THE "INMATE EXCEPTION" AND ITS IMPACT ON HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE IN CALIFORNIA

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FOREWORD

This paper was commissioned by The California Endowment. Our mission was to explore the "inmate" limitations on Medicaid for children in the juvenile justice and child welfare systems, and to offer strategies to address those limitations. We are grateful for The Endowment's support of this important work, and the encouragement we have enjoyed from Program Officer Gwen Foster. We also thank the dozens of unnamed people in probation departments, health agencies, advocacy organizations, legislative offices, and health policy groups who gave us information and their thoughts on the inmate exception. Special thanks go to Mamie Yee and Joy Warren, Youth Law Center staff members who helped to track down and verify information. Our hope is that the paper will move us forward in assuring that children in California public systems receive timely, appropriate health care in the most appropriate setting.

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EXECUTIVE SUMMARY

Introduction

Children come into state custody with enormous health care needs. Medicaid and the State Children's Health Insurance Program (SCHIP) provide federal financial participation for health care coverage for many low-income children. However, Medicaid denies coverage for any individual who is an "inmate of a public institution" and SCHIP excludes from eligibility any "inmate of a public institution." As a result, these programs do not cover health care services for some children in state or county institutions.

Over 114,500 children are in state custody through the juvenile justice or child welfare systems in California. Of these, 97,855 children are in non-secure (unlocked) child welfare or probation placements and approximately 16,694 are in secure (locked) institutions, with stays ranging from a few days to several years. Children in the juvenile justice system who are held in correctional institutions such as juvenile halls, camps, ranches or California Youth Authority facilities are those most affected by the inmate exception.

The Inmate Exception

Medicaid and Medi-Cal

Federal law prohibits Medicaid payments "with respect to care or services for any individual who is an inmate of a public institution." Although federal law and guidance leave questions in several areas, some things are clear: Medicaid coverage may be suspended but eligibility should not be terminated upon incarceration; Medicaid coverage must be immediately restored upon release unless the person is no longer eligible; and youth who have a dispositional (sentencing) order that they be placed in a non-correctional setting such as a group home are not "inmates" under federal law, and are entitled to coverage.

The California legislature clearly intended to maximize access to health care services consistent with federal Medicaid coverage through Medi-Cal, California's Medicaid program. However, state regulations terminate Medi-Cal eligibility for inmates, and a survey of California Probation Departments shows disparities in County practices with respect to Medi-Cal billing for youth in institutions.

SCHIP

The State Children's Health Insurance Program (SCHIP) provides federal funding to states for health insurance coverage of uninsured children up to 200% of the federal poverty level (FPL). California's SCHIP program is called Healthy Families. As of June 2002, 562,614 children were enrolled in Healthy Families. SCHIP excludes from its definition of targeted children "a child who is an inmate of a public institution or a patient in an institution for mental diseases." California has not issued state regulations or policies on the inmate exception and relies on federal law to determine whether children are eligible. State data on reasons for ineligibility do not specifically track the number of children excluded because of the inmate exception.

Maximizing Medicaid Coverage

State and County policy and practice could be changed to increase federal financial participation in health care services to youth in the juvenile justice system. Strategies include 1) coverage of youth awaiting placement, 2) ensuring that court orders, placements, and program structure maximize eligibility for coverage, 3) clarifying state policy concerning termination of eligibility, reinstatement of benefits upon release, and coverage of treatment services provided in the community to youth who are wards of the California Youth Authority. The Little Hoover Commission also recommends pursuing a Medicaid waiver to fund mental health services in the juvenile justice system.

Eliminating the Inmate Exception

Elimination of the inmate exception is controversial. Additional federal and state funds could improve health services in institutions, and offer a way to pay for much needed health and mental health assessments. At the same time, Medicaid coverage might remove incentives to provide services in a non-institutional setting and result in the increased use of correctional settings to provide treatment services. Clearly, there are important considerations on all sides of this debate. Deliberate attention to all points of view and a more through discussion among those involved in treatment for youth in the juvenile justice system could lead to a solution that would provide needed services to youth without contributing to inappropriate institutionalization.

Recommendations

A. Information and Data Collection

An accurate picture of the health care needs of youth in the juvenile justice system, their eligibility for health care coverage, and the current funding structure is critical to any future policy work. However, little data exist on health care needs and eligibility for coverage of these youth. The Foundation could support:

- Better data collection on health care services and outcomes for children in the juvenile justice system, including compliance with Title 15, California Code of Regulations (*Minimum Standards for Juvenile Facilities*) and EPSDT standards.

- Better data collection on Medi-Cal and SCHIP eligibility for children in the juvenile justice system.

- An analysis of the current costs of health care services for youth in the juvenile justice system and the effectiveness of current financing mechanisms.

- Advocacy to require probation departments, juvenile halls, and the California Youth Authority to collect Medi-Cal and SCHIP eligibility information as part of initial health screening.

B. Increasing Medi-Cal Access Under Current Law

California counties could increase their use of Medi-Cal under current state and federal policies. The Foundation could support efforts to:

- Increase the use of Medi-Cal services, such as early mental health intervention and substance abuse treatment to prevent the need for institutionalization.

- Maximize the use of community-based resources that qualify for Medi-Cal funding. Examples include Therapeutic Behavioral Services (TBS), foster care placement, and wrap around services to allow children to live at home or in a non-institutional setting.

- Advocate for intake and classification policies that divert youth with significant treatment needs from correctional institutions to more appropriate settings that qualify for federal financial participation.

- Help health agencies, probation officials and institutional providers maximize Medi-Cal coverage for children in their care. For example, more counties could access Medi-Cal for youth with a disposition order who are awaiting placement outside an institution.

- Help local jurisdictions identify the characteristics of and increase the number of quality treatment programs that are or could be Medi-Cal eligible – *e.g.,* Regional Facilities for Seriously Emotionally Disturbed Wards, Community Treatment Facilities, or other one-of-a-kind treatment programs.

- Advocate for policies that require juvenile halls and the California Youth Authority to take steps to ensure that youth have immediate access to health care coverage upon release.

C. Policy Clarification

Clarifying policy is not without risk. However, clearer policies will encourage more jurisdictions to maximize Medicaid coverage and may expand coverage to children who are currently excluded. The Foundation could support:

- Advocacy to ensure that California policy does not terminate Medi-Cal eligibility in violation of federal law and to require that children have immediate access to services upon leaving inmate status.

- Advocacy to clarify State regulations and Medi-Cal policy guidance to make language consistent with California juvenile court terminology and eliminate confusing and irrelevant terminology and references.

- Research and/or advocacy to clarify state policy with respect to coverage of services provided in community hospitals to wards of the California Youth Authority.

- Research and/or advocacy to clarify federal policy concerning coverage of youth awaiting juvenile court adjudication.

D. Advocating for Policy Change

Elimination of the inmate exception in federal law, or funding institutional services with state Medi-Cal funds, are controversial proposals. A more thorough discussion among those with differing views is necessary before making any recommendation for policy change. The Foundation could support further discussion of these issues including:

- Whether to eliminate the "Inmate Exception" from federal Medicaid Law; whether to eliminate the exception for children only.

- Whether to provide state Medi-Cal funds to cover children in institutional settings (juvenile halls, camps, California Youth Authority); whether to use partial state Medi-Cal funding to expedite provision of services upon release.

- Whether to seek a federal Medicaid waiver permitting California to cover children in juvenile correctional institutions.

I. INTRODUCTION

Children come into state custody with enormous health care needs. As a group, they suffer disproportionately from acute and chronic health problems. Many children[1] do not have adequate access to health care before they come into state care, and many suffer from conditions that develop or worsen while they are in state custody.[2] Medicaid and the State Children's Health Insurance Program (SCHIP) provide federal financial participation for health care coverage for many low-income children. However, Medicaid denies coverage for any individual who is an "inmate of a public institution" and SCHIP excludes from eligibility any "inmate of a public institution." As a result these programs do not cover health care services for some children in state or county institutions.

This paper discusses these Medicaid and SCHIP restrictions and their effect on children in state care in California. It reviews current law and practice, makes recommendations for maximizing coverage under the current law, and sets out policy considerations involved in changing these restrictions to increase federal funding for children in state institutions.

A. Background on Juvenile Court Proceedings and Dispositional Placements

A few preliminary definitions may be useful. Children may come into state care through the child welfare or the juvenile justice system. "Child welfare" refers to juvenile court proceedings concerning child abuse or neglect. In California, child welfare cases are also referred to as "dependency" cases or "300" cases (in reference to the jurisdictional statutes beginning at California Welfare and Institutions Code section 300). Children who have suffered abuse or neglect or who are at substantial risk of harm can be removed from their homes and placed in foster care. Foster care placements include the homes of relatives, foster family homes, group homes, and community treatment facilities. (Appendix A describes the specific stages of child welfare proceedings and placements.)

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[1] The statutory schemes referred to in this paper use a variety of terms, including "children," "minors," "juveniles," and "youth." The terms are used interchangeably in the paper.

[2] Health care needs of California children in the child welfare and juvenile justice system are discussed at greater length in C. Hartney, M. Wordes, B. Krisberg, *Health Care for Our Troubled Youth: Provision of Services in the Foster Care and Juvenile Justice Systems of California* [hereafter "*Health Care for Our Troubled Youth*"], Oakland, CA: National Council on Crime and Delinquency, Mar. 15, 2002, commissioned by The California Endowment, particularly pages 1-3 and 8-10. (http://www.nccd-crc.org/pubs/2002mar_endowment_rpt_mental_health_access_approved.pdf) Health care characteristics of children in juvenile correctional settings are also discussed in American Academy of Pediatrics, Committee on Adolescence, "Health Care for Children and Adolescents in the Juvenile Correctional Care System," *Pediatrics*, Vol. 107, No. 4, April 2001, pp. 799-803. (http://www.aap.org/policy/reoo21.html.)

"Juvenile justice" refers to juvenile court proceedings in which the minor is alleged or found to have committed an act that would be a crime if committed by an adult. In California, juvenile justice proceedings are also referred to as "delinquency" cases or "602" cases (in reference to the jurisdictional statutes beginning at California Welfare and Institutions Code section 602). Minors may be held ("detained") in a juvenile hall pending adjudication (trial) of their case. Youth who are adjudicated delinquent can be placed on probation or in an out-of-home setting. These placement orders are called "dispositions." Out-of-home placements include community care facilities (foster homes, group homes, and community treatment facilities), county probation facilities (county operated juvenile homes, ranches or camps), juvenile halls, and the California Youth Authority. A significant number of youth remain in juvenile hall awaiting placement after the court has issued an order for placement outside the juvenile hall.

B. Child Welfare and Juvenile Justice Statistics on Out-of-Home Placement

Recent data indicate that over 114,500 children are in state custody through the juvenile justice or child welfare systems in California. Of these, 97,855 children are in non-secure (unlocked) child welfare or probation placements[3] and approximately 16,694 are in secure (locked) institutions. In the first quarter of 2002 an average of 6,530 children lived in juvenile halls, and of those, an average of 855 were post-disposition youth awaiting placement in a group home or other non-secure setting.[4] For the same time period, 4,314 children lived in secure camps or ranches.[5] At the end of August 2002, there were 5,799 wards incarcerated in the California Youth Authority.[6]

The median length of stay for children in child welfare placements is about 18 months. While some children spend only a few days in care, others remain for years, and some stay until they emancipate or age out of the system.[7]

The statewide average length of stay in California juvenile halls is 25.2 days; with longer average stays for children released to foster homes or group homes (30.5

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[3] California Department of Social Services, Research and Development Division, "Children's Programs Data Tables" (2002). (http://www.dss.cahwnet.gov/research/default.htm). In August, 2002 90,738 children were supervised by child welfare departments and 6,833 were supervised by probation departments. *Id.*

[4] California Board of Corrections, *Juvenile Detention Profile Survey: 1st Quarter 2002. (http://www.bdcorr.ca.gov/fsod/juvenile%20detention%20survey/2002/quarter_1/summary_results.pdf)*

[5] *Id.*

[6] State of California, Department of the Youth Authority, Administrative Services Branch, Research Division, Ward Information and Parole Research Bureau, *Population Movement Summary,* August 2002, p. 1.

[7] Generally children age out of foster care at age 18. However, some youth may emancipate before 18, and the juvenile court has the authority to retain jurisdiction after the child reaches 18. California Welfare and Institutions Code § 391.

days), or released to camps or ranches (36.8 days), and for youth found unfit for juvenile court treatment (219.8 days).[8] These average figures do not give a full picture because some children are released within a few days, while others are detained for many months pending adjudication, disposition or placement, and still others are "sentenced" to months of juvenile hall time at disposition. Youth placed in camps and ranches spend an average of 114 days in those programs,[9] with some children staying much longer.

Young people committed to the California Youth Authority may be confined up to age 25, depending on their commitment offense and behavior during confinement. The average length of stay for first commitments paroled in 2001 was 22.9 months; with an average length of stay of 70.3 months for the most serious offense category, and 13.2 months for the least serious offense category.[10]

C. Medicaid and SCHIP Eligibility for Children in the Child Welfare and Juvenile Justice Systems

Most foster children in California have health care coverage through Medi-Cal, California's Medicaid program. Children eligible for federal Title IV-E foster care benefits are automatically eligible for Medicaid.[11] In addition, California has chosen to cover foster children who do not meet the requirements of Title IV-E.[12] Youth in the juvenile justice system who are placed in foster homes or group homes are included in these provisions. For example, a youth who is adjudicated delinquent and placed in a Title IV-E qualifying placement is eligible for Medi-Cal.

The number of children in the juvenile justice system who meet the income requirements for Medi-Cal and SCHIP is probably substantial because children in the juvenile justice system are disproportionately poor.[13] However, data on Medicaid eligibility of children in juvenile justice facilities (*i.e.,* placements other than foster family homes or group homes) is limited, and SCHIP data is not kept in this way.

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[8] California Board of Corrections, *Juvenile Detention Profile Survey: 1st Quarter 2002.* (http://www.bdcorr.ca.gov/fsod/juvenile%20detention%20survey/2002/quarter_1/summary_results.pdf)

[9] *Id.*

[10] Youthful Offender Parole Board, *Initial Appearance Hearings 2001*,Table I.

[11] 42 U.S. Code § 1396a (a) (10) (A) (i) (I).

[12] This is a state option under 42 U.S. Code §§ 1396a(10)(A)(ii), 1396d(a)(i)

[13] As researcher Mark Mauer has put it, " The criminal justice system in general and prison in particular have long served as the principal arena for responding to the crimes of lower-income people," M. Mauer, *The Race To Incarcerate*, New York: The New Press, 1999, at p. 162. All children under the age of 19 whose family income is at or below 100% of the federal poverty level are eligible for Medicaid. 42 U.S.C. § 1396a (l) (1) (D).

Neither the counties nor the state collects eligibility data for children in the juvenile justice system. In 1999, health policy analysts surveyed 57 Chief Probation Officers on the Medi-Cal eligibility of their county's juvenile probation population as part of a report to the Legislature on resource gaps in providing specialty mental health services to children in out-of-home placements or at risk of such placement through the child welfare and probation system.[14] County estimates of Medi-Cal eligibility ranged from 15% to 99%, with an average estimate of 47%.[15] The researchers cautioned that, "Estimates were based on perception, since no documentation of that information was routinely kept on a statewide basis."[16]

The absence of readily available data on Medi-Cal and SCHIP eligibility of children in juvenile justice is significant. If eligibility is not tracked in individual cases, counties may be missing an opportunity to access coverage, and children may not be getting the full range of services to which they are entitled. The lack of aggregate data impedes planning and service development. In addition to providing needed health care services to youth, maximizing access to covered services could help to reduce detention time, improve disposition planning, and expedite access to health care services when youth leave detention.

D. Legal Standards for Health Care Are Not Always Met

A governmental entity that institutionalizes a child has an obligation to meet the child's health care needs. Individuals who are involuntarily committed to a state or county institution have a constitutional right to adequate medical care, including mental health services. [17] Children taken into state care for their own protection have the right to adequate care and protection from harm.[18] California statutes and regulations also provide specific rights and protections to children in institutional or other out-of-home placements. (California standards for health care to children in the child welfare and juvenile justice systems are summarized in Appendix B.) However, these youth do not always receive the services they need.

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[14] A.M. Libby, A. Rosenblatt, and L.R. Snowden, "Mental Health Screening, Assessment, and Treatment Services and Additional Costs for Children in Foster Care or on Probation and Their Families," A Report to the Legislature in Response to Chapter 311, Statutes of 1998, Berkeley and San Francisco: Center for Mental Health Services Research, University of California, June 30, 1999, [hereafter "A.M. Libby, *et al.*, *Costs for Children in Foster Care or on Probation*"], p. 13. This report was required by California Welfare and Institutions Code § 5967.5

[15] A.M. Libby, *et al.*, *Costs for Children in Foster Care or on Probation,* at p. 22.

[16] *Id.*, at p. 25.

[17] United States Constitution, Fourteenth Amendment; *and see, for example, Estelle v. Gamble,* 429 U.S. 97, 104 (1976); *D.B. v. Tewksbury*, 545 F.Supp. 896 (D.Or. 1982); *Alexander S. v. Boyd*, 876 F. Supp. 773, 788, 796 (D.S.C. 1995); *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1216 (D.C. La. 1976).

[18] *Youngberg v. Romeo*, 457 U.S. 307 (1982) and *DeShaney v. Winnebago County Dept of Social Services,* 489 U.S. 189, 199-200 (1989), *Lipscomb By and Through DeFehr v. Simmons*, 962 F.2d 1374, 1379 (9th Cir. 1992).

Numerous studies have found serious deficiencies in institutional health care. The most extensive national survey of juvenile facilities undertaken to date measured conformity with six health services criteria, including initial health screening within one hour of admission; health appraisals within seven days; children's access to information about medical services; provision of sick call; written arrangements for emergency care; and staff training in first aid or CPR. Only 26% of youth nationally were held in facilities that met all six criteria.[19] With respect to suicide prevention, facilities were surveyed on four criteria, including whether the facility has a written suicide prevention plan; whether there is suicide risk screening at admission; whether staff receive suicide prevention training in the first year of employment; and whether children on suicide watch are monitored at least every four minutes. Only 25% of youth nationally were in facilities conforming to all four criteria.[20] In describing their challenges in providing health care, many facility directors mentioned that they have trouble hiring qualified staff, and that their facilities have no special budget for medical services.[21]

While California does not regularly collect data on adherence to legal standards for health care, there is no reason to believe that California facilities are any less likely to fall short of legal standards. State and county facilities have been sued for inadequacies in medical or mental health care,[22] and reports have addressed systemic deficiencies. For example, a report by Stanford University experts on the mental health system at California Youth Authority found that the system fails to provide adequate services; and that the system is seriously understaffed. According to the report, Youth Authority needs an additional 33 psychiatrists, 64 psychologists and 89 Masters level persons to meet the needs of the current population.[23] A six-month investigative report of mentally ill children in the juvenile justice system by the *Ventura County Star* found evidence that the local Juvenile Hall has become the repository for children with serious mental health care needs. The report also found that, while many detained children are on psychotropic medications or are at risk of suicide, the Hall suffers from serious

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[19] D. Parent, *et al.* (Abt Associates, Inc.), *Conditions of Confinement: Juvenile Detention and Corrections Facilities – Research Report*, Washington, D.C.:U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, August 1994, p. 71, Executive Summary, p. 6. Conformity with the criteria varied by facility type. Only 4% of ranches complied with all six health care criteria, as compared with 48% of detention centers, 48% of reception centers, and 16% of training schools. *Id.*, at p. 71.

[20] *Id.*, at pp. 114-115. When analyzed by facility type, this meant that 33% of youth in detention centers, 18% in reception centers; 21% in training schools; and 18% in ranches were in facilities that conformed with all four criteria.

[21] *Id.*, at p. 82.

[22] See, for example, *Morris v. Harper*, 94 Cal.App. 4th 52 (2001) [California Youth Authority – failure to meet state licensing requirements for inpatient beds]; *Shaw v. City and County of San Francisco*, Case No. 915763, Superior Court for the City and County of San Francisco, Settlement Agreement filed Oct. 4, 1993 [requiring San Francisco to provide adequate staff to assure that detained youth are not denied health and mental health care].

[23] H. Steiner, M.D., *et al.*, "The Assessment of the Mental Health System of the California Youth Authority," Report to Governor Davis, December 31, 2001, pp. 6, 18.

understaffing, poor documentation of services, and fragmentation of services.[24] These findings, unfortunately, reflect conditions that exist in many other parts of the state.

Health care practitioners and juvenile justice administrators are often quite willing to share their frustrations in meeting the health care needs of youth in out-of-home or institutional care. In December 1999, the California Assembly Human Services Committee held a hearing on "Improving Services for Delinquents with Serious Mental Health Problems."[25] Juvenile justice officials from around the State voiced their concerns about the increasing number of children with serious mental health problems they now see, and the dearth of resources to meet their needs. National Council on Crime and Delinquency researchers learned, similarly, from probation administrators and institutional health care staff, that scarce health care resources are often diverted to forensic assessments; that many jurisdictions lack a system for assuring high quality, standardized assessments; that institutional staff often lack much needed training in mental health and health issues; that the system often lacks the ability to provide proper oversight of care while the child is in custody or continuity of care upon release; that medical records systems are frequently inadequate; and that the provision of dental and vision care is a big problem in some counties.[26]

Clearly many California jurisdictions have difficulty in meeting health care standards for children in their care. Although access to Medicaid and SCHIP would not guarantee that children receive necessary health care,[27] some juvenile justice professionals argue that federal financial participation through these programs would bring in additional resources to meet the needs of youth. Medicaid coverage also provides additional legal tools to obtain health care services because eligible children have an entitlement to certain services once they are Medicaid eligible.[28]

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[24] T. Koehler, "Inspection Opens Eyes to Juvenile Hall Concerns (Mentally Ill: Findings reveal a range of problems that add to suffering)," *Ventura County Star, Jan. 8, 2002,* in the series, "Juvenile Injustice: Mentally Ill Kids Behind Bars," *Ventura County Star,* Jan. 2002.

[25] "Improving Services for Delinquents with Serious Mental Health Problems, Assembly Human Services Committee" (Chaired by the Honorable Dion Aroner), Oakland, CA, Dec. 2, 1999.

[26] *Health Care for Our Troubled Youth*, at pp. 16-21.

[27] Medicaid coverage alone does not ensure that children receive the services they need. *See,* United States General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749, July 2001, http://www.gao.gov/new.items/d01749.pdf; National Health Law Program, *Children's Health under Medicaid: A National Review of Early Periodic Screening, Diagnosis and Treatment*, Los Angeles, CA, 1998, revised January 22, 2002, http://www.nhelp.org/pubs/child1998healthxsum.html; Institute for Research on Women and Families, *Code Blue: Health Services for Children in Foster Care*, 1998; M. Rosenbach, *Children in Foster Care: Challenges in Meeting Their Health Care Needs Through Medicaid*, 6-7, Mathematica Policy Research, Inc. 2001, http://www.mathematica-mpr.com/PDFs/fostercarebrief.pdf; and *Katie A. v. Bontā*, Case No. 02-05662 RSWL (SHX), Complaint for Declaratory and Injunctive Relief filed July 18, 2002, U.S. District Court, Central District of California [challenging failure to provide adequate care to foster children with behavioral, emotional and psychiatric impairments in Los Angeles County.]

[28] See discussion of EPSDT.

II. THE "INMATE EXCEPTION" – FEDERAL AND STATE LAW

A. Medicaid: Federal Law Governing Medicaid Eligibility and Coverage of Services to Inmates in Public Institutions

1. Medicaid Overview

The federal Medicaid program was enacted in 1965 as Title XIX of the Social Security Act.[29] In enacting the program, Congress sought to provide medical assistance to low income people falling into specified categories, including blind, aged and disabled persons; pregnant women; and children. Under Medicaid federal financial participation (FFP) is available for medical assistance provided by the states. FFP is authorized from 50% to 83%, depending on the per capita income of the State, with poorer states receiving a higher percentage.[30] The Federal Medical Assistance percentage (FMAP) for California was 51.40 percent for Fiscal Year 2002.[31]

States that participate in Medicaid must cover Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) services for children and adolescents.[32] EPSDT is a comprehensive and preventive child health program. The Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering Medicaid, describes EPSDT as follows:

> The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to seek out eligibles and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.[33]

Under EPSDT, states must provide or arrange for comprehensive screening including the following components:

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[29] "Grants to States for Medical Assistance Programs," Title XIX of the Social Security Act, Pub. L. No 89-97, 79 Stat. 343 (1965), 42 U.S. Code § 1396a *et seq.*

[30] 42 U.S. Code § 1396d(b)(1).

[31] "Federal Financial Participation in State Assistance Expenditures" for Oct. 1, 2001 through Sept. 30, 2002, 65 Federal Register 69, 650-69, 651, Nov. 17, 2000.

[32] 42 U.S. Code § 1396d(a)(4)(B), 1396a(a)(43), 1396d(r).

[33] http://cms.hhs.gov/medicaid/epsdt/default.asp

- Comprehensive health and developmental history, including assessment of both physical and mental health and development and assessment of nutritional status;

- Comprehensive unclothed physical examination;

- Appropriate immunizations according to age and health history;

- Laboratory tests, including lead blood level assessment appropriate for age and risk factors, anemia test, sickle cell test, tuberculin test, and other tests indicated by the child's age, sex, health history, clinical symptoms, and exposure to disease;

- Health education, including anticipatory guidance designed to assist in understanding the child's development and to provide information about healthy life styles and practices, as well as accident and disease prevention.[34]

In addition, states must provide or arrange for services necessary to treat or ameliorate conditions identified in the screening process, even if those services otherwise would not be covered under the state's Medicaid plan. The services provided must include, at minimum:

- Vision services, including diagnosis and treatment (such as glasses) for defects in vision;

- Dental services, including relief of pain and infections, restoration of teeth and maintenance of dental health;

- Hearing services, including diagnosis and treatment (such as hearing aids) for defects in hearing;

- Other necessary health care, including diagnostic, treatment, and other measures to correct or ameliorate defects, physical or mental illnesses, and conditions discovered through screening.[35]

EPSDT requires states to develop appropriate periodicity schedules for comprehensive health assessments, immunizations, and vision, hearing, and dental services that meet reasonable standards of medical practice.[36] States must also inform eligible individuals about EPSDT services and the benefits of

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[34] 42 U.S. Code §§ 1396d(r)(1), 1396a(a)(43)(B).
[35] 42 U.S. Code §§ 1396d(r)(2)-(5), 1396a(a)(43)(C).
[36] 42 U.S. Code §§ 1396d(r)(1)(A)(i), (2)(A)(i), (3)(A)(i), (4)(A)(i), & 1396s(c)(2)(B)(i); 42 Code of Fed. Regs. § 441.58.

preventive care,[37] provide assistance with scheduling and transportation,[38] coordinate EPSDT services with other related agencies and programs, and refer children for needed services that are not covered by Medicaid.[39]

2. The Medicaid Inmate Exception

Federal law prohibits Medicaid payments "with respect to care or services for any individual who is an inmate of a public institution."[40] This provision has been part of the Medicaid statute since the program's inception. (Appendix C.) Although there is little legislative history, Congress apparently declined to provide federal support for functions that were already taken care of by the States because Medicaid was designed to provide health care coverage for individuals whose health care needs were not being met.[41]

FFP is not available for services provided to "[i]ndividuals who are inmates of public institutions as defined in 42 Code of Fed. Regs. § 435.1009."[42] The regulations clarify that this exclusion "does not apply during that part of the month in which the individual is not an inmate of a public institution."[43] (Appendix D.) Section 435.1009 provides:

> "Inmate of a public institution" means a person who is living in a public institution. An individual is not considered an inmate if –
>
> (a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or

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[37] 42 U.S. Code § 1396a(a)(43)(A), 42 Code of Fed. Regs. § 441.56.
[38] 42 Code of Fed. Regs. § 441.62.
[39] 42 Code of Fed. Regs. § 441.61.
[40] 42 U.S. Code § 1396d(a)(27)(A).
[41] *See*, U.S. Congress, House Report (Ways and Means Committee) No. 89-213, March 29, 1965 (To accompany H.R. 6675) p. 42. "Except in such cases as the Secretary may specify, no payment would be made for items and services which are paid for directly or indirectly by a governmental entity." Although there is little discussion of the Medicaid inmate exception, scholars and judges have discussed the rationale for excluding inmates from eligibility for Social Security benefits or Supplemental Security Income. The main rationales are: (1) inmates do not need these benefits because their "substantial economic needs are already met." *Zipkin v. Heckler*, 790 F.2d 16, 19 (2d Cir. 1986); *see Dept. of Health and Human Servs. v. Chater*, 163 F.3d 1129, 1136 (9th Cir. 1998); *see Davis v. Bowen*, 825 F.2d 799, 801 (4th Cir. 1987); *and see* M. Cable, "Enforcing The Prohibition Against Inmates Receiving Welfare Benefits While Incarcerated," 28 *P.L.J.* 892, 1997, pp. 892-894. Accordingly, providing more money would be "wasteful" and would allow inmates to "double-dip" into the public's pockets. *Davis*, 825 F.2d at 801; *see Zipkin*, 790 F.2d at 19; *and see* M. Cable, 28 *P.L.J.* 892, 892-894; and (2) Social Security funds should not be "used to finance care which traditionally has been the responsibility of State and local governments." Rules and Regulations, Dept. of Health and Human Servs., 1985 WL 86360 (Apr. 25, 1985).
[42] 42 Code of Fed. Regs. § 435.1008(a)(1).
[43] 42 Code of Fed. Regs. § 435.1008(b).

(b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.[44]

The same section states that:

> "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution does not include
>
> (a) A medical institution as defined in this section;
> (b) An intermediate care facility as defined in §§ 440.150 and 440.150 of this chapter;
> (c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or
> (d) A child-care institution as defined in this section with respect to
> (1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and
> (2) Children receiving AFDC – foster care under title IV-A of the Act.[45]

In December 1997, the Health Care Financing Administration sent a memorandum to all of the Associate Regional Administrators, in an effort to clarify Medicaid coverage policy for inmates of a public institution.[46] The memorandum stated that inconsistencies in regional directives and a growing influx of inquiries on the issue had prompted HCFA to "expand and, in some cases, refine our coverage policy in this area." In subsequent letters, HFCA provided further clarification of some issues.[47] The following pertinent points were addressed:

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[44] 42 Code of Fed. Regs. § 435.1009.

[45] *Id.* Title IV-A no longer covers foster care.

[46] Memorandum from the Director, Disabled and Elderly Health Programs Groups, Center for Medicaid and State Operations to All Associate Regional Administrators, Division for Medicaid and State Operations, "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution," Health Care Financing Administration, Department of Health and Human Services, Dec. 12, 1997, [hereafter "HCFA Memorandum, Dec. 12, 1997"]. The Memorandum is included at Appendix E.

[47] Letter from Donna E. Shalala, Secretary of Health and Human Services to the Honorable Charles E. Rangel, House of Representatives (Apr. 5, 2000); *and see*, almost identical letter from Sue Kelly, Associate Regional Administrator, Division of Medicaid and State Operations to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State Department of Health (September 14, 2000). Both letters were in response to inquiries about Medicaid eligibility for detainees and inmates in the New York City jail system. Both letters are included as Appendix F.

a. Eligibility

i. The 1997 Memorandum

The 1997 Memorandum explained that section 1905(a) (A) of the Social Security Act [codified as 42 U.S. Code § 1396d (a) (27) (A)] excludes FFP for services provided to inmates of a public institution, but this does not preclude Medicaid *eligibility* for an individual who meets the appropriate eligibility criteria.[48] Thus federal law does not require that an individual's Medicaid eligibility be terminated upon incarceration.[49]

ii. The 2000 letters

In subsequent guidance HCFA clarified that federal policy permits (but does not require) States to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed.[50] The HCFA Memorandum stated that states may use a simplified process to redetermine eligibility for inmates who are incarcerated for a period of time that exceeds a State's customary period of time for redetermination of eligibility. However, States cannot terminate individuals from Medicaid until a redetermination has been conducted. The letters emphasize that

> Regardless of the simplified procedures used, a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason.[51]

b. The Policies Apply Equally to Juvenile Inmates

The 1997 HCFA Memorandum stated that there is no difference in the application of the inmate policy to juvenile inmates.

> For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution."[52]

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[48] *Id.*
[49] *Id.*
[50] Letter from Donna E. Shalala to the Honorable Charles E. Rangel; letter from Sue Kelley, Kathryn Kumerker.
[51] Letter from Donna E. Shalala to the Honorable Charles E. Rangel.
[52] HCFA Memorandum, Dec. 12, 1997.

c. Criteria for the Prohibition on FFP

The 1997 HCFA Memorandum also discussed the criteria for prohibiting FFP. The inmate restrictions on FFP apply only to people who are involuntarily residing in public institutions. The exception to inmate status for custody, "'while other living arrangements appropriate to the individual's needs are being made' does not apply when an individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations."[53] A public institution is one "under the responsibility of a governmental unit, or over which a governmental unit exercise administrative control."[54] Facilities that contract with private health care entities to provide medical care in public institutions may not receive FFP, since governmental control still exists over the facility, and the private entity is merely a contractual agent of the governmental unit. The same is true, even when the private entity operates a separately housed medical institution, but it is still on the grounds of the public institution. FFP *is* available when the inmate is admitted as an inpatient in a *medical institution*, such as a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility, provided that the services are covered in the State Medicaid plan and the inmate is eligible. However, medical care provided to inmates in a prison hospital or dispensary is not provided in a medical institution and thus does not qualify for FFP.[55]

d. Policy Application

The 1997 HCFA Memorandum concluded with examples involving specific settings and situations:

> Examples when FFP is available:
>
> 1. Infants living with the inmate in the public institution;
> 2. Paroled individuals;
> 3. Individuals on probation;
> 4. Individuals on home release except during those times when reporting for overnight stay;
> 5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (*e.g.*, transfer to a community residence); and
> 6. Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the

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[53] *Id.* This language is a bit convoluted, but the import is that people awaiting criminal proceedings, penal dispositions, and other involuntary detainment determinations are inmates, and services provided to them are not eligible for FFP.

[54] *Id*

[55] *Id.*

mentally retarded (Note: subject to meeting other requirements of the Medicaid program).

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held in detention centers awaiting trial;
2. Inmates involuntarily residing at a wilderness camp under governmental control;
3. Inmates residing involuntarily in half-way houses under governmental control;
4. Inmates receiving care as an outpatient; and
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting.[56]

3. Case Law

There have been surprisingly few cases interpreting the federal law relating to Medicaid services for inmates of public institutions. *Dixon v. Stanton,* 446 F.Supp. 335 (N.D. Ind. 1979), held that homes for the developmentally disabled that were regulated by the state but not administratively under its control were not "public institutions" and that residents could qualify for Medicaid.[57]

Brown v. County Commissioners of Carroll County, 658 A.2d 255 (Md. 1995), held that a pretrial jail detainee who would have been covered under Maryland's Medicaid program if he had been able to post bail, could not be required to pay for the cost of medical services rendered while he was in jail. The court reasoned that the inmate's jail stay was "temporary pending other appropriate arrangements," [58] since he was incarcerated only until he posted bail or until the disposition of the criminal charges against him, and therefore fell into the exception from inmate status contained in 42 Code of Federal Regulations §

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[56] *Id.*

[57] A more recent case, *Department of Health and Human Services v. Chater*, 163 F.3d 1129 (9th Cir. 1998), decided that, for purposes of SSI, a group home for delinquent children *was* a "public institution" (so the youth could not receive SSI). While *Chater* involved SSI, not Medicaid, the conclusion that privately operated group homes are a "public institution" is troubling at first glance, since the SSI definition of "public institution" is similar to the Medicaid definition. However, the Medicaid definition specifically exempts from the definition of "public institution," child-care institutions (State licensed facilities for no more than 25 children) for children for whom foster care maintenance payments are made under Title IV-E of the Act; and children receiving AFDC – foster care under Title IV-A of the Act. (*See* text of 42 Code of Fed. Regs. § 435.1009, *supra*). In California, group homes serving child welfare and delinquent youth fall within that exemption, and thus would not be considered public institutions. Even if that were not the case, *Chater* appears to have involved a State scheme in which there was substantially more State control than exists over group homes in California. Moreover, different policy considerations dictate the provision of federal Medicaid payments for essential health services to youth in group homes, versus SSI cash assistance to youth in State care.

[58] *Brown v. County Commissioners,* 658 A. 2d at p. 262

435.1009(b). Absent persuasive authority holding that pretrial detainees are excluded from Medicaid coverage under federal law, the court refused to let the county hold the inmate responsible for the costs of medical care.[59] *Brown* was decided before the 1997 HCFA Memorandum stating that inmates awaiting trial are not entitled to FFP; it is unclear whether the same decision would be reached based on current federal guidance.

4. Discussion of Federal Medicaid Provisions

Although federal law and guidance leave questions in several areas, some things are clear. First, Medicaid coverage may be suspended but eligibility should not be terminated upon incarceration. Second, Medicaid must be immediately restored upon release unless there has been a determination that the person is no longer eligible. Third, youth who have a dispositional (sentencing) order that they be placed in a non-correctional setting such as a group home are not "inmates" under federal law, and are entitled to FFP.[60]

B. Medi-Cal: State Law Governing Medicaid Eligibility and Coverage of Services to Inmates in Public Institutions

1. Medi-Cal Overview

California has participated in Medicaid since its inception; the statute creating Medi-Cal, California's Medical Assistance program,[61] was passed in 1965 and become operative on March 1, 1966.[62] The purpose of Medi-Cal is to provide eligible individuals health care and related remedial or preventive services, including related social services.[63] California law specifically incorporates EPSDT in the definition of health care services covered by Medi-Cal.[64] The California Department of Health Services (DHS) is the single state agency

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[59] *Id.*, at pp. 263-264

[60] During the preparation of this paper, these issues were specifically discussed with Tom Shenk, the person at the Centers for Medicare & Medicaid Services (CMS) most knowledgeable about the inmate provisions of Medicaid. Mr. Shenk confirmed that "children in post-adjudication, awaiting placement in a non-secure facility, are no longer considered inmates and FFP would be available. Being found "guilty" has no bearing on whether FFP is available...the deciding factor is where the individual is residing or will reside...i.e. a secure facility." With respect to termination, Mr. Shenk confirmed that "A state may not terminate eligibility for an individual from the Medicaid program based on inmate status...the difference is that FFP pertains to financing...eligibility refers to status.... under Medicaid an inmate can still be eligible for Medicaid...but Federal financing is not available for medical services provided while incarcerated." (E-mail from Tom Shenk to Sue Burrell, Aug. 22, 2002). Mr. Shenk subsequently reviewed a draft of this paper and confirmed its accuracy with respect to federal law and guidance, but also stated that CMS is in the process of changing its policy, which may make some of what is stated incorrect. (E-mail from Tom Shenk to Alice Bussiere, Oct. 9, 2002).

[61] California Welfare and Institutions Code § 14063.

[62] California Welfare and Institutions Code §§ 14000, *et seq.* (Added by Stats.1965, 2nd Ex.Sess., c. 4, p. 103, § 2, eff. Nov. 15, 1965, operative March 1, 1966.)

[63] California Welfare and Institutions Code § 14000.

[64] California Welfare and Institutions Code § 14132(v).

responsible for administering Medi-Cal in accordance with federal requirements.[65]

California provides EPSDT services through two programs. Screening services are generally provided through the Child Health and Disability Prevention (CHDP) program;[66] diagnosis and treatment services are generally provided through Medi-Cal.[67] CHDP programs in each of the 58 counties and the City of Berkeley also provide outreach, health education, assistance with scheduling and transportation, and follow-up with families and providers to ensure that children receive both health assessments and necessary diagnostic and treatment services.[68] Under the fee-for-service system, providers bill CHDP for screening services and Medi-Cal for diagnostic and treatment services. A growing number of children receive Medi-Cal services through managed care plans. Some children enrolled in managed care plans get CHDP services through their managed care provider while others access services through CDHP programs.

2. Statutes, Regulations, and Other Guidance

Medi-Cal coverage with respect to inmates follows federal law, and the legislature clearly intended to maximize access to health care services consistent with FFP. State law excludes from the definition of Medi-Cal covered services the care or services for anyone who is an inmate of a public institution, except to the extent coverage is permitted by federal law.[69] (Appendix G.) State law protects individuals not specifically excluded; if FFP is available, benefits cannot be denied solely because a person is incarcerated in a county or city jail or juvenile detention facility.[70] Counties, cities and the Youth Authority are specifically authorized to claim Medi-Cal reimbursement for services that are eligible for FFP.[71]

State regulations do not provide any further definition of "inmate" or "public institution."[72] (Appendix H.) Rather they provide examples of individuals who are and are not considered inmates of a public institution.

For example, the following are considered inmates of a public institution:

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[65] California Welfare and Institutions Code §§ 14100.1 & 14061-14062.
[66] California Health and Safety Code §§ 124025, *et seq.*
[67] For a description of funding for children's mental health services in California, *see* C. Anders, "Financing Children's Mental Health Programs," CWTAC UPDATES (The Cathie Wright Center for Technical Assistance to Children's System of Care May/June, 1999). *See* Cathie Wright Center at http://www.cimh.org .
[68] CHDP covers all children eligible for Medi-Cal and many low income children who are not Medi-Cal eligible. California Health and Safety Code §§ 124,090 & 104,395.
[69] California Welfare and Institutions Code § 14053(b).
[70] California Welfare and Institutions Code § 11016.
[71] California Penal Code § 4011.1(a).
[72] The only state court decision to address the inmate exception does not provide any additional guidance. *County of Santa Clara v. Hall,* 23 Cal App. 3d 1059 (1972). This case addressed county share of cost for uncompensated care for inmates under the Health Care Deposit Fund.

A minor in a juvenile detention center prior to disposition (judgment) due to criminal activity of the minor.

A minor after disposition, placed in a detention or correctional facility, including a youth ranch, forestry camp, or home which is part of the criminal justice system.

A minor placed on probation by a juvenile court on juvenile intensive probation with specific conditions of release, including residence in a juvenile detention center.

A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is part of the criminal justice system.[73]

The following are not considered inmates of a public institution:

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or in the best interest of the child if there is a specific plan for that person that makes the stay at the detention center temporary.[74]

A minor placed on probation by a juvenile court on juvenile intensive probation with home arrest restrictions.

A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment center is *not* part of the criminal justice system.

A minor placed on probation by a juvenile court on juvenile intensive probation with treatment as a condition of probation in a psychiatric hospital, in a residential treatment center, or as an outpatient.[75]

The *Medi-Cal Eligibility Procedures Manual* adds further guidance. (Appendix I.) It points out that an individual is covered if he or she is released to inpatient or out patient treatment or is released from incarceration due to a medical emergency,[76] but an individual released due to a medical emergency who would

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[73] 22 Calif. Code of Regs. § 50273(a)(5)-(8).
[74] As discussed in the next section, this language, borrowed from federal guidance to Arizona, has caused confusion for California practitioners trying to apply this language to California proceedings.
[75] 22 Calif. Code of Regs. § 50273(c)(6)-(8)
[76] *Medi-Cal Eligibility Procedures Manual*, Section No. 50273, Manual Letter No. 241 (April 18, 2001), Article 6C-2(c) & (d).

otherwise be incarcerated but for the medical emergency is not covered.[77] The *Manual* also notes that facilities eligible for Title IV-E foster care payments and community care facilities (*e.g.*, foster family homes, groups homes, and community treatment facilities) do not come within the definition of "public institution." [78]

3. Discussion of Medi-Cal Provisions

The inmate exception does not have an effect on most children in state care. The interplay of the definition of "inmate of a public institution" and permissible placements for children under California law prevent many children in state care from coming within the exception. Foster children[79] and status offenders[80] do not come within the examples identified in the *Medi-Cal Eligibility Procedures Manual.* Thus only children held as a result of delinquency[81] or found unfit for juvenile court and transferred to the adult system[82] are likely to be affected.

Of these, the status of the case and the specific court orders may dictate whether the child is considered an inmate of a public institution. State policy specifically excludes from the inmate exception youth awaiting trial at home, youth released on probation, and youth placed in foster homes or group homes, even if placed by probation. A minor in juvenile hall awaiting trial is considered an inmate of a public institution,[83] but a minor in juvenile hall awaiting placement in a non-secure setting such as a group home is not considered an inmate of a public institution.[84] A minor released to a treatment facility is eligible for coverage, but a minor transferred due to a medical emergency but still incarcerated is not.[85] The nature of the institution can also be important. For example, a minor placed in a secure treatment facility that is part of the criminal justice system is considered an inmate,[86] but a minor placed in a psychiatric hospital or residential treatment center that is not part of the criminal justice system is not considered an inmate of a public institution.[87]

C. State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) provides federal funding to states for health insurance coverage of uninsured children up to 200% of the

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[77] *Id.*, Article 6C-1(e).
[78] *Id.*, Article 6B.3, Section No. 50273.
[79] California Welfare and Institutions Code § 300.
[80] California Welfare and Institutions Code § 601.
[81] California Welfare and Institutions Code § 602.
[82] California Welfare and Institutions Code §§ 602(b), 707.
[83] 22 Calif. Code of Regs. § 50273(a)(5).
[84] 22 Calif. Code of Regs. § 50273(c)(5), *Medi-Cal Eligibility Procedures Manual*, Article 6D (4).
[85] *Medi-Cal Eligibility Procedures Manual*, Article 6C-1(e), 6C-2(c) & (d).
[86] 22 Calif. Code of Regs. § 50273(a)(8).
[87] 22 Calif. Code of Regs. § 50273(c)(7) & (8).

federal poverty level (FPL).[88] States may provide this coverage by expanding Medicaid or by expanding or creating a state children's health insurance program.

California's SCHIP program is called Healthy Families. California has opted not to use the expanded Medicaid model; health services are delivered primarily through HMO's. Families participating in the program choose their health, dental and vision plan and pay premiums of $4-$9 per child per month (maximum of $27 per family) to participate in the program.[89] The Managed Risk Medical Insurance Board (MRMIB) is responsible for oversight for the program.[90] As of June 2002, 562,614 children were enrolled in Healthy Families.[91]

Unlike Medicaid, SCHIP applies the inmate exception to the child, not coverage of the services.[92] (Appendix J.) SCHIP excludes from its definition of targeted children "a child who is an inmate of a public institution or a patient in an institution for mental diseases"[93] and uses the Medicaid definition for the term "inmate of a public institution."[94] California has not issued state regulations or policies on the inmate exception and relies on federal law in to determine whether children are eligible.[95] State data on reasons for ineligibility do not specifically track the number of children excluded because of the inmate exception.[96]

III. IMPLEMENTATION OF THE INMATE EXCEPTION

A survey of California Probation Departments shows disparities in County practices with respect to Medi-Cal billing. Some Counties do not attempt to obtain Medi-Cal reimbursement for youth in juvenile hall at all, others bill after disposition for youth awaiting placement, and some consider youth detained awaiting adjudication as youth who are in the institution for a ternporary period pending other arrangements appropriate to their needs.[97] Most probation staff

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[88] 42 U.S. Code §§ 1397aa, *et seq.*
[89] http://www.mrmib.ca.gov
[90] http://www.mrmib.ca.gov
[91] http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.html
[92] In answering a question about children who reside in an Institution for Mental Diseases (IMD), SCHIP guidance notes the difference between eligibility and coverage of service. The Administration's Responses to Questions About the State Children's Health Insurance Program - July 29, 1998 -- Fifth Set, Questions 73 & 74. The Guidance addresses the apparent conflict between the eligibility exclusion for children who reside in an IMD and the coverage of inpatient mental health services and concludes that a child who resides in an IMD at the time of application or eligibility determination is not eligible for SCHIP, but an eligible child who subsequently needs inpatient services in an IMD would be covered.
[93] 42 U.S. Code §1397jj(b)(2)(A), 42 Code of Fed. Regs. §457.310(c)(2).
[94] 42 Code of Fed. Regs. §§ 457.310(c)(2), 435.1009; 66 Federal Register 2490, 2535 (January 11, 2001).
[95] Telephone conversation with Irma Michel, MRMIB eligibility section (September 30, 2002).
[96] http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt8.pdf
[97] Services for these youth would be covered under 42 Code of Fed. Regs. § 435.1009(b).

were not aware of County practices concerning retaining eligibility for youth while they are incarcerated or reenrolling youth in Medi-Cal as part of discharge planning and release. In some cases probation staff indicated that Medi-Cal enrollment is the responsibility of the placement staff or other agency, not the Probation Department.[98] In some counties the juvenile detention facility is certified as a Medi-Cal provider to facilitate the provision of covered services, such as youth awaiting placement. These variations suggest that some counties could increase their use of Medi-Cal funds as discussed below.

The California Youth Authority has explored Medi-Cal reimbursement but has not identified any basis for reimbursement for services provided in its facilities.[99] The Youth Authority has been informed that Medi-Cal will not cover services to wards of the Youth Authority treated in a hospital in the community, and that Medi-Cal applications cannot be filed until a youth is actually discharged from the Youth Authority.[100]

IV. MAXIMIZING MEDICAID COVERAGE UNDER CURRENT LAW

State and County policy and practice could be changed to maximize FFP in health care services to youth in the juvenile justice system under current law.

A. Youth Awaiting Placement

Federal and state law clearly allow Medi-Cal coverage of youth awaiting placement. Although some counties take advantage of this coverage, others are losing the chance to draw down federal and state funds and may be depriving youth of Medi-Cal services to which they are entitled.

B. Court Orders and Placement Decisions

Counties could maximize FFP by paying attention to whether court orders, placements, and program structure are consistent with Medi-Cal eligibility. For example, use of community placements instead of juvenile hall confinement for youth who need treatment would avoid the application of the inmate exception altogether. Correctional facilities could implement intake criteria that would divert youth with serious health care needs, including mental health conditions, to a more appropriate setting that would better meet therapeutic needs and be eligible for FFP. For example, the California Youth Authority has developed a screening policy to identify youth with mental health needs that cannot be met in the correctional setting and who should be referred to a more appropriate

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[98] Probation staff also identified continued Medi-Cal coverage for youth who return home as a problem. Youth may qualify for Medi-Cal in placement but may lose eligibility when they return home.

[99] Telephone conversation with Kip Lowe, Assistant Deputy Director of the California Youth Authority (Oct. 31, 2002); telephone conversation with Dr. Jerrold Wheaton, Medical Director, California Youth Authority (Oct. 31, 2002).

[100] Telephone conversation with Dr. Jerrold Wheaton.

placement.[101] For incarcerated youth who need intensive treatment, release to a medical or mental health facility allows coverage of services that could not be covered in a correctional setting. Highly structured treatment programs run by mental health rather than probation would allow the program's services to be covered.

C. Clarifying Federal and State Policy

1. Continuous Medi-Cal Eligibility

California has created an additional barrier to prompt Medi-Cal coverage by terminating the Medi-Cal eligibility of inmates rather than suspending coverage of services while an individual is incarcerated. Although the California statute follows federal law in applying the inmate exclusion to health care services, [102] state regulations purport to make any inmate ineligible for Medi- Cal.[103] While this may appear to be a difference in semantics, it has a practical effect on whether a child's Medi-Cal eligibility is terminated during incarceration. This is significant because termination requires an individual to reapply for benefits upon leaving the institution. Reapplication can mean waiting weeks or months for an eligibility determination and access to services. Conditions that were stabilized in the institution may deteriorate in that time, and continuity of care can be compromised by gaps in coverage. If coverage is merely suspended and eligibility is continued, the child can begin to receive Medi-Cal immediately upon release.

California is not alone in this policy. A survey conducted by the Council of State Governments found that 46 state and two territories have policies that require termination of Medicaid for people in jail.[104] California does this by matching Medi-Cal eligibility with California Youth Authority and jail registry systems.[105] This appears to be at odds with federal law, which says that FFP is not available for services to inmates, but that inmates who are otherwise eligible do not lose eligibility because of incarceration.[106]

Dr. Jerrold Wheaton, Medical Director for the California Youth Authority, is concerned that many youth leave the Youth Authority with serious health problems that need ongoing treatment, including not only youth who need psychotropic medication but also those with chronic medical conditions such as diabetes, hypertension, or asthma that require ongoing medical supervision. The Youth Authority has been informed that Medi-Cal applications cannot be submitted before a youth is discharged, leaving youth uncovered on the day they

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[101] Telephone conversation with Kip Lowe.
[102] California Welfare and Institutions Code § 14053(b)
[103] 22 Calif. Code of Regs. §§ 50271 & 50273(a).
[104] C. Brown, "Jailing the Mentally Ill," *State Government News,* Apr. 2001, p. 28.
[105] Council of State Governments, "Final Results of State Medicaid Agencies Survey," October 16, 2000.
[106] HCFA Memorandum, Dec. 12, 1997.

are released and disrupting continuity of care.[107] Continuous Medi-Cal eligibility or early Medi-Cal application procedures would allow better planning of care and transition for these youth.

Some jurisdictions have changed their termination of benefits policies to enhance access to care. For example, Lane County, Oregon, recognized that many of its jail detainees were individuals with mental health and substance abuse problems who were diverted into community treatment programs within a fairly short time period. Under then-existing State law, inmates lost their eligibility upon incarceration. This created substantial barriers to diversion and ongoing treatment for low-level offenders whose substance abuse and mental health problems had been stabilized in the jail, since they had to reapply for benefits upon release. After discussion with the health and mental health agencies, the State adopted a policy specifying that individuals may not be disenrolled in their first 14 days of incarceration, and that benefits are merely suspended during the period of incarceration. This substantially increased the County's ability to assure continuity of care for those in its diversion program.[108]

Colorado legislation provides, beginning January 1, 2003, inmates who were eligible for Colorado's Medicaid program at the time they were incarcerated or who are reasonably expected to meet eligibility criteria, must be given assistance in applying for Medicaid at least 90 days prior to release.[109] The Department of Health Services must provide training to the facilities on eligibility, assist the facilities to expedite the process, and promulgate rules to simplify the application process. If a person is found to be eligible, the county department of social services must enroll the inmate upon release, and at the time of release must give the inmate information about how to access medical assistance.[110]

The Colorado approach, although not yet implemented, could improve inmates' access to health care services upon release, but it does not completely resolve the issue of improper termination. HCFA guidance suggests that termination of Medicaid eligibility upon incarceration is improper. This is especially important for children in custody because their length of stay is typically shorter than the length of stay for adults, making it more difficult to implement policies to re-establish eligibility and access services upon release. Also, since many children who are in juvenile halls awaiting placement in non-secure programs are entitled to coverage, termination effectively prevents them from accessing Medi-Cal services while they are still physically present in juvenile hall.

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[107] Telephone conversation with Dr. Jerrold Wheaton.

[108] "Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Abuse Disorders," National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 1999, p. 2.

[109] House Bill 02-1295, General Assembly of Colorado, codified as Colorado Revised Statutes, 17-1-113.5, 17-27-105.7, 24-43-104. The Bill provides for inmates of correctional facilities and community correctional programs. It provides identical protections for Supplemental Security Income recipients or inmates reasonably expected to meet eligibility criteria.

[110] *Id.*

The Bazelon Center for Mental Health Law has prepared an excellent set of recommendations for dealing with the termination/suspension issues, which embody federal law. They include: (1) state policy should permit inmates to keep their Medicaid eligibility (as federal rules permit); (2) state procedures should ensure that inmates who are about to be released are reinstated so that providers may be paid, even while eligibility re-determinations are being conducted; (3) state procedures should ensure that Medicaid benefits be suspended not terminated for inmates whose eligibility is linked to Supplemental Security Income (SSI); (4) state policy should ensure Medicaid coverage for individuals released from custody who have serious mental illness, with provision for retroactive reimbursement for those who have applied and ultimately will be found eligible; and (5) state policy should ensure that inmates who retain eligibility have a Medicaid card in hand upon release to access services immediately.[111]

2. Federal Guidance

Federal law and guidance have been interpreted inconsistently among and within the States, including California. For example, some argue that the HFCA guidance prohibiting Medicaid coverage for all youth awaiting trial[112] is inconsistent with the federal regulation that permits coverage for individuals in a public institution for a temporary period pending other arrangements.[113]

This creates a perplexing problem for policy advocates. Should efforts be directed at seeking additional clarification of the law? The answer depends on whom you ask. There is some concern that further clarification could further restrict coverage and hurt well-intentioned programs and providers who have provided Medicaid services to young people under interpretations of the law that later turn out to be wrong. For these programs and providers, further clarification could result in fiscal problems (*e.g.,* for improperly seeking federal reimbursement) and a cutback of services now funded by Medicaid. On the other hand, confusion about the law may make many jurisdictions in California reluctant to implement policies that are appropriate and could maximize Medicaid funding.

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[111] Bazelon Center for Mental Health Law, *Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules*, Mar. 2001, [hereafter, "Bazelon Center, *Finding the Key*"], at p. 12. http://www.bazelon.org/findingthekey.html The Center is also preparing a model law to address transition issues for individuals with mental disabilities who are being released from jail or prison. It will be available on the Bazelon Center web site later this Fall.

[112] HCFA Memorandum, Dec. 12, 1997.

[113] 42 Code of Fed.Regs. §435.1009, Definition of "inmate of a public institution" section (b).

3. State Regulations and Guidance

Although California intended to implement the inmate exception as it exists in federal law, the State regulations and *Medi-Cal Eligibility Procedures Manual* create confusion because their terminology and description of circumstances are not consistent with the juvenile law process in California. This may be because the regulations were amended to reflect HCFA guidance that was issued in response to a question about Arizona. For example, the regulations and *Manual* refer to children held by child protective services in a detention center,[114] but holding such a child in a secure setting would be contrary to California law,[115] and most counties never hold dependent children in juvenile hall facilities. The *Manual* refers to a minor sentenced to a mental institution,[116] but California law does not specifically authorize such a sentence.[117] The Department of Health Services notes that it finds Probation references to "a 602 child" confusing;[118] however, "602" is a meaningful term to professionals involved with juvenile court proceedings. Given that children processed under section 602 can be in a variety of living situations and legal statuses, more precise definition of Medi-Cal coverage in the context of juvenile justice proceedings and placements would be helpful. Clarification of Department of Health Services policy on coverage for California Youth Authority wards when they are treated in community hospitals would also be helpful.

D. Medicaid Waivers

The Little Hoover Commission has urged the California Department of Mental Health to "...pursue a waiver to use Medi-Cal to fund mental health services in the juvenile justice system."[119] Presumably the Commission is referring to a "demonstration waiver" which permits states to implement projects that are likely to assist in promoting the objectives of the Medicaid statute.[120] The Regional Facilities for Seriously Emotionally Disturbed Wards[121] are an example of a program that might benefit from such a waiver. A waiver may also provide an opportunity to evaluate potential changes in the Medicaid exception before making a recommendation.

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[114] 22 Calif. Code of Regs. § 50273(c)(5), *Medi-Cal Eligibility Procedures Manual*, Article 6C - 2(e).
[115] California Welfare and Institutions Code § 206.
[116] *Medi-Cal Eligibility Procedures Manual*, Article 6J - Question 3.
[117] California Welfare and Institutions Code § 727; *and see, e.g., In re Michael E.* (1975) 15 Cal.3d 183.
[118] *Medi-Cal Eligibility Procedures Manual*, Article 6J - Question 1.
[119] State of California, Little Hoover Commission, *Young Hearts and Minds: Making a Commitment to Children's Mental Health,* October 2001, p. 53.
[120] 42 U.S. Code § 1315(a) (Section 1115 of the Social Security Act). It is unclear whether anyone has explored the legal basis for such a waiver.
[121] California Welfare and Institutions Code §§ 5695 through 5697.5.

E. State Funding Solutions to Inmate Restrictions

Because many children are Medicaid eligible when they are detained and will be eligible upon release, it makes good policy sense to find a way to maintain service coverage during the period of detention, and to prevent unnecessary delay in access to services upon release. One way to do this is to use state Medicaid funds, *i.e.,* Medi-Cal funds. Massachusetts has accomplished this through administrative agreements between the Department of Public Welfare and Department of Youth Services.[122]

The rationale for this decision was that the detention system in Massachusetts is state run (as opposed to California's county-based systems), so the state has ultimate responsibility for children in the child welfare system and juvenile justice system. By paying for services to delinquent youth through the Department of Public Welfare, the state could buy health care for otherwise ineligible children (because of inmate status) at the much lower Medicaid cost than if the Department of Youth Services would have been charged.[123] The Departments of Public Health and Public Welfare supported this initiative because it was clear that the unserved youth were mostly low-income youth who were at higher risk for health problems than non-delinquent adolescents. The Department of Youth Services assisted in maximizing funding by aggressively seeking private insurance information from parents; completing Medicaid applications for every youth on a quarterly basis to maximize FFP for eligible youth; cooperating with the placement of Medicaid recipients in managed care plans; and cooperating in auditing of the system.[124]

Other jurisdictions have also elected to use their State Medicaid funds to pay for portions of inmate care. New York uses state funds to pay for medications for inmates leaving jail or prison, provided that the inmate applies for Medicaid. As discussed above, Lane County, Oregon, provides that state Medicaid payments may continue for 14 days after arrest, after which benefits are suspended, not terminated to facilitate immediate reinstatement upon release.[125]

V. VIEWS ON ELIMINATION OF THE INMATE EXCEPTION

Elimination of the inmate exception is controversial. Resistance to expanding a federal program that requires a state match is to be expected. However, important policy issues are also involved. Although additional federal and state funds could improve health services in institutions, Medicaid coverage might also remove a disincentive to provide services in a non-institutional setting and

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[122] G. Shostack, "Navigating Benefits Systems to Ensure Incarcerated Youth's Health Care" [hereafter, "Shostack, 'Navigating Benefits Systems' "], in P.M. Sheahan, Ed., *Health Care of Incarcerated Youth: Report from the 1991 Tri-Regional Workshops*, Washington, D.C.: National Center for Education in Maternal and Child Health, 1991, pp. 112-119, at p. 115.

[123] Shostack, "Navigating Benefits Systems," at p. 116.

[124] Shostack, "Navigating Benefits Systems," at p. 117.

[125] Bazelon Center, *Finding the Key*, at p. 12.

increase the development of treatment services provided in correctional institutions.

Most juvenile justice officials and some health care experts view the inmate exception as an impediment to care that must be eliminated. As one expert put it, "There are federal funds for fighting crime – why not expend them for medical rehabilitation?"[126] Studies by federal agencies have agreed. The Office of Technology Assessment report to Congress on Adolescent Health included actions that could be taken to improve the health of adolescent delinquents. Included as "Option 1" was the following: "Change Federal regulations so that adolescents in correctional facilities are eligible for Medicaid."[127] Policy recommendations from Maternal and Child Health Bureau conferences have pointed to the need to change Medicaid to permit reimbursement for youth confined in juvenile justice institutions.[128]

The National Commission of Correctional Health Care strongly supports elimination of the "inmate exception," urging that Congress act to restore Medicaid benefits for incarcerated individuals.[129] The American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice strongly endorses eliminating the inmate exception from federal Medicaid law,[130] and the Society of Adolescent Medicine has voiced its position that "Medicaid coverage should continue for otherwise eligible incarcerated children and adolescents."[131] The National Council on Crime and Delinquency also recommends coverage of incarcerated youth. [132]

Other members of the juvenile justice and health advocacy communities vehemently disagree that the inmate exception should be repealed. In their view, eliminating the inmate restrictions on Medicaid for institutional status would work at cross-purposes with efforts to reduce institutional confinement in the mental health and correctional systems. These concerns center primarily on expansion of mental health services in the correctional setting.

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[126] H.W. Ris, "The Integration of a Comprehensive Medical Program in a Juvenile Correctional Institution," *Journal of the American Medical Women's Association*, Vol. 30, No. 9, 1975, pp. 367-368.

[127] U.S. Congress, Office of Technology Assessment, *Adolescent Health – Volume 1: Summary and Policy Options*, OTA-H-468, Washington, D.C.: U.S. Government Printing Office, April 1991, p.106, Table 20 – "Specific Options Related to Delinquency."

[128] L.S. Thompson, "Improving the Quality of Health Care for Juvenile Delinquents: Recommendations for an Action Agenda," in L.S. Thompson, Ed., *The Forgotten Child in Health Care: Children in the Juvenile Justice System*, Washington, D.C.: National Center for Education in maternal and Child Health, 1991, pp. 99-103, at p. 102.

[129] National Commission on Correctional Health Care, "Third Party Reimbursement for Correctional Health Care," Position Paper, adopted Sept. 19, 1993.

[130] E-mail message from Dr. William Arroyo, Co-Chair Committee on Juvenile Justice Reform, American Academy of Child and Adolescent Psychiatry, to Sue Burrell (Oct. 15, 2002).

[131] "Health Care for Incarcerated Youth: Position Paper of the Society for Adolescent Medicine," 27 *Journal of Adolescent Health,* 2000, pp. 73-75.

[132] *Health Care for Our Troubled Youth*, pp. 22-23.

Ira Burnim, Legal Director of the Judge David L. Bazelon Center for Mental Health Law, points out that repeal of the inmate exception would remove a disincentive to institutional care. Current law provides an incentive to serve children in the community and to use small (16 beds or fewer) facilities because federal financial participation is available in these settings but not in correctional facilities.[133] Mr. Burnim also notes that juvenile justice facilities are not now viewed as providing mental health treatment. If Medicaid dollars increase the therapeutic programs in correctional institutions, judges might be inclined to send even more youth to these facilities rather than ordering community based treatment.[134]

Children's advocates also worry that increasing Medicaid coverage for services in institutions would lead to more mental health units in correctional facilities, when our priority should be serving people with mental illness in the community.[135] In the words of Patrick Gardner, an attorney with the National Center for Youth Law:

> Institutional care already vastly dominates the mental health delivery system to the detriment of consumers and home and health care. Diverting still more resources to institutions will aggravate the balance. ... Net-widening is not something advocates merely "worry" about. Research shows that it's a very real problem. As well, there is already a serious problem in the community such that parents often feel that they have to have their child arrested or made a ward of the state to get adequate mental health care. Adding more resources within the criminal justice system will make this problem worse.[136]

This is an important issue for California. One unintended consequence of recent federal construction funding for juvenile halls, is expanded juvenile detention facilities beyond current need.[137] It would be unfortunate, indeed, if California counties decided to dedicate this "new" bedspace for institutional treatment facilities or assessment centers at juvenile halls, instead of using increased access to Medicaid funding to move children quickly into more appropriate community-based treatment programs.

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[133] A variety of funding sources is available to serve children in the juvenile justice system in their communities. *See*, B. Burke, "Funding Available to Serve Children in the County Probation System," *CWTAC Updates* ,March/April, 2000; C. Anders, "Financing Social Supports and Services for Children and Families," *CWTAC Updates* , July/August, 1999; T. Sosna, "Financing Partnerships with Family Members as Medi-Cal Reimburseable Mental Health Service Providers," *CWTAC Updates*, November/December, 1999.

[134] Telephone conversation with Ira Burnim (Oct. 30, 2002).

[135] Kip Lowe, Assistant Deputy Director of the California Youth Authority also has concerns about developing mental health treatment at the Youth Authority rather than community based services. Telephone conversation with Kip Lowe (Oct. 31, 2002).

[136] Comments of Patrick Gardner on discussion draft (Oct. 17, 2002).

[137] Some counties have expanded the capacity of their juvenile halls in order to qualify for federal funds through the Violent Offender Incarceration and Truth in Sentencing Act, 42 U.S. Code §§ 13702, *et seq.*

Some practitioners have tried to address all of these concerns and have suggested that expansion of Medicaid funding could be implemented in a manner that would not produce inappropriate institutionalization. For example, it may be possible to use Medicaid funding as an instrument for deinstitutionalization of detained youth.[138] For children with chronic illness or serious mental health needs, better access to comprehensive assessment and treatment during incarceration may contribute to faster placement in appropriate, community-based programs. Time in placement could almost certainly be reduced by better services in detention that prevent further deterioration of physical or mental conditions.

Dr. William Arroyo, Medical Director for Children's Services for the Los Angeles County Department of Mental Health, who embraces the idea of community treatment and is also a strong advocate for eliminating the inmate exception, points out the need to serve youth who remain in institutions:

> However, the fact remains that there are youth who cannot be released for reasons of public safety and general lack of appropriate services in the community and who suffer needlessly in detention facilities because the institutions don't have funding to pay for these critical services.[139]

Dr Arroyo also notes the importance of transition to the community.

> I am in complete agreement with the statement that Medi-Cal/EPSDT funding could be used to ensure a safe transition to the community.[140]

Abigail English, Director of the Center for Adolescent Health and the Law, also stresses the importance of transition and continuity of care in urging serious consideration of elimination of the inmate exception.

> I am strongly influenced by my belief that for those youth who are eligible, maintaining coverage in a continuous way is far more likely to lead to continuous care and to addressing problems when they arise than can occur with disruptions in Medicaid payments (if not eligibility.)[141]

Before embarking on expanded coverage, Ira Burnim suggests that we need to come to a common understanding of what expansion of mental health treatment in a correctional setting would achieve. How severe are the mental health needs of youth in correctional institutions and what services do these youth really need?

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[138] S. Burrell, "Financing, " in L.S. Thompson and J.A. Farrow, Eds., *Hard Time, Healing Hands: Developing Primary Health Care Services for Incarcerated Youth*, Arlington, VA: National Center for Education in Maternal and Child Health, 1993, p. 209, at p. 227.

[139] E-mail from Dr. William Arroyo, Co-Chair Committee on Juvenile Justice Reform, American Academy of Child and Adolescent Psychiatry, to Sue Burrell (Oct. 15, 2002).

[140] *Id.*

[141] Email message from Abigail English to the authors (Oct. 30, 2002.)

How many require medication or crisis intervention and how many require counselors or someone to talk to? Is the goal to protect incarcerated youth from harm or to provide rehabilitation and treatment? Can you successfully provide rehabilitation services to youth who are incarcerated or are you going to invest a lot of money in a venture that is bound to fail? In simple terms:

> What are we talking about? If you say incarcerated youth need "appropriate services," what are they? What is it that we don't now have that we need?[142]

Mr. Burnim also questions whether increasing Medicaid coverage will necessarily expand services to incarcerated youth. "What's to stop states from getting FFP for what they already do and transferring money into the general fund?" [143]

Abigail English also proposes questions to consider: What would be the cost of various changes? Would more children get care? Who would end up paying for the care? Would the State's costs go up or down? She points out that various options might result in a transfer of obligations from Counties to the State and/or from the State and Counties to the federal government; in this era of fiscal crisis, the question of how costs will play out could be determinative.[144]

Clearly there are important considerations on all sides of this debate. Deliberate attention to all points of view and a more thorough discussion among those involved in treatment for youth in the juvenile justice system could lead to a solution that would provide needed services to youth without contributing to inappropriate institutionalization.

VI. RECOMMENDATIONS FOR FUTURE WORK

A. Information and Data Collection

An accurate picture of the health care needs of youth in the juvenile justice system, their eligibility for health care coverage, and the current funding structure is critical to any future policy work. However, little data exist on health care needs and eligibility for coverage of these youth. The California Endowment could support:

- Better data collection on health care services and outcomes for children in the juvenile justice system, including compliance with Title 15, California Code of Regulations (*Minimum Standards for Juvenile Facilities*) and EPSDT standards.

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[142] Telephone Conversation with Ira Burnim (Oct. 30, 2002).
[143] *Id.*
[144] Email message from Abigail English to the authors.

- Better data collection on Medi-Cal and SCHIP eligibility for children in the juvenile justice system.

- An analysis of the current costs of health care services for youth in the juvenile justice system and the effectiveness of current financing mechanisms.

- Advocacy to require probation departments, juvenile halls, and the California Youth Authority to collect Medi-Cal and SCHIP eligibility information as part of initial health screening.

B. Increasing Medi-Cal Access Under Current Law

California counties could increase their use of Medi-Cal under current state and federal policies. The California Endowment could support efforts to:

- Increase the use of Medi-Cal services, such as early mental health intervention and substance abuse treatment to prevent the need for institutionalization.

- Maximize the use of community-based resources that qualify for Medi-Cal funding. Examples include Therapeutic Behavioral Services (TBS), foster care placement, and wrap around services to allow children to live at home or in a non-institutional setting.

- Advocate for intake and classification policies that divert youth with significant treatment needs from correctional institutions to more appropriate settings that qualify for federal financial participation.

- Help health agencies, probation officials and institutional providers maximize Medi-Cal coverage for children in their care. For example, more counties could access Medi-Cal for youth with a disposition order who are awaiting placement outside an institution.

- Help local jurisdictions identify the characteristics of and increase the number of quality treatment programs that are or could be Medi-Cal eligible – *e.g.,* Regional Facilities for Seriously Emotionally Disturbed Wards, Community Treatment Facilities, or other one-of-a-kind treatment programs.

- Advocate for policies that require juvenile halls and the California Youth Authority to take steps to ensure that youth have immediate access to health care coverage upon release.

C. Policy Clarification

As discussed above, clarifying policy is not without risk. However, clearer policies will encourage more jurisdictions to maximize Medicaid coverage and may expand coverage to children who are currently excluded. The California Endowment could support:

- Advocacy to ensure that California policy does not terminate Medi-Cal eligibility in violation of federal law and to require that children have immediate access to services upon leaving inmate status.[145]

- Advocacy to clarify State regulations and Medi-Cal policy guidance to make language consistent with California juvenile court terminology and eliminate confusing and irrelevant terminology and references.

- Research and/or advocacy to clarify state policy with respect to coverage of services provided in community hospitals to wards of the California Youth Authority.

- Research and/or advocacy to clarify federal policy concerning coverage of youth awaiting juvenile court adjudication.

D. Advocating for Policy Change

As discussed above, elimination of the inmate exception in federal law, or funding institutional services with state Medi-Cal funds, are controversial proposals. A more thorough discussion among those with differing views is necessary before making any recommendation for policy change. The California Endowment could support further discussion of these issues including:

- Whether to eliminate the "Inmate Exception" from federal Medicaid Law; whether to eliminate the exception for children only.

- Whether to provide state Medi-Cal funds to cover children in institutional settings (juvenile halls, camps, California Youth Authority); whether to use partial state Medi-Cal funding to expedite provision of services upon release.

- Whether to seek a federal Medicaid waiver permitting California to cover children in juvenile correctional institutions..

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[145] The need to simplify the process for applying and maintaining coverage, and to assure immediate access upon exiting the juvenile justice and child welfare systems was also recommended by NCCD in *Health Care for Our Troubled Youth*, pp. iii, 22-23.

VII. CONCLUSION

The inmate exception restricts the use the Medicaid and SCHIP funds for youth in the juvenile justice system. Changes in policy and practice could increase FFP under the current law, but elimination of the inmate exception is controversial. The California Endowment could play an important role in maximizing coverage for children under the current law and moving toward a consensus on whether the exception should be eliminated or significantly changed.

APPENDIX A

JUVENILE COURT PROCEEDINGS AND PLACEMENTS

Child Welfare (Dependency) Proceedings

Children may come within the child welfare (dependency) jurisdiction of the juvenile court for a variety of reasons, including serious physical harm inflicted by the parent; neglect; serious emotional damage as a result of the parent's conduct; sexual abuse; abuse, neglect or killing of a sibling; inability of the parent to support the child; or failure to protect the child from cruelty.[146] Children removed from home on one of these grounds by a social worker or peace officer without a court order must be given a detention hearing within one judicial day after the removal.[147] All children receive a jurisdictional hearing to determine whether they come within the provisions of California Welfare and Institutions Code § 300.[148] This is called the adjudication hearing. The court holds a separate hearing to determine the proper disposition for the child.[149] This is called the dispositional hearing.

Children placed out of home through child welfare proceedings are typically placed with relatives, in foster homes (either directly by the county or through foster family agencies,) or in group homes.[150] Since 2001, county operated emergency children's shelters have had to be licensed as group homes.[151] All of these placements are non-secure (unlocked). State law also authorizes Community Treatment Facilities (CTFs) to provide mental health services to children with serious emotional disturbance (SED) in a group setting.[152] These facilities may provide secure confinement, but children have due process rights equivalent to those for commitment to a mental hospital.[153] As of April 2002, the California Department of Social Services reported that five CTFs with 137 beds had been licensed by the Community Care Licensing Division and certified by the Department of Mental Health.[154]

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[146] California Welfare and Institutions Code § 300.
[147] California Welfare and Institutions Code § 315.
[148] California Welfare and Institutions Code § 355.
[149] California Welfare and Institutions Code § 358.
[150] California Welfare and Institutions Code section 361.2; California Health and Safety Code § 1502.
[151] Peremptory Writ of Mandate, *Warren v. Saenz* (No. 317487) San Francisco Superior Court, (Filed May 4, 2001); Community Care Licensing Division, *Children's Residential Update,* Dec. 2001.
[152] California Health & Safety Code § 1502(a) (8), California Welfare & Institutions Code §§ 4094, *et seq*, 22 Calif. Code of Regs. §§ 84110, *et seq.*, 9 Calif. Code of Regs. §§ 1900, *et seq.*
[153] California Welfare & Institutions Code § 4094(g), 9 Calif. Code of Regs. § 1923, California Department of Social Services, Manual of Policies and Procedures 84168.1.
[154] Community Care Licensing Division, Children's Residential Update (April, 2002).

Juvenile Justice (Delinquency) Proceedings

A juvenile justice (delinquency) case begins with an arrest based on alleged commission of a crime, after which the child is released, delivered to a shelter or diversion program; released and cited to appear before the probation officer; or held and transported to the probation officer.[155] The probation officer, in turn, may release the child on a promise to appear, release the child on home supervision, place the child in a non-secure detention facility, or order detention in the juvenile hall.[156] For detained children, a formal juvenile court petition must be filed within 48 hours of being taken into custody, excluding non-judicial days, and the child must be taken before the juvenile court before the expiration of the next judicial day after the petition is filed.[157]

At the juvenile court detention hearing, the petition is read, and the minor admits or denies the allegations.[158] The judge may order the child released, placed on home supervision, placed in a non-secure detention facility, or detained in the juvenile hall pending adjudication (trial) of the case at a jurisdictional hearing.[159] The jurisdictional hearing for children detained in juvenile hall must take place within 15 judicial days of the court's initial detention order.[160] At the time of the jurisdictional hearing, the court hears the evidence in an adjudication (court trial) and decides whether or not the minor comes within the jurisdiction of the court based on proof beyond a reasonable doubt that the minor committed a crime.[161] In many juvenile cases, there is no adjudication, but the minor admits some or all of the allegations in the petition, in a process roughly equivalent to a guilty plea in adult court.[162] In cases where the child is detained, the court may then set the case for disposition up to 10 judicial days after the jurisdictional hearing.[163]

At the disposition hearing, the court decides whether the child will be released on probation, or placed in some form of institutional custody.[164] State law permits the detention of children pending execution of the disposition order, subject to court approval at periodic reviews to be held every 15 days.[165] The statutory timelines for detained juvenile justice cases envision that the adjudication and disposition of the case will occur in approximately a month.[166] Post-disposition

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[155] California Welfare and Institutions Code §§ 626, 626.5.
[156] California Welfare and Institutions Code §§ 628, 628.1, 629, 629.1, 636.2.
[157] California Welfare and Institutions Code §§ 631, 632.
[158] California Welfare and Institutions Code §§ 633, 657.
[159] California Welfare and Institutions Code §§ 636, 636.2.
[160] California Welfare and Institutions Code § 657(a)(1).
[161] California Welfare and Institutions Code §§ 701, 702.
[162] California Rules of Court, Rule 1487(c). Note, that in some cases, children may admit the allegations at an earlier time, such as at the initial detention hearing.
[163] California Welfare and Institutions Code § 702.
[164] California Welfare and Institutions Code §§ 727, 731.
[165] California Welfare and Institutions Code § 737.
[166] In practice it may take much longer for cases to reach disposition because of continuances (California Welfare and Institutions Code § 682). Also, in cases where the prosecutor has filed a

time in custody can be much longer, since it often involves additional time spent waiting for the dispositional order to be carried out, plus the period of custody for whatever facility or program has been ordered by the juvenile court.

Children and youth placed out of home through the juvenile justice system may be placed in foster care, licensed group homes, or community treatment facilities, just like children in the child welfare system.[167] Youth may be incarcerated in juvenile halls pending adjudication (trial) of their case, or as a disposition (sentence). Juvenile halls are sometimes referred to as detention centers. In California, juvenile halls are county-operated,[168] secure (locked) facilities. Youth involved in juvenile justice proceedings may also receive a disposition sending them to a county-operated juvenile home, ranch, camp, or forestry camp.[169] Further, youth involved in juvenile justice cases may receive a disposition committing them to the California Youth Authority.[170] The Youth Authority is a state-operated system of 11 institutions and 4 camps;[171] all of the facilities are secure. California law also allows for the establishment of regional facilities for seriously emotionally disturbed wards.[172]

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petition to have the minor found unfit for treatment in the juvenile justice system, or the minor is detained pending trial in the adult criminal system (California Welfare and Institutions Code §§ 602(b), 707), the length of stay in detention may be much longer.

[167] California Welfare and Institutions Code § 727(a).

[168] California Welfare and Institutions Code § 850.

[169] California Welfare and Institutions Code §§ 628; 636(a); 730(a); and 880.

[170] California Welfare and Institutions Code § 731.

[171] California Youth Authority, "About the CYA", http://www.cya.ca.gov.

[172] California Welfare and Institutions Code §§ 5695 through 5697.5. At the present time, Humboldt County operates the only regional facility, serving Humboldt, Lake, Mendocino and Del Norte Counties. Shortly after the legislation was enacted, there was a plan to operate a regional facility by a number of Southern California Counties (Riverside, San Bernardino, San Diego, Orange, and at some point in the process, Los Angeles). The Southern California project ran into funding problems, and despite ongoing efforts, has not yet come to fruition.

APPENDIX B

LEGAL STANDARDS FOR HEALTH CARE TO CALIFORNIA CHILDREN IN INSTITUTIONAL SETTINGS

California imposes a comprehensive range of standards for health care to children in out-of-home or institutional placements. The standards for children in the child welfare system focus primarily on access to care and responsibility for assuring care, since children in child welfare placements are automatically entitled to receive the full range of EPSDT/Medicaid services. In contrast, the legal standards for children in California juvenile justice facilities delineate the particular services that must be provided. These may or may not be as broad as EPSDT/Medicaid requirements for particular areas of care.

Child Welfare

In California, two departments within the Health and Welfare Agency have responsibilities related to the provision of health care to foster children. The Department of Health Services (DHS) administers health care programs, including Medi-Cal and the Child Health and Disability Prevention (CHDP) program. The Department of Social Services (DSS) establishes and enforces state child welfare policy.

Generally, children in foster care have been removed from their parents or legal guardians and placed in the legal custody of the county welfare department. In some cases, children in the custody of the county probation department or a non-related legal guardian may also be in foster care. Although health care coverage is provided through Medi-Cal and CHDP, responsibility for arranging and consenting to services is fragmented. Depending on the child's circumstances, the legal authority to consent to care may be shared among the child's parents, the Department of Social Services, the foster care provider, and the Juvenile Court. [173] The responsibility for arranging care falls primarily on the child's social worker, but the foster parent or group home may be responsible for actually taking the child to the health care provider.

The child's social worker has responsibility for developing a plan to ensure that the child will receive medical and dental care, paying particular attention to preventive services, including periodic health care assessments in accordance with schedules set in the CHDP Program.[174] The case plan must also include information about the child's health providers, immunization records, medical problems, and medications.[175] Each child must receive a medical and dental

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[173] California Welfare and Institutions Code § 369; California Health and Safety Code § 1530.6.
[174] California Department of Social Services, Manual of Policies and Procedures 31-206.36.
[175] California Department of Social Services, Manual of Policies and Procedures 31-206.35.

examination no later than 30 days after placement (preferably sooner)[176] and appropriate arrangements must be made for necessary treatment.[177] The social worker also has an ongoing obligation to monitor the child's physical and emotional condition and take necessary actions to safeguard the child's growth and development while in placement.[178]

The social worker must provide the child's out-of-home care provider with information about the CHDP program and the medical and behavioral history of the child.[179] The foster parent or group home also has responsibilities designed to ensure that each child receives needed medical and dental services, including medical assessments, immunizations, and first aid, and that medications are stored and administered properly.[180] Specialized foster family and group homes and community treatment facilities (CTF's) have additional requirements.[181]

Juvenile Justice

Health care requirements for children in the juvenile justice system are governed by specific laws and regulations that vary by the type of placement or institution. For example, delinquent children placed in group homes or foster care have the same rights to health care services as those placed through child welfare proceedings (*see discussion, supra*).

Children detained in juvenile halls are entitled to a range of medical and mental health services detailed in Title 15, California Code of Regulations, *Minimum Standards for Juvenile Facilities*, promulgated by the California Board of Corrections.[182] At the time of admission, they are entitled to a systematic intake health screening by health care personnel or health trained staff for intoxication; other conditions requiring medical clearance; medical, dental and health concerns that may need treatment while the minor is in the facility; and communicable disease.[183] Within 96 hours of admission to the facility, children must receive a full "health appraisal/medical examination" by a physician or certified health professional working within his or her scope of practice under the

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[176] California Department of Social Services, Manual of Policies and Procedures 31-206.361.
[177] California Department of Social Services, Manual of Policies and Procedures 31-206.362.
[178] California Department of Social Services, Manual of Policies and Procedures 31-405 (j) & (l).
[179] California Department of Social Services, Manual of Policies and Procedures 31-405(k), (p) & (q).
[180] 22 Calif.Code of Regs. §§ 80069, 80075, 22 Calif.Code of Regs. §§ 84069.1, 84075 (Group Homes), 22 Calif.Code of Regs. §§ 87069, 87075 (Family Foster Homes).
[181] *See, e.g.,* 22 Calif.Code of Regs. § 87069.1 (Individualized Health Plans for Specialized Family Foster Homes), 22 Calif. Code of Regs. § 84069.2 (Individualized Health Plans for Specialized Group Homes), 22 Calif. Code of Regs. §§ 84110, *et seq.* (Community Treatment Facilities.)
[182] 15 Calif.Code of Regs. §§ 1400 through 1454 (Board of Corrections, *Minimum Standards for Juvenile Facilities: Titles 15 and 24, California Code of Regulations: 2001 Revisions*). (Note that the *Minimum Standards* are on the Board of Corrections web site: http://www.bdcorr.ca.gov/regulations/regulations.htm.)
[183] 15 Calif.Code of Regs. §§ 1430, 1431.

direction of a physician.[184] At a minimum, this examination must include a health history, physical examination, laboratory and diagnostic testing, and necessary immunizations.[185] The regulation also provides for medical clearance of minors transferred among facilities in the same detention system.[186] The health care requirements for juvenile halls also apply in county-operated juvenile camps, ranches, forestry camps and boot camps.[187]

While they are detained in California juvenile halls, children may request emergency and non-emergency health services;[188] consent to or refuse non-emergency medical care;[189] receive dental care "necessary to respond to acute conditions and to avert adverse effects on the minor's health";[190] and receive and retain prostheses and orthopedic devices (e.g., medical or dental prostheses, eyeglasses, hearing aids) needed to prevent adverse effects on their health.[191]

In addition, detained children are entitled to a range of mental health services, including screening at intake; crisis intervention; stabilization of mental disorders and prevention of psychiatric deterioration in the facility setting; elective therapy and preventive services where resources permit; medication support; transfer to licensed mental health facilities where the juvenile hall cannot meet treatment needs; and professional assessment of minors exhibiting severe depression, suicidal ideation, violent or self-destructive behavior, or who receive psychotropic drugs.[192] Children in juvenile halls may receive prescription medications or psychotropic drugs in conformity with state regulations.[193]

State law also provides for health services to young people committed to the California Youth Authority. The Youth Authority may authorize the performance of necessary medical, surgical or dental services to wards in its care,[194] and may transfer wards that are "mentally disordered" or "developmentally disabled" to state hospitals for treatment.[195] State law specifically provides for AIDS education of wards; birth control, pregnancy options, and delivery of children by female wards; administration of psychotropic medicines to wards; and procedures for testing for AIDS and tuberculosis.[196]

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[184] 15 Calif. Code of Regs. § 1432(a).
[185] 15 Calif. Code of Regs. §§ 1432(a) (1) (A) through (D).
[186] 15 Calif. Code of Regs. §§ 1432(c) and (d).
[187] 15 Calif.Code of Regs. § 1310(c).
[188] 15 Calif.Code of Regs. § 1433.
[189] 15 Calif.Code of Regs. § 1434.
[190] 15 Calif.Code of Regs. § 1435.
[191] 15 Calif.Code of Regs. § 1436.
[192] 15 Calif.Code of Regs. § 1437.
[193] 15 Calif.Code of Regs. §§ 1438 and 1439.
[194] California Welfare and Institutions Code § 1755.3.
[195] California Welfare and Institutions Code § 1756.
[196] California Welfare and Institutions Code §§ 1123, 1753.6, 1753.7, 1755.4, 1768.9, 1768.10, 1774. There are also institutional policies on these issues, including Department of the Youth Authority, *Institutions and Camps Branch Manual,* "Administration of Medication," Policy No.

Youth Authority policy more specifically addresses wards rights to care for medical emergencies, acute illnesses, traumatic injuries, ongoing care for the maintenance of health, and the correction of significant functional defects that would otherwise result in further loss of function or health impairment, and the right to refuse or consent to treatment.[197] Wards are to receive a complete physical and dental examination upon admission to a reception center-clinic, and before transfer to a Youth Authority camp.[198] Institutional policy also provides guidelines for treatment in the institutions or at outside facilities.[199] The Youth Authority Health Services Branch has its own operational manuals and policies.

Apart from the health services provided to all wards, the California Youth Authority operates a number of programs that provide additional medical and mental health resources. For example, Youth Authority operates an extensive drug and alcohol treatment facility; two sex offender treatment programs; four intensive treatment programs, and four specialized counseling programs.[200] By 2004, Youth Authority will also have three licensed correctional treatment centers, and a licensed mental health facility jointly operated with the Department of Mental Health.[201]

6230; "Family Planning Services," Policy No. 6265; "Pregnancy/Abortion," Policy No. 6270; and "Acquired Immuno-Deficiency Syndrome (AIDS)," Policy No. 6290.

[197] Department of the Youth Authority, *Institutions and Camps Branch Manual*, "Medical Care Guidelines," Policy No. 6170; "Medical Consent," Policy No. 6245; "Refusal of Medical Care," Policy No. 6250; and "Compulsory Care of Institutionalized Wards," Policy No. 6255 (03/97).

[198] Department of the Youth Authority, *Institutions and Camps Branch Manual*, "Admittance to Reception Center-Clinic," Policy No. 6175; "Examination, Ward Transfer to Camp Program," Policy No. 6205 (03-97).

[199] Department of the Youth Authority, *Institutions and Camps Branch Manual*, "Treatment Centers," Policy No. 6180; "Emergency Medical Care," Policy No. 6185; "Outside Hospitalization," Policy No. 6190 (03-97).

[200] Department of the Youth Authority, *Population Management and Facilities Master Plan 2001-2006*, p. 13; Department of the Youth Authority, *Strategic Plan for Mental Health* (July 11, 2000), p. 13.

[201] "Revised and Stipulated Order for Enforcement of Judgment" (filed June 24, 2002), *Morris v. Harper*, Superior Court for the County of San Francisco, Case No. 312092; published decision, *Morris v. Harper*, 94 Cal.App.4th 52 (2001).

APPENDIX C

FEDERAL MEDICAID STATUTE

42 United States Code § 1396d Definitions.

For purposes of this subchapter:

(a) Medical assistance

(27) . . except as otherwise provided in paragraph (16), such term does not include -

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

APPENDIX D

FEDERAL MEDICAID REGULATIONS

42 Code of Federal Regulations § 435.1008 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in Sec. 435 1009; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under Sec. 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22

42 Code of Federal Regulations § 435.1009 Definitions relating to institutional status:

For purposes of FFP, the following definitions apply:

. .

Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

. . .

Public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term ``public institution" does not include

(a) A medical institution as defined in this section;

(b) An intermediate care facility as defined in Secs. 440.140 and 440.150 of this chapter;

(c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or

(d) A child-care institution as defined in this section with respect to

(1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and

(2) Children receiving AFDC--foster care under title IV-A of the Act.

Publicly operated community residence that serves no more than 16 residents is defined in 20 Code of Federal Regulations § 416.231(b)(6)(i). A summary of that definition is repeated here for the information of readers

(a) In general, a publicly operated community residence means—

(1) It is publicly operated as defined in 20 Code of Federal Regulations § 416 231(b)(2).

(2) It is designed or has been changed to serve no more than 16 residents and it is serving no more than 16; and

(3) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 Code of Federal Regulations § 228.1; and

(b) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:

(1) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

(2) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.

(3) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

(4) Hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

APPENDIX E

HCFA MEMORDANDUM, DEC. 12, 1997

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

DEC 12 1997

FROM: Director
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

SUBJECT: Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

TO: All Associate Regional Administrators
Division for Medicaid and State Operations

The purpose of this memorandum is to clarify current Medicaid coverage policy for inmates of a public institution. Recently, central office staff have become aware of a number of inconsistencies in various regional office directives on this subject which have been sent to States. Moreover, the growing influx of inquiries from the internet has prompted us to expand and, in some cases, refine our coverage policy in this area. Therefore, in the interest of insuring consistent and uniform application of Medicaid policy on inmates of a public institutution, we believe that this communication is necessary.

Statute and Parameters

Section 1905(a)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. An individual who is voluntarily residing in a public institution would not be

considered an inmate, and the statutory prohibition of FFP would not apply. Likewise, an individual, who is voluntarily residing in a public educational or vocational training institution for purposes of securing education or vocational training or who is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made, would not be considered an inmate. It is important to note that the exception to inmate status - based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, a facility is a public institution when it is under the responsibility of a governmental unit; or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling or transferring ownership rights of the prison's medical un' 'including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

Exception to Prohibition of FFP

As noted in the above cited statute, an exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and

the 'inmate' is Medicaid-eligible We would note that in those cases where an 'inmate' becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

Policy Application

As a result of a significant number of recent inquiries from the internet and regional offices, we have provided policy guidance involving issues where inmates receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination

Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e.g., transfer to a community residence)
6. Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control

4 Inmates receiving care as an outpatient

5 Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If there are any questions concerning this communication, please contact Thomas Shenk or Verna Tyler on 410 786-3295 or 410 786-8518, respectively.

Robert A. Streimer

APPENDIX F

2002 LETTERS

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 6 2000

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-3215

Dear Mr. Rangel

Thank you for your letter requesting clarification of Federal law regarding the eligibility of detainees/inmates in the New York City jail system. You asked if Federal policy requires or allows States to suspend (or end) Medicaid eligibility for inmates entering the New York City Jail System at Rikers Island. You also asked about Federal policy on reinstating Medicaid eligibility upon release of such an inmate. I regret the delay in this response.

Since Federal Financial Participation is not available for services rendered to a Medicaid-eligible individual during the period of incarceration (see section 1905(a) of the Social Security Act), Federal policy permits (but does not require) States to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed. In addition, for inmates with longer periods of incarceration, a State can periodically redetermine eligibility as required by 42 CFR 435.916, but use simplified procedures to do so. Regardless of the simplified procedures used, a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason.

I have asked Ms. Judy Berek, the Health Care Financing Administration's Regional Administrator for the New York area, to contact the State and ensure that Federal policy is understood and implemented correctly.

I appreciate your bringing this matter to our attention.

Sincerely,

Donna E. Shalala

DEPARTMENT OF HEALTH & HUMAN SERVICES

Administration

Health Care Financing

Refer to

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

September 14, 2000

Kathryn Kuhmerker, Director
Office of Medicaid Management
New York State
Department of Health
Corning Tower - Room 1441
Empire State Plaza
Albany, New York 12237

Dear Ms. Kuhmerker:

As you know, we have received some inquiries regarding Medicaid eligibility for detainees and inmates in the New York City jail system. Since Federal Financial Participation is not available for services rendered to Medicaid-eligible individuals during the period of incarceration (Section 1905(a) of the Social Security Act), Federal policy permits States to use administrative measures that include temporarily suspending eligible individuals from payment status during the period of incarceration.

Additionally for inmates with longer periods of incarceration, specifically a period of time that exceed the State's customary period of time before a eligibility redetermination would be conducted. States can use simplified procedures to redetermine eligibility as required by 42 CFR 435.916. However, a State does not need to do a redetermination as long as the individual remains incarcerated, but once the discharge appears imminent, States must do a redetermination. As per the Health Care Financing Administration's letter of April 7, 2000, States cannot terminate individuals from Medicaid until a redetermination has been conducted, including an ex-parte review.

Regardless of the simplified procedures used, unless a State has determined that an individual is no longer eligible for Medicaid, States must ensure that incarcerated individuals are returned to the rolls immediately upon release. Thus, allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility.

If you have any questions or would like to discuss this further, please contact Patricia Ryan of my staff at (212) 264-9122.

Sincerely,

Joe Kelly
Associate Regional Administrator
Division of Medicaid and State Operations

APPENDIX G

STATE STATUTES

California Welfare and Institutions Code § 14053

(a) The term "health care services" means the benefits set forth in Article 4 (commencing with Section 14131) of this chapter and in Section 14021. The term includes inpatient hospital services for any individual under 21 years of age in an institution for mental diseases. Any individual under 21 years of age receiving inpatient psychiatric hospital services immediately preceding the date on which he or she attains age 21 may continue to receive these services until he or she attains age 22. The term also includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age.

(b) The term "health care services" does not include, except to the extent permitted by federal law, any of the following:

(1) Care or services for any individual who is an inmate of an institution (except as a patient in a medical institution)

...

California Welfare and Institutions Code § 11016

Notwithstanding any other provision of law, no person for whom federal financial participation is available shall be denied benefits, for which federal participation is available, solely because such person is incarcerated in a county or city jail or juvenile detention facility.

APPENDIX H

STATE REGULATIONS

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 22. SOCIAL SECURITY
DIVISION 3. HEALTH CARE SERVICES
SUBDIVISION 1. CALIFORNIA MEDICAL ASSISTANCE PROGRAM
CHAPTER 2. DETERMINATION OF MEDI-CAL ELIGIBILITY AND SHARE OF COST
ARTICLE 6. INSTITUTIONAL STATUS
This database is current through 8/23/2002, Register 2002, No. 34

s 50273. Medi-Cal Ineligibility Due to Institutional Status.

(a) Individuals who are inmates of public institutions are not eligible for Medi-Cal: The following individuals are considered inmates of a public institution:

(1) An individual in a prison, or a county, city, or tribal jail

(2) An individual in a prison or jail: Prior to arraignment, prior to conviction, or prior to sentencing

(3) An individual who is incarcerated, but can leave prison or jail on work release or work furlough and must return at specific intervals

(4) Individuals released from prison or jail due to a medical emergency who would otherwise by incarcerated but for the medical emergency Institutional status of such persons is not affected by transfer to a public or private medical facility

(5) A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity of the minor

(6) A minor, after disposition, placed in a detention or correctional facility, including a youth ranch, forestry camp, or home which is part of the criminal justice system

(7) A minor placed on probation by a juvenile court on juvenile intensive probation with specific conditions of release, including residence in a juvenile detention center

(8) A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is part of the criminal justice system.

(9) Individuals between the ages of 21-65 who are in an institution for mental diseases shall be considered inmates of a public institution until they are unconditionally released

(b) Ineligibility for individuals classified as inmates in (a) begins on the day institutional status commences and ends on the day institutional status ends.

(c) The following individuals are not considered inmates of a public institution and shall be eligible for Medi-Cal provided that all other requirements for eligibility set out in this chapter are satisfied:

(1) An individual released from prison or jail on permanent release, bail, own recognizance (OR), probation, or parole with a condition of:

(A) Home arrest;

(B) Work release;

(C) Community service;

(D) Outpatient treatment;

(E) Inpatient treatment.

(2) An individual who, after arrest but before booking, is escorted by police to a hospital for

medical treatment and held under guard

(3) An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order

(4) An individual released from prison or jail under a court probation order due to a medical emergency.

(5) A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or in the best interest of the child (e g , Child Protective Services) if there is a specific plan for that person that makes the stay at the detention center temporary This would include those juveniles awaiting placement but still physically present in juvenile hall

(6) A minor placed on probation by a juvenile court on juvenile intensive probation with home arrest restrictions.

(7) A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is not part of the criminal justice system

(8) A minor placed on probation by a juvenile court on juvenile intensive probation with treatment as a condition of probation:

(A) In a psychiatric hospital;

(B) In a residential treatment center;

(C) As an outpatient.

(9) Individuals released from an institution for mental diseases or transferred from such an institution to a public or private medical facility

(10) Individuals on conditional release or convalescent leave from an institution for mental diseases

(11) Individuals under age 22 who are patients in an institution for mental diseases, were institutionalized prior to their 21st birthday, and continue to receive inpatient psychiatric care.

APPENDIX I

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO. 241

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

April 18, 2001

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 241

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

REVISIONS TO THE MEDI-CAL ELIGIBILITY PROCEDURES MANUAL--ARTICLE 6

Enclosed are revisions to Article 6, Institutional Status, of the Medi-Cal Eligibility Procedures.

Procedure Revision	Description
Article 6	Revisions of this Article are due to clarifications in policy.

Filing Instructions:

Remove Pages	Insert Pages
Article 6 Procedure Table of Contents Page PTC-7	Article 6 Procedure Table of Contents Page PTC-7
Article 6 Table of Contents Page TC-1	Article 6 Table of Contents Pages TC-1 and TC-2
Pages 6A-1 through 6A-3 Pages 6B-1 and 6B-2 Pages 6C-1 through 6C-3 Pages 6D-1 through 6D-4 Pages 6E-1 through 6E-5 Page 6F-1 Pages 6G-1 through 6G-4	Page 6A-1 Pages 6B-1 through 6B-3 Pages 6C-1 through 6C-3 Pages 6D-1 through 6D-4 Pages 6E-1 through 6E-2 Pages 6F-1 through 6F-8 Pages 6G-1 and 6G-2 Page 6H-1 Page 6I-1 Pages 6J-1 through 6J-4

If you have any questions concerning a specific revision, please contact Ms. Elena Lara at (916) 657-0712.

Sincerely,

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosures

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6A--INTRODUCTION

1. PURPOSE

Medi-Cal is not available to certain individuals in a public institution or in an institution for mental diseases (IMDs). Federal Medicaid regulations prohibit Federal Financial Participation (FFP) for certain individuals due to institutional status . This article will distinguish for both adults and juveniles who is eligible for Medi-Cal benefits if an individual is a resident of a public institution or IMD.

2. BACKGROUND

Title 42, United States Code (U.S.C.), Section 1396d and Title 42, Code of Federal Regulation (CFR), Section 435.1008(a)(1) state that FFP is not available in expenditures for services provided to individuals who are residing in public institutions. Title 42 CFR Section 435.1009 states that an inmate of a public institution is a person who is residing in a public institution.

Under federal guidelines from the Health Care Financing Administration (HCFA), dated January 13, 1992, to the Director of the Arizona Health Care Cost Containment System, the term "inmate of a public institution" was further defined for purposes of Medicaid eligibility under Title XIX of the Social Security Act (SSA) The guidelines clarify that an individual is considered an "inmate of a public institution" from the date of actual incarceration in a prison, county, city, or tribal jail until permanent release, bail, probation, or parole.

Under the Social Security Act (SSA) Section 1905(a)(24)(A) and (B), Medicaid services are available for any individual over age 65 in an institution for mental diseases (IMDs), and is available for psychiatric inpatient hospital services for individuals up to age 22. HCFA Medicaid Regional Memo Number 98 clarified that an individual between the ages of 22 and 65 may be eligible for Medi-Cal/Medicaid, but there is no FFP. These persons may be eligible for state-only Medi-Cal with no FFP.

HCFA has continued to approve California's waiver request for the Medi-Cal Specialty Mental Health Services Consolidation Program authorized under Section 1915(b)(1) and 1915(b)(4) of the Social Security Act as long as California demonstrates that the program is consistent with the purpose of the Medicaid Program and complies with specific conditions set forth in their waiver approval, which include outreach and identification activities and coordination with programs such as foster care, special education, and juvenile justice.

For persons of any age who are detained under the penal system, the responsible third party is the penal institution or administration who retains authority over the individual. Under Section 4011.1 of the Penal Code a county may choose to cover prisoners under the county medical program; however, such coverage is optional. If a county does not choose to cover prisoners, the medical provider must collect directly from the penal authority, i.e., city jail for city prisoners, county jail or sheriff's office for county prisoners, etcetera.

3. IMPLEMENTATION

HCFA guidelines which clarified the federal statute were sent to all county welfare departments on July 7, 1993. A retroactive period of one year previous to this date was granted for any case which resulted in a wrongful denial of Medi-Cal eligibility based upon institutional status. This would include any case wherein the final determination of ineligibility was made during the time period July 7, 1992 until July 7, 1993.

6B--PUBLIC INSTITUTION

1. DEFINITION

Public (nonmedical) institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Individuals in these public institutions are not eligible for Medi-Cal.

2. PUBLIC INSTITUTIONS

The following are identified as public institutions, and Medi-Cal is not available for inmates of these institutions:

- State or Federal Prisons
- Correctional Facilities
- County, city or tribal Jails
- Detention Centers
- CYA Camps

The following facilities may be publicly operated community residences that serve no more than 16 residents, but they are considered public institutions and Medi-Cal is not available for residents of these institutions:

- residential facilities located on the grounds of or adjacent to any large institution;
- correctional or holding facilities for prisoners or individuals being held under court order as witnesses;
- detention facilities, forestry camps, training schools, or any other facility for children determined to be delinquent; or,
- educational or vocational training institutions that provide an accredited program for its residents.

[NOTE: Persons who reside in public institutions in order to receive educational or vocational training provided by the facility (e.g., a state school for the blind) are not considered to be "inmates" of public institutions and are therefore entitled to Medi-Cal coverage if they are otherwise eligible.]

3. NOT PUBLIC INSTITUTIONS

The following facilities are **not public institutions** and Medi-Cal is possible:

- a medical institution;
- an intermediate care facility;

- a publicly operated community residence that serves no more than 16 residents; or
- a child care institution:
  - for children who receive foster care payments under Title IV-E of Social Security Act (SSA);
  - for children who receive CalWORKs-foster care under Title IV-A of SSA;
  - that accommodates no more than 25 children;
- an institution for the mentally retarded or persons with related conditions (chronic disability attributable to cerebral palsy or epilepsy or any other condition other than mental illness closely related to mental retardation); Eligibility and placement is usually through Regional Center Administered by the Department of Developmental Services.
- a community care facility (Health & Safety Code, Section 1502): Any facility, place, or building which is maintained and operated to provide nonmedical, 24-hour residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children.
  - Residential Facility - family home, or group care facility for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for protection of individual.
  - Adult Day Care Facility - provides nonmedical care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for protection of individual on less than 24-hour basis.
  - Therapeutic Day Services Facility - provides nonmedical care, counseling, educational or vocational support, or social rehabilitation services on less than 24-hour basis to persons 18 years or under who would otherwise be placed in foster care or are returning to family from foster care.
  - Foster Family Home - residential facility which provides 24-hour care for six or fewer foster children and is the residence of the foster parent or parents, including their family.
  - Small Family Home - residential facility which provides 24-hour care to six or fewer foster children who have mental disorders or developmental or physical disabilities and who require special care and supervision as a result of their disabilities. This home can also accept children without special health care needs.
  - Social Rehabilitation Facility - a residential facility which provides social rehabilitation services for no longer than 18 months in a group setting to adults recovering from mental illness who temporarily need assistance, guidance, or counseling
  - Community Treatment Facility - residential facility which provides mental health treatment services to children in a group setting.

- Group Homes - residential facility which provides 24-hour care and supervision for juveniles under age 18 who have been adjudged wards of the court for violation of a state or federal law. Pending legislation may require reporting the presence of these juveniles to local law enforcement authorities. (Section 1530.8, Health & Safety Code.)

- Temporary shelter care facility – a 24-hour residential facility owned and operated by the county that provides short-term residential care and supervision for dependent children under 18 years of age who have been removed from their home because of abuse or neglect. (Section 300, Welfare & Institutions Code; Section 1530.8, Health & Safety Code.)

6C--INMATES OF A PUBLIC INSTITUTION

Counties must consider both the facility and the person's circumstances when making a Medi-Cal determination of eligibility for either a juvenile or an adult who is incarcerated or placed in any type of public institution. In making these determinations, follow the guidelines below as well as the chart in Section 6H:

1. THE FOLLOWING MAY NOT RECEIVE MEDI-CAL BENEFITS:

   a. An inmate in a prison;
   b. An inmate of a county, city, or tribal jail; or,
   c. An inmate in a prison or jail:

      - Prior to arraignment;
      - Prior to conviction; or,
      - Prior to sentencing.

      Unless they are out on bail or own recognizance (OR).

   d. An individual who is incarcerated, but can leave prison or jail on work release or work furlough and must return at specific intervals.

   e. Individuals released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency.

   f. A minor in a juvenile detention center prior to disposition (judgment) due to criminal activity of the minor.

   g. A minor, after disposition, placed in a detention or correctional facility, including a youth ranch, forestry camp, or home which is part of the criminal justice system.

   h. A minor placed on probation by a juvenile court on juvenile intensive probation with specific conditions of release, including residence in a juvenile detention center.

   I. A minor placed on probation by a juvenile court or on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is part of the criminal justice system.

2. THE FOLLOWING MAY RECEIVE MEDI-CAL BENEFITS:

   a. An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard

   b. An individual in prison or jail who transfers temporarily (one to two months) to a halfway house or residential treatment facility prior to a formal probation release order.

   c. An individual released from prison or jail on probation, parole, or release order; with a condition of:

      - home arrest;
      - work release;
      - community service;

- outpatient treatment; or,
- inpatient treatment.

d. Individuals released from prison or jail under a court probation order due to a medical emergency.

e. A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or in the best interest of the child (e.g., Child Protective Services) if there is a specific plan for that person that makes the stay at the detention center temporary (one to two months). This could include those juveniles awaiting placement but still physically present in juvenile hall.

f. A minor placed on probation by a juvenile court on juvenile intensive probation with home arrest restrictions.

g. A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is not part of the criminal justice system. This would include juveniles who become wards of the court and placed in a 24-hour non-medical residential facility which provides counseling and other rehabilitative services. (AB 2773 (Ch. 1056, Stats. 1998); AB 2310 (Ch. 572, Stats. 1998.)

h. A minor placed on probation by a juvenile court or on juvenile intensive probation with treatment as a condition of probation:

- in a psychiatric hospital;
- in a residential treatment center; or,
- as an outpatient.

i. Individuals with tuberculosis who are under an order of detention to protect public health:

- In a residential treatment center,
- In a skilled nursing facility,
- In a county, city, or tribal jail awaiting placement for treatment.

3. INMATES UNDER PENAL CODE SECTIONS 1367, 1370, and 1372

a. **Penal Code 1367:** Those charged with a misdemeanor, but who are incompetent to stand trial, and who will be treated by a mental health facility.

Penal Code Section 1367 provides that "A person cannot be tried or adjudged to punishment while that person is mentally incompetent." If the judge finds reason to believe that the defendant may be incompetent to stand trial, he/she may order that the defendant be referred for 72-hour treatment and evaluation. Defendant may receive Medi-Cal benefits. If evaluation results in placement in a mental health facility for treatment, then the individual may receive Medi-Cal services. **Place the individual in an appropriate aid code for disability.**

b. **Penal Code 1370:** A Murphy Conservatorship may be established if a state hospital patient charged with a specified serious felony is not restored to competence upon expiration of a Penal Code 1370 commitment. The establishment of a Murphy Conservatorship ends the Penal Code commitment, regardless of the expiration date of the Penal Code 1370

commitment. A Murphy Conservatorship requires the determination that the patient is gravely disabled in accordance with Welfare and Institutions Code (WIC) Section 5008 (h)(1). This state hospital patient may receive Medi-Cal benefits and should be placed in a qualifying aid code.

c. **Penal Code 1372:** Those felons incompetent to stand trial, previously treated at the state hospital, but whose competency has been restored and are returned to the Inpatient Unit to stand trial. When a defendant is returned to court with a certification that competence has been regained, the court shall determine whether the person is entitled to be admitted to bail. An individual who is released from incarceration on bail is not a resident of a public institution, and may be eligible for Medi-Cal. If not released on bail, the individual is likely to be held in a prison or jail prior to conviction or sentencing. The individual would then be a resident of a public institution, and would not receive Medi-Cal benefits.

6D--JUVENILES IN PUBLIC INSTITUTIONS

In determining the Medi-Cal eligibility of juveniles (under the age of 18), the Health Care Financing Administration (HCFA) distinguishes between the nature of the detention, pre- and post-disposition situations, and types of facilities.

1. Disposition

Disposition in a juvenile case is the decision made by the court for the juvenile's welfare. A disposition order is the court decision as to whether the minor will be placed in foster care, sentenced, placed on probation, or released either temporarily or permanently. When the juvenile is adjudged a "Ward of the Court" and is awaiting foster care placement and not awaiting sentencing for a criminal violation of law, the juvenile is eligible for Medi-Cal.

2. Before Disposition

A juvenile who is in a detention center due to criminal activity is a resident of a public institution and is not eligible for Medi-Cal.

A juvenile who is in a detention center due to care, protection, or in the best interest of the child is not an "inmate of a public institution" if there is a specific plan for him/her that makes the stay temporary (one to two months). He/She may be eligible for Medi-Cal.

3. After Disposition

Juveniles on intensive probation with a plan of release which includes residence in a detention center are not eligible for Medi-Cal benefits until released. If the juvenile is placed on intensive probation in a residential facility, he/she is eligible for Medi-Cal benefits if the facility is not part of the criminal justice system.

4. Nature of the Facility

The nature of the facility is extremely important in determining Medi-Cal eligibility because federal regulations at Title 42, Code of Federal Regulations, Section 435.1008 prohibit Federal Financial Participation (FFP) to "inmates of public institutions." Title 42 CFR 435.1009 defines a public institution. Publicly operated community residences that serve no more than 16 residents are excluded from this definition except as specified in 6B-2, and FFP is allowed for these facilities. These facilities may be psychiatric nursing facilities licensed by the Department of Mental Health or other community care facilities. In making an eligibility determination, both the **status** of the juvenile and the **facility** must be taken into consideration. The juvenile is not eligible if he/she is a resident of a public institution for a criminal offense.

EXAMPLE:

A juvenile is detained for criminal activity. He/she is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from this detention center, he/she would be placed on probation with his/her mother. Because of the nature of his/her custody and the nature of the facility as a detention center (public institution), he/she is not eligible for Medi-Cal benefits. The juvenile is living in a public institution and is not eligible for Medi-Cal benefits during the period of incarceration. After release from the detention center and while on probation, the juvenile may be eligible for Medi-Cal benefits.

Do not consider that a short stay in a detention facility as set forth above is a temporary placement pending other arrangements. Under HCFA guidelines, this would be incorrect. Incarceration in a detention center due to criminal activity makes the juvenile an inmate of a public institution and ineligible for Medi-Cal benefits. If the juvenile were awaiting placement in juvenile hall after his/her case was adjudicated and he/she was declared a Ward of the Court, he/she would be eligible for Medi-Cal because he/she would be considered a foster care child awaiting placement by the court.

5. Foster Care

The purpose of the Foster Care Program is to provide financial and medical assistance for those children who are in need of substitute parenting and who have been placed in foster care -- that is, outside of the home of the parents or legal guardian. Juveniles may be declared Wards of the Court with the Court being the entity that decides which placement is in the best interests of a juvenile or child. Foster Care placement may be in a relative's or non-relative's home as well as a ranch, institution, group home, or a facility which offers 24-hour non-medical care and is not under the criminal justice system.

Foster Care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. This is clarified in Section 903 of the Welfare and Institutions Code, Liability for Costs of Support. The Medi-Cal program automatically grants a Medi-Cal card to children in Foster Care.

Foster Care children are excluded from being classified as an "inmate of a public institution" when such children are temporarily in an institution pending more suitable arrangements such as Foster Care placement in a foster family or group home. Specifically, this includes a minor in a juvenile detention center prior to disposition (judgment) due to care, protection or in the best interest of the child (e.g., Child Protective Services) if there is a specific plan for that person that makes the stay at the detention center temporary (one to two months). This could include those juveniles awaiting placement but still physically present in juvenile hall.

The Kin-GAP Program was implemented on January 1, 2000, via the California Department of Social Services All County Letter No. 99-97. This program specifically serves children who are leaving the foster care system and enter a guardianship with a relative. Two new aid codes have been designated for the Kin-GAP program:

4F: Kin-GAP program for children in relative placement receiving cash assistance with federal financial participation (FFP) on cash payments. Children in this aid code receive full-scope Medi-Cal services.

4G: Kin-GAP program for children in relative placement receiving cash assistance with no FFP on the cash payments. This is a state-only cash assistance program in which children will receive full-scope Medi-Cal benefits.

6. Emergency Assistance (EA) Program

The EA program is a federally funded program under Title IV-A of the Social Security Act. Federal funding of 50 percent (50 percent federal/50 percent county) is available for a period of up to 12 months or until the emergency is over, whichever is less, for children under the age of 22 in accordance with 45 CFR 233.120. Eligibility for EA requires that an emergency must exist within the family in order for a child to be considered eligible for assistance.

There are two distinct definitions of an "emergency" that apply to probation cases and child welfare services cases. The definition of an emergency for a probation case is "a child's behavior that results in the child's removal from the home and a judicial notice that the child must remain in out of home care for more than 72 judicial hours." The definition of an emergency for a child welfare services case is "a child is at risk of abuse, neglect, abandonment or exploitation."

The Medi-Cal program has implemented two new aid codes to be used for the EA Foster Care portion of the EA program:

- 4K - for probation cases which result in out-of-home Foster Care; and,
- 5K - for children at risk of abuse, neglect, abandonment, or exploitation placed in out-of-home Foster Care.

Children receiving EA services who are temporarily detained in an institution, such as a county operated juvenile assessment center or residential treatment facility pending foster care placement, are prohibited from being placed into the 4K (Probation) or 5K (Child Welfare Services) aid codes. These children, if determined Medi-Cal eligible, will remain in aid code 45.

7. **Sample Disposition Orders**

In making a determination of eligibility for a juvenile who has entered the juvenile justice system, it is very important to review the judge's decision. The decision or dispositional order must be read to determine both the **status** of the minor and to determine the **nature** of the facility where he will be placed. Because of the diversity of juvenile and adult court orders and the judgements rendered and/or specific situations pertinent to each individual case, several case situations and the Medi-Cal eligibility determination are listed below to demonstrate that each must be read individually to determine Medi-Cal eligibility.

a. Juvenile Court Order Status: Minor is in Foster Care in Licensed Residential Treatment Facility. Minor is eligible for Medi-Cal.

b. Juvenile Court Order Status: Minor is on Probation Awaiting Placement in Foster Care. Minor is eligible for Medi-Cal.

c. Juvenile Court Order Status: Minor is on Probation with residence in Licensed Residential Facility pending permanent placement. Minor is eligible for Medi-Cal.

d. Juvenile Court Order Status: Placement in psychiatric facility - furtherance of detention under Section 602. Minor is not eligible for Medi-Cal.

e. Juvenile Court Order Status: Minor is placed in Residential Treatment Center and then Psychiatric Hospital. Minor is eligible for Medi-Cal.

f. Juvenile Court Order Status: Minor is placed with parents with permission to place minor in Mesa Vista Hospital. This would be viewed as Foster Care/Probation Placement with parents. Minor is eligible for Medi-Cal. If committed to psychiatric unit, Minor would continue to be eligible for Medi-Cal.

g. Juvenile Court Order Status: Minor is released on Probation to parents with hospital stay; then placement to 24-hour school on release from hospital. Minor is eligible for Medi-Cal because Minor is on probation. If 24-hour school is part of criminal justice system and is a correctional facility, then Minor would not be eligible for Medi-Cal.

h. Juvenile Court Order Status – Minor is declared a Ward of the Court and is placed in a non-profit, residential facility which is a boy's camp to receive mentoring and counseling services. The facility is a 24-hour, non-medical facility which is not part of the criminal justice system. The minor would be eligible for Medi-Cal services. A ward of the court is a child for whom the court will make a determination for placement as a foster child.

The following Exhibits are included as examples of Disposition Orders:

a. Exhibit A - Probation to Correctional Facility

A sample court order for a minor ordered to a juvenile detention center for a temporary period (one to two months) pending placement. This minor is eligible for Medi-Cal because of the temporary placement and because he/she is on probation.

b Exhibit B - Sentence to Correctional Facility

A sample court order for a minor committed to a correctional facility to serve a sentence--Clifton Tatum Center (correctional detention center) for five days. This minor is not eligible for Medi-Cal because he/she has been sentenced to a correctional facility for criminal activity.

c. Exhibit C - Placement in Foster Care

A sample court order for a juvenile placed on probation and ordered to suitable placement. If placement is in foster care and not a correctional facility, this minor is eligible for Medi-Cal.

6E--INSTITUTION FOR MENTAL DISEASES (IMD)

1. Definition

IMDs are defined in federal law as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an IMD.

2. IMD Exclusion

The Social Security Act, Section 1905(a) (Title 42, United States Code (U.S.C.), Section 1396d); Title XVI, Supplementary Security Income for the Aged, Blind and Disabled, Section 1611 (Title 42, U.S.C., Section 1382); and Title 42, Code of Federal Regulations (CFR), Sections 435.1008 and 1009) prohibit federal financial participation (FFP) through Medi-Cal for individuals who are between 21 and 65 years of age in an IMD. However, even though the Act prohibits FFP for services provided to individuals in IMDs, they are still Medi-Cal eligible with no FFP. HCFA clarified that even though FFP is not available for services, this does not mean that the individuals may not be Medicaid eligible. They can be Medicaid eligible but there is no FFP for services.

3. Services Provided to Individuals 21 to 65 Years of Age in an IMD:

- Facility charges (the daily bed rate) is paid for by the county realignment program set up by the Bronzan-McCorquodale Act of 1992 for IMDs that are skilled nursing facilities with a special treatment program certified by the State Department of Mental Health and administered by the county mental health departments. The facility will bill the county mental health department.

- State-Only Medi-Cal outpatient ancillary services include Medi-Cal covered physician services, prescription drugs, laboratory and X-ray services, and dental and vision services. The facility or the service provider will bill the Medi-Cal program for these state-only services. When the beneficiary is a member of a Medi-Cal managed care plan, the facility or the service provider will bill the Medi-Cal managed care plan.

- State-Only Medi-Cal outpatient ancillary services include psychiatrist and psychologist services. When these services are delivered to treat the diagnoses listed in Title 9, California Code of Regulations, Section 1830.205, the services are the responsibility of county mental health plans (MHPs). The facility or the service provider will bill the county MHP. When the services are delivered to treat other diagnoses, the facility or service provider will bill the Medi-Cal program or the Medi-Cal managed care plan, if the beneficiary is a member of one of the few Medi-Cal managed care plans that cover specialty mental health services.

The CWD shall determine the Medi-Cal eligibility of an individual admitted to an IMD or who is a resident of an IMD as follows:

- If disability has not been established, request determination for disability, and place the individual in Aid Code 53 until disability has been determined.

- When disability has been approved, place the individual in a disability aid code.

- The provider will bill Electronic Data Systems (EDS), the Medi-Cal managed care plan or the MHP as appropriate for state-only Medi-Cal outpatient ancillary services provided by the facility or other service providers.

- If the individual is transferred to a nursing facility that is not an IMD, the nursing facility may bill EDS or the Medi-Cal managed care plan for the facility charges. The provider of outpatient ancillary services may continue to bill for these services as described above.

- Share of Cost – In determining share of cost for these individuals, the county would allow a $35 maintenance need. The difference between the individual's countable income and this maintenance need would be their share of cost (SOC). The Department of Mental Health must determine and capture the portion of IMD care which is paid for by the individual. The medical expense which is paid for by the individual must then be sent to Medi-Cal in order to clear the SOC.

4. Individual 22 Years of Age in an IMD

Under Section 1905(a) of the Social Security Act, if an individual between the ages of 22-65 has been receiving psychiatric inpatient hospital services prior to his/her 21st birthday and receives such services continuously until the age of 22, he is eligible for Medi-Cal benefits. Counties should continue to use Aid Code 82 (Medically Indigent - Children Under 21).

For an individual under 21 who is a patient in an IMD, the aid code assigned would be appropriate for the medical condition. If the individual was assigned Aid Code 82, a normal Eligibility Status Action Code (ESAC) ("1" or "6") could be used to place him/her in this aid code. When the individual reaches 21 years 1 month of age, he/she is placed on hold at Renewal and the alert message, "SPECIAL ESAC REQUIRED FOR AID CODE OR AID CODE AND AGE," is issued to the county. The county can put a qualifying individual back on Medi-Cal Eligibility Data System (MEDS) in Aid Code 82 by assigning a special ESAC of "4" or "9." The individual then remains eligible until age 22. At age 22 and 1 month, he/she will be placed on hold at Renewal and the alert message, "AGE NOT WITHIN ACCEPTABLE RANGE FOR AID CODE," is issued to the county. At this time, eligibility needs to be re-determined, and, if still eligible, place in a qualifying aid code.

Counties will be able to use Aid Code 82 with an ESAC of "4" or "9" on the following batch and line transactions:

EW05 Transfer County of Responsibility
EW15 Request Medi-Cal ID Card-New Eligible or Data Change
EW20 Add New Recipient
EW30 Modify Existing MEDS Record (Individual)

6F--MENTAL HEALTH MANAGED CARE

The State of California has expanded managed care in the Medi-Cal program in order to improve beneficiaries access to quality, coordinated services, and this includes implementation of a Medi-Cal Managed Mental Health Care System.

Phase I of this plan was the reform of the Short-Doyle/Medi-Cal program which was accomplished in 1993. Phase II was the consolidation of Short-Doyle and other Medi-Cal Specialty Mental Health Services. A Mental Health Plan (MHP) in each county is responsible for payment/authorization of Specialty Mental Health services through a contract with the State Department of Mental Health. Phase II was fully implemented on July 1, 1998

Phase III will be the implementation of full capitated funding for mental health services through managed care contracts. State hospitals, however, will not be included in this capitation program.

The goal is to ultimately provide a system that will ensure that adequate services are accessible and provided in a coordinated, efficient, cost effective, and culturally competent manner, and under which mechanism care will be coordinated between the various physical health and mental health care facilities The program provides specialty mental health services to ALL Medi-Cal beneficiaries in the county through a Mental Health Plan (MHP), a managed care plan specializing in mental health services.

1 Beneficiary Notice

In mid-1998 all counties were sent a packet of the Beneficiary Notice Re Medi-Cal Specialty Mental Health Services in Different languages. The notice was to be displayed in the county welfare offices and to be given to each Medi-Cal applicant or beneficiary.

2 Individuals Eligible to Receive Specialty Mental Health Services through the MHP:

All Medi-Cal beneficiaries are eligible to receive medically necessary psychiatric inpatient hospital, rehabilitative and case management services.

3. Medi-Cal Share of Cost

Mental health plans are required to cover Medi-Cal services. Medi-Cal beneficiaries with a share of cost are not eligible for Medi-Cal services until they meet their share of cost. Mental health beneficiaries are identified as an individual who has been certified eligible for services under the Medi-Cal program. Certification would mean that this beneficiary had met his/her share of cost. Once share of cost is met, the MHPs are responsible for providing services. However, this does not preclude a Medi-Cal beneficiary with a share of cost from receiving services from a provider in the MHP. The beneficiaries' payments to the mental health provider can count towards meeting the share of cost just as in the Medi-Cal program MHPs are not contractually obligated to provide services before the share of cost is met, but they are not prohibited from doing so.

4. Not Qualified Aliens Under PRWORA

PRWORA prohibits certain Legal Permanent Residents and undocumented aliens from receiving full-scope Medi-Cal benefits. This would hold true for provision of mental health services through the county MHP. These aliens would receive emergency services. A 72-hour hold in Medi-Cal matches the criteria for an emergency admission for psychiatric inpatient hospital services, so the service would be covered for aliens with restricted benefits such as in Aid Code 58.

5. Minor Consent

   Beneficiaries in Minor Consent aid codes in Medi-Cal are eligible for mental health benefits provided by the MHPs to the extent the services are covered by the aid category; e.g., psychiatric inpatient hospital services are not minor consent services and are not provided to beneficiaries in minor consent aid codes by the MHPs.

6. County MHPs are listed on the next few pages with local and toll-free telephone numbers, address, and implementation date:

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
Alameda County Mental Health Plan 2000 Embarcadero Cove, Suite 400 Oakland, CA 94606 Local Number: (510) 567-8100 Toll-free Number: 1-800-491-9099	November 1, 1997	Colusa County Department of Behavioral Health Services 85 East Webster Street Colusa, CA 95932 Local Number: (530) 458-0520 Toll-free numbers: Business hours 1-888-793-6580 After hours 1-800-700-3577	April 1, 1998
Alpine County Mental Health Svcs. P.O. Box 545 Markleeville, CA 96120 Local Number: (530) 694-2146 Toll-free Number: 1-800-486-2163	June 1, 1998	Contra Costa County Mental Health Plan 595 Center Avenue, Suite 200 Martinez, CA 94553 Local Number: (925) 313-6101 Toll-free Number: 1-888-678-7277	April 1, 1998
Amador County Mental Health Plan 20 North Highways 49/88 Jackson, CA 95642 Local Number: (209) 223-6412 Toll-free Number: 1-888-310-6555	April 1, 1998	Del Norte County Mental Health Plan 206 Williams Drive Crescent City, CA 95531 Local Number: (707) 464-7224 Toll-free Number: 1-888-446-4408	April 1, 1998
Butte County Department of Behavioral Health 107 Parmac Road, Suite 4 Chico, CA 95926 Local Number: (530) 891-2810 Toll-free Number: 1-800-334-6622	April 1, 1998	El Dorado County Mental Health Plan 344 Placerville Drive, Suite 20 Placerville, CA 95667 Local Numbers: Beneficiaries call Administration (530) 621-6200 Placerville clinic (530) 621-6290 South Lake Tahoe clinic (530) 573-3251 Providers call (530) 621-6200 Toll-free Number: 1-800-929-1955	June 1, 1998
Calaveras County Mental Health Department 891 Mountain Ranch Road San Andreas, CA 95249 Local Number: (209) 754-6525 Toll-free Number: 1-800-499-3030	April 1, 1998	Fresno County Mental Health Plan 2536 No. Grove Industrial Drive Fresno, CA 93727 Local Numbers: (559) 488-2796 (8 a.m.-5 p.m.) Toll-free Number: 1-800-654-3937	April 1, 1998

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
Glenn County Mental Health 242 North Villa Willows, CA 95988 Local Number: (530) 934-6582 Toll-free Numbers: Business hours 1-888-624-5820 After hours 1-800-700-3577	April 1, 1998	Kern County Mental Health Department P.O. Box 1000 Bakersfield, CA 93302 Local Number: (805) 868-6600 Toll-free Number: 1-800-991-5272	November 1, 1998
Humboldt County Medi-Cal Managed Care Mental Health Care 720 Wood Street Eureka, CA 95501 Local Number: (707) 268-2955 Toll-free Number: 1-888-849-5728	April 1, 1998	Kings View Mental Health and Substance Abuse Services for Kings County 1393 Bailey Drive Hanford, CA 93230 Local Numbers: (209) 582-4481 (Hanford) (209) 992-2111 (Corcoran) (209) 386-5222 (Avenal) Toll-free Number: 1-800-655-2553	April 1, 1998
Imperial County Mental Health Plan 801 Broadway El Centro, CA 92243 Local Numbers: For Beneficiaries (760) 339-4501 (clinic) (760) 339-4496 (patient rights Advocate) For Providers (760) 339-4501 Toll-free Number: 1-800-817-5292	April 1, 1998	Lake County Mental Health Plan 922 Bevins Court Lakeport, CA 95453 Local Number: (707) 263-2258 Toll-free Number: 1-800-900-2075	June 1, 1998
Inyo County Mental Health Plan 162 J Grove Street Bishop, CA 93514 Local Number: (760) 873-6533 Toll-free Number: 1-800-841-5011	April 1, 1998	Lassen County Mental Health Plan 555 Hospital Lane Susanville, CA 96130 Local Number: (530) 251-8108 Toll-free Numbers: Beneficiaries 1-888-289-5004 Providers 1-888-530-8688	January 1, 1998
Los Angeles County Local Mental Health Plan 550 South Vermont Avenue 12th Floor Los Angeles, CA 90020 Local Numbers: Beneficiaries (213) 738-2814 Providers (213) 738-4949 Toll-free Number: 1-800-854-7771	June 1, 1998	Merced County Mental Health Department 480 East 13th Street Merced, CA 95340 Local Number: (209) 381-6800 Toll-free Number: 1-888-334-0163	April 1, 1998

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
Madera County Mental Health Department 14215-A Road 28 Madera, CA 93638 Local Number: (209) 657-7850 Toll-free Number: 1-888-275-9779	April 1, 1998	Modoc County Mental Health Services 131-A Henderson Street Alturas, CA 96101 Local Number: (530) 233-6312 Toll-free Number: 1-800-700-3577	April 1, 1998
Marin Mental Health Plan Community Mental Health Services 250 Bon Air Road Greenbrae, CA 94904 Local Numbers: Beneficiaries (415) 499-4271 Providers (415) 499-7587 Toll-free Number: 1-888-818-1115	January 1, 1998	Mono County Mental Health P.O. Box 2619 Mammoth Lakes, CA 93546 Local Number: (760) 934-8648 Toll-free Numbers: Business hours 1-800-687-1101 After hours 1-800-700-3577	April 1, 1998
Mariposa Counseling Center Mariposa County 5085 Bullion Street Mariposa, CA 95338 Local Numbers: Beneficiaries (209) 966-2000 Providers (209) 966-2000 Toll-free Numbers: Beneficiaries 1-800-549-6741 Providers 1-800-549-6741	January 1, 1998	Monterey County Behavioral Health 1270 Natividad Road Salinas, CA 93906-3198 Local Number: Providers (408) 755-4509 Toll-free Number: 1-888-258-6029	January 1, 1998
Mendocino County Mental Health Services 860 North Bush Street Ukiah, CA 95482 Toll-free Number: 1-800-555-5906	January 1, 1998	Napa County Mental Health Plan 2261 Elm Street Napa, CA 94559-3721 Local Number: (707) 259-8151 Toll-free Number: 1-800-648-8650	April 1, 1998

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
Nevada County Mental Health Plan 10433 Willow Valley Road, Ste. A Nevada City, CA 95959 Local Number: (530) 265-1437 Toll-free Number: 1-888-801-1437	April 1, 1998	Sacramento County Mental Health Plan 2130 Stockton Boulevard Sacramento, CA 95817 Local Number (916) 875-1055 Toll-free Number: 1-888-881-4881	June 1, 1998
Orange County ABC Behavioral Health Plan 405 West 5th St., Ste. 550 Santa Ana, CA 92701 Toll-free Numbers: Beneficiaries 1-800-723-8641 Providers 1-800-716-1166	January 1, 1998	San Benito County Mental Health Plan 1111 San Felipe Road, Ste. 104 Hollister, CA 95023 Local Number (408) 636-4020 Toll-free Number: 1-888-636-4020	April 1, 1998
Placer County Mental Health Svcs. 11533 C Avenue Auburn, CA 95603 Local Number: (530) 889-6791 Toll-free Number: 1-800-895-7479 Also Serves Sierra County	November 1, 1997	San Bernardino County Dept. of Behavioral Health 700 E. Gilbert Street, Bldg. 6 San Bernardino, CA 92415 Local Number: (909) 381-2420 Toll-free Number: 1-888-743-1478 Toll-free (TDD): 1-888-743-1481	April 1, 1998
Plumas County Mental Health Plan 270 County Hospital Road, Ste. 229 Quincy, CA 95971 Local Number: (530) 283-6307 Toll-free Number: 1-800-757-7898	April 1, 1998	County of San Diego Mental Health Plan 3851 Rosecrans Street San Diego, CA 92110 Local Number: (619) 641-6800 Toll-free Numbers: Beneficiaries 1-800-479-3339 Providers 1-800-798-2254	July 1, 1998
Riverside County Mental Health Plan P.O Box 7549 Riverside, CA 92513 Toll-free Number: 1-800-706-7500	November 1, 1997	San Francisco Mental Health Plan 1380 Howard Street, 5th Floor San Francisco, CA 94103 Local Number: (415) 255-3737 Toll-free Number: 1-888-246-3333	April 1, 1998
San Joaquin County Mental Health Plan 1212 North California Street Stockton, CA 95202 Toll-free Number: 1-888-468-9370	November 1, 1997	Shasta County 2640 Breslauer Way Redding, CA 96001 Local Number: (530) 225-5200 Toll-free Number: 1-888-385-5201	January 1, 1998

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
San Luis Obispo County Mental Health Plan 2180 Johnson Avenue San Luis Obispo, CA 93408 Local Number: (805) 781-4768 Toll-free Number: 1-800-838-1381	April 1, 1998	For Sierra County – See Placer County	
Santa Barbara County Mental Health Plan 300 North San Antonio Santa Barbara, CA 93101 Local Number for providers: (805) 884-1639 Toll-free Number: 1-888-868-1649	April 1, 1998	County of Siskiyou Behavioral Health Plan 804 South Main Street Yreka, CA 96097 Local Number: (530) 841-4100 Toll-free Numbers: 1-800-842-8979 (24 hours) 1-800-452-3669 (After-hours crisis line)	January 1, 1998
Santa Clara County Mental Health Department 645 South Bascom Avenue San Jose, CA 95128 Toll-free Number: 1-800-704-0900	June 1, 1998	Mental Health Plan of Sonoma County 3322 Chanate Road Santa Rosa, CA 95404 Toll-free Number: 1-800-870-8786	April 1, 1998
Santa Cruz County Mental Health Plan 1400 Emeline Avenue Santa Cruz, CA 95060 Local Number (408) 454-4170 Toll-free Number: 1-800-952-2335	June 1, 1998	Stanislaus County Mental Health Plan 800 Scenic Drive Modesto, CA 95350 Local Number for Providers: (209) 558-4639 Toll-free Number: 1-888-376-6246	January 1, 1998
Sutter-Yuba Bi-County Mental Health Plan (SYCMHP) 1965 Live Oak Boulevard Yuba City, CA 95591 Local Number: (530) 822-7200 Toll-free Number: 1-888-923-3800	April 1, 1998	Ventura County Mental Health Plan 300 Hillmont Avenue Ventura, CA 93003 Toll-free Number: 1-800-671-0887	April 1, 1998
Tehama County Mental Health Plan Tehama County Health Agency-- Mental Health Division 1860 Walnut Street Red Bluff, CA 96080 Local Number: (530) 527-5637 Toll-free Number: 1-800-240-3208	April 1, 1998	Yolo County Mental Health Plan 14 North Cottonwood Street Woodland, CA 95695 Local Number: (530) 666-8630 Toll-free Number: 1-888-965-6647	January 1, 1998

Address/Telephone Number	Implementation Date	Address/Telephone Number	Implementation Date
Trinity County Counseling Center P O. Box 1640 1 Industrial Park Way Weaverville, CA 96093 Local Number: (530) 623-1362 Toll-free Number: 1-888-624-5820	April 1, 1998	Yuba County Refer to: Sutter-Yuba Bi-County Mental Mental Health Plan	
Tulare County Health & Human Services Mental Health Branch 3300 South Fairway Visalia, CA 93277 Local Numbers: For beneficiaries (209) 733-6880 For providers (209) 733-6690 Toll-free Number: 1-800-320-1616	April 1, 1998	San Mateo County Mental Health Plan 225 37th Avenue San Mateo, CA 94403 Local Numbers: Beneficiaries (650) 573-2303 Provider Relations: (650)573-2226 Consumer Relations: (650)573-2635 Toll-free Number:1-800-686-0101	April 1, 1995
Tuolumne County Mental Health Kings View Corporation 12801 Cabezut Road Sonora, CA 95370 Local Number: (209) 533-3553 Toll-free Number: 1-800-630-1130	June 1, 1998	Solano Partnership Health Plan Of California 421 Executive Court North, Suite A Suisun City, CA 94585 Local Numbers: Beneficiaries: (707)863-4120 Providers: (707)863-4284 Toll-free Number: 1-800-547-0495	May 1, 1995*

*Solano County provides Medi-Cal specialty mental health services through its county organized health system.

6G--FLEEING FELONS

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Fleeing Felons are not eligible for CalWORKs, SSI/SSP, or Food Stamps. Medi-Cal eligibility is not denied. Drug abuse felons are likewise not eligible for the three programs, but they are distinctly allowed Medi-Cal benefits. Therefore, individuals who have violated probation or parole by committing a criminal act are eligible for Medi-Cal benefits until they are re-booked and incarcerated.

1. Fleeing Felon:

   An individual who is ". . . fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or which, in the case of New Jersey, is a high misdemeanor under the laws of such State; or violating a condition of probation or parole imposed under Federal or State law." (PRWORA)

   Fleeing Felons are subject to all the eligibility requirements of this Article and to Article 21 of the Medi-Cal Eligibility Procedures Manual (MEPM). Fleeing Felons who have not been booked, sentenced, or incarcerated are eligible for Medi-Cal benefits until one of the three has occurred.

2 Income Eligibility Verification System (IEVS)

   The following data match systems have been implemented in the IEVS system:

   a. Jail Registry System (JRS) Match - This match will be processed monthly from records submitted to the JRS by the city and/or county jails in the State of California. County staff are required to process matches received on all active Medi-Cal cases to determine if Medi-Cal benefits were received by a beneficiary while residing in a public institution for a criminal offense. (Article 21M of MEPM)

   b. California Youth Authority System (CYA) - CYA data files will be matched against MEDS for beneficiaries for the month of incarceration plus one prior month. County staff are required to process matches received and follow instructions in Recipient System Procedures Article 21E. (Article 21J of MEPM)

3. SSI CODES

The following chart identifies NEW Social Security Administration Payment Status Codes that will be sent through the State Data Exchange (SDX) regarding termination of benefits for certain individuals who are not eligible under PRWORA and the Balanced Budget Act for SSI benefits. These codes are for individuals who are not eligible for SSI/SSP-based Medi-Cal because of their residency status.

County welfare departments are not to do anything with these SDX codes. A&I will receive these codes and will review and evaluate the individual and will inform the county of the status of the individual on a form entitled "A&I Branch Investigative Report." At that point, the county may discontinue or deny Medi-Cal eligibility if necessary.

PAYMENT STATUS CODE (MEDS QX SCREEN)	RESIDENCY STATUS	MEDI-CAL ONLY ELIGIBILITY
N22	Claimant is an Inmate of a Public Institution.	Ineligible
N23	Claimant is not a resident of the United States.	Restricted Services
N24	Claimant has been convicted of a felony of fraudulently misrepresenting residence in order to receive benefits/services (SSI, Medicaid, CalWORKs, Food Stamps) simultaneously in two or more states.	Ineligible
N25	Claimant is fleeing to avoid prosecution for, or custody or confinement after conviction for, a crime which is a felony under the law of the place from which he/she flees, or is violating a condition of probation or parole imposed under Federal or State Law.	Eligible Until Re-Incarcerated

Attachment 1: Eligibility Chart

6H--CHART

INSTITUTIONAL STATUS OF AN INDIVIDUAL

	JUVENILES					VOLUNTARY (Including Parolee/ Probationer)		
TYPE OF INSTITUTION	Pre-Booking	Sentenced 21-64	Sentenced 65 or Over	Under W&I 601, 300*	Sentenced W&I 602	Others Under 21	21-64	65 or Over
Public Nonmedical Institution (Correctional)	Eligible	Ineligible	Ineligible	Eligible	Ineligible	Ineligible	Ineligible	Ineligible
Public or Private General Medical Facility (non-IMD)	Eligible	Ineligible	Ineligible	Eligible	Ineligible	Eligible	Eligible	Eligible
Public or Private Mental Facility IMD)	Eligible	Ineligible	Ineligible	Eligible to Age 22 in Specific Facilities	Ineligible	Eligible to Age 22 in Specific Facilities	Eligible	Eligible
Community Care Facility or Residential Treatment Center, or Board and Care Home (non-correctional)	Eligible	Ineligible	Ineligible	Eligible	Ineligible	Eligible	Eligible	Eligible
Public or Private Intermediate Care or Skilled Nursing Facility (non-IMD)	Eligible	Ineligible	Ineligible	Eligible	Ineligible	Eligible	Eligible	Eligible
House Arrest	Eligible	Eligible	Eligible	Eligible	Eligible	Eligible	Eligible	Eligible

NOTE:

1. Approval of an application of an inmate eligible above shall be contingent upon all other eligibility criteria being met.
2. Person institutionalized prior to their 21st birthday is eligible until they reach their 22nd birthday as long as they remain continuously institutionalized and receive inpatient psychiatric care in an acute psychiatric hospital or a psychiatric health facility certified by Medi-Cal to provide inpatient hospital services.
3. Individuals released on bail or own recognizance (OR) are eligible for Medi-Cal.
4. Welfare and Institutions Code Number Explanations:
   a. W&I 300 - Person needs care due to mental or physical deprivation.
   b. W&I 601 - Uncontrollable - Ward of Court.
   c. W&I 602 - Violation of law.
5. No one under sentence is eligible for Medi-Cal. However, under Penal Code Section 1367, if a person is incompetent to stand trial, he remains in a mental facility and is eligible for Medi-Cal.
6. If a Murphy Conservatorship is established, sentence is terminated and person is eligible for Medi-Cal.
7. If a person is under sentence but transferred to a residential treatment center or board and care home prior to release, he/she is eligible for Medi-Cal.
8. Fleeing Felons and violators of probation and parole are eligible for Medi-Cal until they have been re-incarcerated.
9. Individuals under an order of detention because of TB are eligible for Medi-Cal unless they are booked and sentenced for a criminal offense.

6I--NOTICES OF ACTION

Since Title 22, California Code of Regulations (CCR), Section 50273, precludes Medi-Cal eligibility for certain institutionalized individuals from the date of entry into an institution through the date of release, a ten-day Notice of Action (NOA) is not required prior to discontinuance as discontinuance due to entry into an institution is not considered an adverse action (Title 22, CCR, Section 50015). County welfare departments should immediately discontinue individuals found to be institutionalized/sentenced for a violation of law with an appropriate NOA and request return of the Medi-Cal card. The discontinuance date would be the actual day the individual is booked and placed in a jail cell.

A NOA for the Specialty Mental Health Program may be used:

1 When the MHP (or its provider) assesses a beneficiary and decides that the beneficiary does not meet medical necessity.

2. When the MHP denied, reduces/modifies, defers longer than 30 days or terminates services that a provider is requesting.

The fair hearing process has not been changed. Notices of Action will be printed in threshold languages of California beneficiaries.

6J--QUESTIONS AND ANSWERS

This section contains various questions that have been asked regarding institutional status and our responses to those questions.

QUESTION 1:

Since there is a real distinction between detention, adjudication, and dispositional orders issued under Welfare and Institutions (W&I) Code, Section 602, and since Section 50273(a)(2) of the Medi-Cal Eligibility Procedures Manual specifically identifies only children detained under Section 602, is a child who is in Juvenile Hall awaiting placement in a foster home or group home as a result of a dispositional order of the Juvenile Court eligible for Medi-Cal benefits since the dispositional court order supersedes the detention orders?

RESPONSE:

Children who are paroled or placed on probation under Section 602 are not considered to be under a penal hold (see Title 22, California Code of Regulations, Section 50273(d)). Similarly, children who have completed their sentence, or against whom all charges have been dropped or dismissed, are not considered to be under a penal hold. Such children could be eligible for Medi-Cal even if still physically present in the Juvenile Hall. The MC 250 would be an appropriate application for these children if they are awaiting placement in foster care (Title 22, California Code of Regulations, Section 50161(b)). Any other "disposition order" would require further review to establish eligibility. Please be advised that a very common problem which occurs with juveniles on probation under Section 602 is that the probation department frequently continues to refer to the juvenile as a "602 child." Eligibility workers should be very careful to accurately ascertain the status of the child prior to completing the eligibility determination. In addition, county probation departments should be advised that the generic term "602 child" is confusing and could lead to an improper denial of Medi-Cal benefits.

QUESTION 2:

In some counties a court may review an arrested juvenile's record and decide to place the child in an alternative living arrangement under the supervision of the probation department without sentencing the child or placing the child on probation. Is such child eligible for Medi-Cal?

RESPONSE:

Such juveniles are generally first-time offenders or repeat offenders the court believes would benefit from removal from an abnormal home situation or from severance of past associations. These are wards of the court, and the court order will generally dispose in some way of the charges brought against the child, i.e., drop the charges, suspend the sentence, place the child on probation, etc. These children would be eligible.

QUESTION 3:

Is a "602 child" in a mental institution eligible?

RESPONSE:

A child placed by the court in a mental institution for pretrial or presentencing observation or who is sentenced to a mental institution is not eligible. Similarly, a child sentenced to Juvenile Hall or other correctional facility and then transferred to a mental institution due to abnormal behavior is not eligible. A child on probation against whom the charges have been dropped or the sentence suspended or completed is eligible.

QUESTION 4:

Are juveniles arrested and incarcerated under Penal Code sections, rather than Section 602 of the W&I Code, eligible?

RESPONSE:

Anyone of any age who is arrested and incarcerated is ineligible regardless of the code section used. However, most juveniles will initially be arrested under Section 602 even though they may later be charged as adults if the court so decides.

QUESTION 5:

A minor child is sentenced to a term of incarceration. However, due to inadequate space in the juvenile detention center, the child is temporarily placed in a foster home pending available space in the detention center. Is this child eligible?

RESPONSE:

The child is ineligible. The penal authority retains full responsibility for the child, and anyone serving a sentence and not formally released is ineligible.

QUESTION 6:

Are adult offenders sentenced to mental institutions eligible?

RESPONSE:

No. An adult over 22 and under 65 years of age who is serving a sentence for a criminal offense is not eligible when residing in a mental institution. Persons over 65 years of age who are sentenced for a criminal offense are not eligible. Any individual, child or adult, is not eligible if serving a sentence in a mental institution. See the chart on 6H of this Article.

QUESTION 7:

Are pregnant women serving sentences in jail or prison eligible?

RESPONSE:

No. Care for such women is the responsibility of the jail or prison. However, once born the child is eligible even if living with the mother in the jail or prison as the child has committed no criminal offense and is not sentenced to the jail/prison regardless of the living arrangement.

QUESTION 8:

Are persons sentenced under alternative sentencing methods eligible?

RESPONSE:

Eligibility depends on the wording of the sentence rendered by the court as well as the legal responsibility of a law enforcement agency. In short, to be eligible, the sentence rendered by the court must include the periodic release of the individual and the individual must be released from the jurisdiction of the law enforcement agency for periods of not less than 24 consecutive hours with the law enforcement agency retaining no responsibility for the needs of the individual during that period. Several examples are set forth below:

EXAMPLE A:

An individual is sentenced by the court to serve a term in jail. The sentence provides that the individual is to be permitted to leave the jail daily to attend or go to work; however, the individual must return to the jail after work or school each day and remain incarcerated on weekends, holidays, etc

RESPONSE A:

This individual is not eligible while serving the sentence. The penal authority retains the responsibility for the individual's care and support.

EXAMPLE B:

An individual is sentenced to jail only on weekends but is not incarcerated during the week by order of the court.

RESPONSE B:

This individual is eligible only during the week and becomes ineligible every weekend. The penal authority is only responsible for the individual's care on weekends.

EXAMPLE C:

A married couple is sentenced to jail. However, due to the presence of minor children in the home, the court orders that each parent be released on alternate weeks so that one parent is available to care for the children.

RESPONSE C:

Each parent is eligible for the weeks spent in the home and ineligible for any week in which he/she is incarcerated.

EXAMPLE D:

An individual is sentenced to be incarcerated for a given period with no provision for temporary release as described above. The penal authority chooses to place the individual in such a program without confirmation by the court, alteration of sentence, formal parole, or probation.

RESPONSE D:

The individual is not eligible. The penal authority has not been released from responsibility for the individual's care.

EXAMPLE E:

An individual is sentenced to perform community service work in lieu of incarceration. The individual resides at home, performs his/her community service, and is (usually) loosely supervised to ensure compliance with the sentence.

RESPONSE E:

This individual is eligible. The individual is not the financial responsibility of a penal authority until and unless the individual fails to comply with the sentence requirements. If the individual fails to comply with the sentence and is, as a result, incarcerated, the individual becomes ineligible

APPENDIX J

FEDERAL SCHIP PROVISIONS

STATUTE

42 United States Code § 1397jj Definitions

(a) Child health assistance

For purposes of this subchapter, the term "child health assistance" means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 1397ee(a)(1)(D)(i) of this title, payment for part or all of the cost of providing any of the following), as specified under the State plan: ...

(b) "Targeted low-income child" defined ..

(2) Children excluded

Such term does not include -

(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; ...

REGULATION

42 Code of Federal Regulations § 457.310 Targeted low-income child:

(c) Exclusions. ...

(2) *Residents of an institution*. A child must not be –

(i) An inmate of a public institution as defined as § 435.1009 of this chapter;