) and limited redetermination to once per year. In addition, children can stay on their parents' insurance until age 26, and youth formerly in foster care can maintain Medicaid eligibility to age 26 regardless of income.

In 2012, the U.S. Supreme Court declared mandatory Medicaid expansion unconstitutional, leaving the choice to expand up to individual states. States now have the option to cover childless, nondisabled adults up to 133% of the FPL. As of March 2022, 38 states, Washington, D.C., and three territories—Guam, Puerto Rico, and the U.S. Virgin Islands—have expanded Medicaid (Kaiser Family Foundation, 2022).

The SUPPORT for Families and Communities Act of 2018 guarantees Medicaid coverage to youth formerly in foster care to age 26 regardless of the state they lived in when they aged out of foster care. The provision goes into effect in 2023 (Purington, 2018).

The Public Health Emergency (PHE) first declared on January 27, 2020 in response to the COVID-19 pandemic, and renewed several times during the pandemic, requires states to maintain Medicaid enrollment for individuals enrolled on or since March 18, 2020 for the duration of the Public Health Emergency (among other flexibilities granted to states). The PHE is currently set to expire in mid-July 2022. While states will soon be in a process to "unwind" the continuous coverage of people on Medicaid, many people are at risk of being removed from Medicaid rolls for reasons including income changes and having moved during the pandemic (Wilke et al., 2022).

The Families First Coronavirus Response Act (FFCRA) of 2020, which was updated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, provides states with a temporary FMAP increase and coverage for COVID-19 testing.

The American Rescue Plan Act of 2021, also enacted as a COVID-19 recovery measure, provides states with the option to extend postpartum Medicaid coverage, which is normally 60 days, to a full year. This option is available to states from 2022 to 2027 (Ranji et al., 2021).

REFERENCES

American Council on Aging. (2022). *2022 Federal Poverty Levels/Guidelines & How They Determine Medicaid Eligibility.* https://www.medicaidplanningassistance.org/federal-poverty-guidelines/

Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (n.d.). *Health coverage for homeless and at risk youth* [Fact sheet]. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//145351/HomelessHealth.pdf

Bullinger, L. R., & Meinhofer, A. (2021). The Affordable Care Act increased Medicaid coverage among former foster youth. *Health Affairs*, *40*(9), 1430–1439. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00073

Centers for Disease Control and Prevention. (2022). What Is health literacy? https://www.cdc.gov/healthliteracy/learn/index.html.

Centers for Medicare and Medicaid Services. (n.d.). Eligibility. https://www.medicaid.gov/medicaid/eligibility/index.html

Centers for Medicare and Medicaid Services. (n.d.). *Implementation Guide: Medicaid State Plan Eligibility; Eligibility Groups – Mandatory Coverage Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care.* Centers for Medicare and Medicaid Services. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-children-with-title-ive-adoption-assistance-foster-care-guardianship-care.pdf

Centers for Medicare and Medicaid Services. (n.d.). List of eligibility groups. https://www.medicaid.gov/sites/default/files/2019-12/list-of-eligibility-groups.pdf

Centers for Medicare and Medicaid Services. (n.d.) Medicaid state plan amendments. https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html

Centers for Medicare and Medicaid Services. (n.d.). Modified Adjusted Gross Income (MAGI). https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/

Centers for Medicare and Medicaid Services. (n.d.). What to include as income? https://www.healthcare.gov/income-and-household-information/income/#magi

Centers for Medicare and Medicaid Services. (2020). *MAGI 2.0: Building MAGI Knowledge, Part 2: Income Counting.* [PowerPoint slides, December 11, 2020). https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/part-2-income.pdf

Child Welfare Information Gateway and Children's Bureau. (2022). *Healthcare coverage for youth in foster care—and after.* Office of the Administration for Children and Families https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf

CMS All State SOTA Call (2017). Ensuring access to Medicaid coverage for former foster care youth [PowerPoint slides]. https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/foster-care-ensuring-access.pdf

Conway, D. (2020). Adults age 26 had highest uninsured rate among all ages, followed by 27-year-olds. United States Census Bureau. https://www.census.gov/library/stories/2020/10/uninsured-rates-highest-for-young-adults-aged-19-to-34.html

Foundations for Social Change. (2021). *New Leaf Project: Taking Bold Action on Homelessness*. https://forsocialchange.org/impact

Internal Revenue Service. (n.d.) Adjusted Gross Income. https://www.irs.gov/e-file-providers/definition-of-adjusted-gross-income

Internal Revenue Service. (n.d.) Gift tax. https://www.irs.gov/businesses/small-businesses-self-employed/gift-tax.

Kaiser Family Foundation. (2022). *Status of State Medicaid Expansion Decisions: Interactive Map.* https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Kull, M. A., Griffin, A. G., Alexcee, A., & Farrell, A.F. (2022). *Youth mental health & homelessness: Looking upstream for solutions.* Social Work Today, *22*(2), 16.

Loeser, J., Özler, B., & Premand, P. (2021). What have we learned from cash transfers. World Bank Blogs. https://blogs.worldbank.org/impactevaluations/what-have-we-learned-about-cash-transfers

Medicaid and CHIP Payment and Access Commission. (n.d.) Non-citizens. https://www.macpac.gov/subtopic/noncitizens/

Medicaid and CHIP Payment and Access Commission. (n.d.) People with disabilities. https://www.macpac.gov/subtopic/people-with-disabilities/

Medicaid and CHIP Payment and Access Commission. (n.d.) Pregnant women. https://www.macpac.gov/subtopic/pregnant-women/

Morton, M. H., Dworsky, A., & Samuels, G. M. (2017). *Missed opportunities: Youth homelessness in America. National estimates*. Chapin Hall at the University of Chicago. https://voicesofyouthcount.org/wp-content/uploads/2017/11/VoYC-National-Estimates-Brief-Chapin-Hall-2017.pdf

National LGBTQIA+ Health Education Center. (2020). *Supportive Housing and Health Services for LGBTQIA+ Youth Experiencing Homelessness: Promising Practices.* A Program of the Fenway Institute. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/07/Supportive-Housing-and-Health-Services-for-LGBTQIA-Youth-Experiencing-Homelessness.pdf

Olivet, J., Wilkey, C., Richard, M., Dones, M., Tripp, J., Beit-Arie, M., Yampolskaya, S., & Cannon, R. (2021). Racial inequity and homelessness: Findings from the SPARC Study. *The ANNALS of the American Academy of Political and Social Science, 693*(1), 82–100. https://journals.sagepub.com/doi/full/10.1177/0002716221991040

Point Source Youth. (n.d). *Direct cash transfers, youth empowerment, racial justice, and housing stability* [Fact sheet]. https://static1.squarespace.com/static/60418acae851e139836c67ed/t/609ea51a49bf1861360a378f/1621009690555/Direct%2BCash%2BTransfers%2C%2BYouth%2BEmpowerment%2C%2B%2BRacial%2BJustice%2C%2Band%2BHousing%2BStability.pdfhttps://static1.squarespace.com/static/60418acae851e139836c67ed/t/609ea51a49bf1861360a378f/1621009690555/Direct%2BCash%2BTransfers%2C%2BYouth%2BEmpowerment%2C%2B%2BRacial%2BJustice%2C%2Band%2BHousing%2BStability.pdf

Purington, K. (2018). SUPPORT for Families and Communities Act: New funding and flexibility for states to address substance use disorder. National Academy for State Health Policy. https://www.nashp.org/support-for-families-communities-act-funding-state-medicaid-programs-opioid-crisis/

Ranji, U., Salganicoff, A., & Gomez, I. (2021). Postpartum coverage extension in the American Rescue Plan Act of 2021. Kaiser Family Foundation. https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/

Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry, 30*(4), 259–292.

Social Security Administration. (n.d.) Medicaid information. https://www.ssa.gov/disabilityresearch/wi/medicaid.htm

U.S. Department of Housing and Urban Development. (n.d.) *Housing First in permanent supportive housing.* https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf.

West, S., Baker, A., Samra, S., Coltrera, E. (2021) *Preliminary analysis: SEED's first year.* Stockton Economic Empowerment Demonstration.https://static1.squarespace.com/static/6039d612b17d055cac14070f/t/603ef1194c474b329f33c329/1614737690661/SEED_Preliminary+Analysis-SEEDs+First+Year_Final+Report_Individual+Pages+-2.pdf

Wilke, S. & Wagner, J. (2022). Unwinding the Medicaid continuous coverage requirement: Frequently asked questions. Center for Budget and Policy Priorities. https://www.cbpp.org/research/health/unwinding-the-medicaid-continuous-coverage-requirement

Recommended Citation

Buck, L., & Arbutina, S. (2022). *Direct cash transfers and Medicaid: Considerations for addressing benefit eligibility and access*. Chicago, IL: Chapin Hall at the University of Chicago.

Disclaimer

The opinions expressed are solely those of the authors and do not necessarily reflect the official position of funders. Nothing in this work should be construed as legal advice. This work would not be possible without the generous support of the Annie E. Casey Foundation. We offer thanks to the numerous individuals who contributed their lived and subject matter expertise, review, and input, which were critical to shaping this product, including: Michael Nardone, Health Policy Consultant; Marcy Thompson, United States Interagency Council on Homelessness; Mollie Hertel, NORC at the University of Chicago; Jennifer Wagner, Center on Budget and Policy Priorities; Clare Anderson, Julie McCrae, Emely Hernandez and Noelani McComb, Chapin Hall at the University of Chicago.