Improving Access to Medi-Cal for Youth in the Juvenile Justice System

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Attachments:

Executive Summary

This is the report of a multi-year effort, funded by The California Endowment, to improve Medi-Cal coverage for youth in the California juvenile justice system. In 2002, the Youth Law Center, commissioned by The Endowment, researched California's implementation of the Medicaid inmate payment exception, which prohibits federal Medicaid funding for services provided to an inmate of a public institution. The Youth Law Center found significant barriers to health care coverage for youth in the juvenile justice system and identified problems in the way California implements federal law.[1] These findings formed the basis for a Youth Law Center project designed to improve Medi-Cal coverage by:

- providing training and technical assistance to counties, focusing particularly on coverage for youth who move in and out of secure facilities such as juvenile halls;

- providing consultation to the California Division of Juvenile Justice (DJJ) (formerly the California Youth Authority) to assist DJJ in obtaining coverage for youth transitioning out of state facilities; and

- initiating discussions with the California Department of Health Services (CDHS) to encourage CDHS to improve state policy and increase the support and technical assistance CDHS provides to counties.

Project objectives were:

1) Improved knowledge in the field about barriers to health coverage and funding for incarcerated populations;

2) Improved capacity for county probation and health personnel to utilize Medi-Cal services for youth in the juvenile justice system, including incarcerated youth to the extent permissible under federal law;

3) County uniformity in leveraging federal resources for Medi-Cal eligible juvenile justice youth;

4) Reduction in gaps to mental health and health care services as youth move to less restrictive levels of care; and

[1] S. Burrell and A. Bussiere, *The "Inmate Exception" and Its Impact on Health Care Services for Children in Out-of-Home Care in California,* Youth Law Center (November 2002) (hereafter "Inmate Exception Paper.")

5) Improved capacity for CDHS to support counties in properly interpreting the inmate payment exception law.

The Youth Law Center, working with the Chief Probation Officers of California (CPOC), the Probation Youth Subcommittee of the Accessing Health Services for California's Children in Foster Care Task Force, and public health professionals, conducted a series of Symposia in Sacramento (June 2005), Fresno (October 2005), and Los Angeles (April 2006) to help county probation, public health, mental health, and eligibility staff learn about Medi-Cal policies that apply to youth in the juvenile justice system, share best practices, and discuss ways to overcome the problems they encounter in providing health care services to the youth they serve. More than 300 individuals from 40 counties participated in the Symposia.

The Youth Law Center conducted a preliminary survey of probation, public health, and other county staff to identify current practices, promising ideas, and barriers to health care coverage. Before each Symposium, the Youth Law Center collected additional data from participants as part of the registration process to identify the level of familiarity participants had with Medi-Cal issues and the questions that most concerned them. At the end of each Symposium, participants completed a written evaluation. Three months after each Symposium, the Youth Law Center conducted a follow-up survey of participants to identify what had been accomplished, whether the Symposium and written materials were helpful in practice, and what challenges remained.

Youth Law Center attorneys, CPOC, and Probation Youth Subcommittee members also met several times with staff from the California Department of Health Services to discuss barriers to Medi-Cal coverage for youth in the juvenile justice system, and confusion about Medi-Cal policies, particularly those implementing the inmate payment exception. CDHS staff members were invited to participate in all three Symposia and to respond to the questions about Medi-Cal policy raised by Symposium participants.

On October 5, 2006, the Youth Law Center convened a final project meeting to solicit comments on a draft of this report and discuss draft recommendations.

Key Project Findings

1. Training, information sharing, and discussion of the issues have improved knowledge in the field about barriers to health care coverage and funding for incarcerated populations.

2. Improved knowledge about Medi-Cal and new relationships among professionals serving youth in the juvenile justice system have increased the capacity of county probation and health personnel to utilize Medi-Cal services.

3. Some counties have improved their ability to leverage federal resources for Medi-Cal eligible youth in the juvenile justice system; however, differences among counties still exist.

4. Data is not available to identify services provided or to measure gaps in mental health and health care services for youth in the juvenile justice system.

5. Individual CDHS staff members provide helpful information when county staff seek answers to specific questions, but CDHS could provide additional leadership and assistance in helping counties access Medi-Cal for youth in the juvenile justice system.

6. Some Medi-Cal policies impede access to Medi-Cal for eligible youth and create additional work for county probation, public health, and eligibility staff.

7. Some counties have developed practices to expedite Medi-Cal coverage and maintain continuity of care as youth move to less restrictive forms of care; however, challenges remain.

8. Some counties have used Medi-Cal and other funding sources to develop evidence-based programs and services to avoid unnecessary incarceration.

9. Some professionals in the juvenile justice system recommend elimination of the inmate payment exception altogether.

Recommendations

1. CDHS should revise Medi-Cal policies to (1) implement the inmate payment exception without terminating Medi-Cal eligibility, (2) clarify provisions that have caused confusion, and (3) make policies more consistent with the juvenile justice system and easier to understand.

2. A mechanism should be developed to provide ongoing training on Medi-Cal issues and to facilitate sharing of information and best practices to individuals who work with youth in the juvenile justice system. CDHS and other state agencies should expand the technical assistance provided to county probation departments and other professionals working with youth in the juvenile justice system by providing on-site training, consultation, and problem solving.

3. Counties and the Division of Juvenile Justice should increase health care coverage for youth in the juvenile justice system by: (1) identifying sources

of health care coverage for youth as early as possible; (2) making health care coverage part of services, disposition, and transition planning; and (3) assisting youth to establish eligibility for Medi-Cal, Healthy Families, and other programs.

4. Counties should fully implement the Health and Education Passport (HEP) for youth in the juvenile justice system, and the Child Welfare Services/Case Management System (CWS/CMS) should be accessible to probation staff.

5. Interdisciplinary teams that include probation, public health, eligibility, mental health, and other relevant professionals should meet regularly to resolve problems, review and improve practices, and make policy recommendations at the county and state level.

6. California should collect and track health care data, including health care coverage, for youth in the juvenile justice system and use it to identify trends, evaluate the effectiveness of programs and services, and improve the system overall.

7. California should expand the Health Care Program for Children in Foster Care (HCPCFC) to provide public health nurses in all county probation departments and to provide services to youth in juvenile detention facilities, regardless of placement recommendation, and to youth returning to the community.

8. The California Health and Welfare Agency should resolve problems that inappropriately terminate Medi-Cal coverage, interfere with continuity of care, and/or create additional work for county staff in obtaining health and mental health services for eligible youth.

9. The Counties and the Division of Juvenile Justice should use Medicaid and other funds to develop and expand alternatives to secure confinement for youth who can safely live in the community.

10. Juvenile justice and mental health professionals, advocates, and others involved with the juvenile justice system should continue the discussion about the advisability of the inmate payment exception policy and the best ways to provide adequate mental health services to youth in the least restrictive setting.

Immediate Next Steps

At the October 5, 2006 meeting and in subsequent comments, participants identified some immediate next steps:

1. Work together to effectively implement the provisions of SB 1469.[2]

2. Use SB 1469 as an opportunity to discuss other ways of improving continuity of health care for youth in the juvenile justice system.

3. Develop a tool kit that includes information about Medi-Cal and other resources for serving youth in the juvenile justice system.

4. Create a mechanism for interdepartmental and interagency training and technical assistance, which may include California Department of Health Services, California Department of Mental Health, California Department of Social Services, California Department of Developmental Services, California Department of Education, California Department of Corrections and Rehabilitation, California Department of Alcohol and Drug Programs, and experienced staff from the counties. Coordinate with existing training resources such as the regional Training Academies.

5. Begin a dialogue to identify and amend Medi-Cal policies that create barriers to health care services for youth in the juvenile justice system.

6. Continue current efforts such as the California Juvenile Justice Data Project[3] and the dialogue with California Department of Social Services to make CWS/CMS more accessible to probation departments.

[2] SB 1469 (Cedillo) enacted in 2006, requires county juvenile detention facilities to provide information to the county welfare department in relation to youth committed to a county juvenile hall, ranch, or camp for 30 days or longer, for the county welfare department to begin the Medi-Cal eligibility process. Parents are to be given the opportunity to opt out, and applications are to be expedited in cases where the youth is scheduled to be released in fewer than 45 days. With the parent's consent, applications are to be forwarded to the Healthy Families Program or other health coverage program, if Medi-Cal eligibility cannot be established. If Medi-Cal eligibility is established, the youth must be given documentation enabling him or her to obtain medical care upon release. The Bill is to be implemented through protocols and procedures developed by CDHS in consultation with the Chief Probation Officers of California and the County Welfare Directors Association by June, 2007.

[3] The Juvenile Justice Data Project is a multi-year project aimed at analyzing California's state and county-level juvenile justice data collection system with an eye to improving the system's capacity to collect data and outcomes.

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I. Introduction

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- providing training and technical assistance to counties, focusing particularly on coverage for youth who move in and out of secure facilities such as juvenile halls;

- providing consultation to the California Division of Juvenile Justice (DJJ) (formerly the California Youth Authority) to assist DJJ in obtaining coverage for youth transitioning out of state facilities; and

- initiating discussions with the California Department of Health Services (CDHS) to encourage CDHS to improve state policy and increase the support and technical assistance CDHS provides to counties.

Project objectives were:

1) Improved knowledge in the field about barriers to health coverage and funding for incarcerated populations;

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3) County uniformity in leveraging federal resources for Medi-Cal eligible juvenile justice youth;

[4] S. Burrell and A. Bussiere, *The "Inmate Exception" and Its Impact on Health Care Services for Children in Out-of-Home Care in California,* Youth Law Center (November 2002) (hereafter "Inmate Exception Paper.")

4) Reduction in gaps to mental health and health care services as youth move to less restrictive levels of care; and

5) Improved capacity for CDHS to support counties in properly interpreting the inmate payment exception law.

II. Background

Youth involved with the juvenile justice system have enormous health care needs. As a group, they suffer disproportionately from acute and chronic health problems.[5] Mental health needs are of particular concern. In 2001, the Little Hoover Commission estimated that the prevalence of mental illness for California youth in the juvenile justice system ranges from 50 to 90% as compared with 10% for children in the general population. Recent national studies confirm the high rate of mental disorders among these youth.[6] A one day snapshot of youth in California county juvenile facilities in mid-2006 revealed that 3,071 youth had open mental health cases and 1,158 were receiving psychotropic medication.[7]

Many of these mental health needs remain unmet. Hundreds of California youth are detained in county juvenile halls awaiting community mental health treatment.[8] The gaps in county level mental health services mean that some youth who would most appropriately be served at the county level are committed to the state system. Yet these problems exist at the state level as well; experts have found mental health treatment for youth in Division of Juvenile Justice (DJJ) facilities to be severely lacking.[9] While DJJ is actively engaged in efforts to

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[5] K. Clark & S. Gehshan, *Meeting the Health Needs of Youth Involved in the Juvenile Justice,* National Academy for State Health Policy (September 2006). Available at: http://www.nashp.org/Files/Health_Needs_of_Youth_in_JJ_System_9.2006.pdf. R. Gupta, K. Kelleher, K. Pajer, J. Stevens, and A. Cuellar, "Delinquent Youth In Corrections: Medicaid and Reentry Into the Community," *Pediatrics*, Vol. 115, No. 4 *(*April 2005); pp. 1077-1083.

[6] *See, e.g.,* J. Shufelt and J. Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Mulit-State Prevalence Study,* Research and Program Brief, National Center for Mental Health and Juvenile Justice (June 2006). Available at: http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf.

[7] California Department of Corrections and Rehabilitation, Corrections Standards Authority, *Juvenile Detention Profile Survey Second Quarter 2006*, p. 5. Available at: http://www.cya.ca.gov/DivisionsBoards/CSA/JuvenileDetentionSurveyResults/JDSRdocs/2006_2nd_Quarter_full_report.pdf

[8] United States House of Representatives, Committee on Government Reform-Minority Staff, Special Investigations Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in California* (January 2005). Available at: http://www.democrats.reform.house.gov/Documents/20050124112914-80845.pdf. S. Burrell and A. Bussiere, *"Difficult to Place": Youth with Mental Health Needs in California Juvenile Justice,* Youth Law Center (August 2005). Available at: http://ylc.org/DifficulttoPlaceAugust2005final.doc.

[9] E. Trupin and R. Patterson, *Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities (December 2003);* H. Steiner, et al., *The Assessment of the Mental Health System of the California Youth Authority: Report to Governor Davis* (December 31, 2001). *See also,* M. Puisis and M. LaMarre, *Review of Health Care Services in the California Youth Authority (CYA)* (August 23, 2003).

improve mental health services in its facilities as part of corrective action in the *Farrell v. Hickman* litigation, there is increasing recognition that the state system must not serve as a repository for youth with serious mental health needs, and that local capacity to serve these youth must increase. DJJ is seeking to reduce the number of youth with serious mental health needs in its facilities and has pledged to work with state and local stakeholders to find appropriate mental health placements for these youth.[10]

Mental health services are of particular concern for youth of color who are in the juvenile justice system. The National Mental Health Association reports that children of color, particularly African American males, are underserved by community mental health systems, and are more likely to be treated in a manner that moves them deeper into the juvenile justice system once they come in contact with that system.[11] In addition, increased attention is being focused on the unmet needs of girls with mental health disorders who are involved with the juvenile justice system.[12]

Many young people do not have adequate access to health care before they enter the juvenile justice system, and some suffer from conditions that develop or worsen while they are in custody.[13] Adequate health care coverage is essential not only to improve the health status of these youth but also to support evidence-based alternatives to incarceration and successful transition from secure

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[10] California Department of Corrections and Rehabilitation, Division of Juvenile Justice, *Mental Health Remedial Plan* (August 24, 2006), p. 35. Available at: http://www.cya.ca.gov/DivisionsBoards/DJJ/docs/MentalHealthPlan.pdf

[11] National Mental Health Association, *Mental Health and Youth of Color in the Juvenile Justice System* (2006). Available at: http://www.nmha.org/children/justjuv/colorjj.cfm. A report by the United States Surgeon General confirms that striking disparities in mental health treatment exist for racial and ethnic minorities, United States Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity. A Report of the Surgeon General* (2001). Available at: http://www.mentalhealth.samhsa.gov/cre/default.asp.

[12] B. Veysey, *Adolescent Girls with Mental Health Disorders Involved with the Juvenile Justice System,* Research and Program Brief, National Center for Mental Health and Juvenile Justice (July 2003). Available at: http://www.ncmhjj.com/pdfs/Adol_girls.pdf. L. Prescott, *Adolescent Girls with Co-Occurring Disorders in the Juvenile Justice System,* GAINS Center (December 1997). Available at: http://www.ncmhjj.com/pdfs/publications/GAINS_Adol_girls.pdf.

[13] Health care needs of California children in the child welfare and juvenile justice system are discussed at greater length in C. Hartney, M. Wordes, and 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")*, National Council on Crime and Delinquency (Mar. 15, 2002) commissioned by The California Endowment, particularly pages 1-3 and 8-10. Available at: www.nccd-crc.org/nccd/pubs/2002_youth_healthcare.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. Available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/4/799. *Also see*, A. Dienst and L.K. Foster, *Mental Health Needs and Services for Youth in the Foster Care and Juvenile Justice Systems: An Annotated Bibliography of Selected Resources*, California Research Bureau (August 2005). Available at: http://www.library.ca.gov/crb/05/notes/v12n1.pdf.

confinement.[14] Although health care coverage alone will not ensure that youth receive necessary services, adequate coverage removes a significant barrier to appropriate care and increases the likelihood that youth will receive continuity of care when they move in and out of state care or between placements.[15] This, in turn, may prevent many youth from intruding farther into the juvenile justice system and from experiencing unnecessary incarceration simply because they are unable to access needed services.

Most youth involved in the California juvenile justice system are eligible for Medi-Cal, California's Medicaid program.[16] However, state policies and local practices can impede access to Medi-Cal by eligible youth. One of these barriers is California's implementation of a federal restriction often known as the "inmate payment exception." The inmate payment exception denies federal financial participation (FFP) for medical assistance provided to any individual who is an inmate of a public institution, and California has chosen not to cover these services with state Medi-Cal funds. As a result, counties bear the cost of providing heath and mental health services to youth in their juvenile justice facilities.

The federal inmate payment exception is specifically defined in federal law. Not all youth involved in the juvenile justice system are affected, and some services provided to youth who reside in institutions can be covered. (*See* Attachment 6 for a more complete explanation.) For example, FFP is available after arrest but before booking into a correctional institution and when a youth is living in an institution for a temporary period pending other arrangements appropriate to his or her needs. However, the rules are complicated and not always clear to the

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[14] Gupta, *supra;* B. Kamradt, *Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities*, Research and Program Brief, National Center for Mental Health and Juvenile Justice (December 2002), pp. 4-5, http://www.ncmhjj.com/pdfs/publications/Funding_Mental_Health_Services.pdf. *See also,* K. Skowyra and S. Davidson Powell, *Juvenile Diversion: Programs for Justice-Involved Youth with Mental Health Disorders,* Research and Program Brief, National Center for Mental Health and Juvenile Justice (June 2006). Available at: http://www.ncmhjj.com/pdfs/publications/DiversionRPB.pdf.

[15] Clark & Gehshan, *supra* at pp. 7 & 9.

[16] Although exact data on Medi-Cal eligibility is not available, a significant number of youth involved in the juvenile justice system are low income and therefore likely eligible for Medi-Cal. 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. 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, 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 Calif. Welf. & Inst. Code § 5967.5. County estimates of Medi-Cal eligibility ranged from 15% to 99%, with an average estimate of 47%. *Id.,* at p. 22. The researchers cautioned that, "Estimates were based on perception, since no documentation of that information was routinely kept on a statewide basis." *Id.*, at p. 25.

juvenile justice officials who must administer them. Some of the rules were written with adults in mind and do not make sense when applied to youth or the juvenile justice system.

Even though California law prohibits the denial of Medi-Cal coverage when FFP is available,[17] some youth have been denied Medi-Cal coverage for services that should be covered. In addition, California's practice of terminating Medi-Cal eligibility, rather than suspending coverage during periods of inmate status requires eligible youth to reapply for Medi-Cal. This creates additional work for families and county staff and causes delays in service and interruptions in continuity of care. While the Medi-Cal program permits retroactive payment for services provided to youth who are ultimately found to be eligible, many providers are unwilling to gamble on the outcome of the eligibility determination process and decline to provide services to youth who lack evidence of current Medi-Cal coverage.

Thousands of California youth are affected by the inmate payment exception as they move in and out of juvenile institutions. At the end of 2005, over 13,000 youth were housed in county juvenile halls, camps, or other county juvenile facilities,[18] and 2,881 were living in Division of Juvenile Justice facilities.[19] Many are youth of color. According to the California Department of Justice, youth identified as Hispanic, black, or Asian were less likely to be diverted from the juvenile justice system and more likely to be confined in a secure correctional facility than youth identified as white.[20]

Other barriers also inhibit effective health care coverage for these youth, particularly as they transition from institutional care to less restrictive settings or the community. Some barriers, such as the difficulty in obtaining services when youth are placed out of county, are shared with all youth in out-of-home care. Others, such as the failure to screen youth for health insurance eligibility and assist in enrollment, are missed opportunities to help youth who come into contact with government agencies.

III. Methodology

In this project, the Youth Law Center, working with the Chief Probation Officers of California (CPOC), the Probation Youth Subcommittee of the Accessing Health

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[17] Calif. Welf. & Inst. Code § 11016.

[18] California Department of Corrections and Rehabilitation, Corrections Standards Authority, *Juvenile Detention Profile Survey Fourth Quarter 2005*. Available at: http://www.corr.ca.gov/DivisionsBoards/CSA/fsod/juvenile_detention_survey/2005/quarter_4/full_report.pdf.

[19] California Department of Correction and Rehabilitation, Division of Juvenile Justice, *Population Overview as of December 31, 2005.* Available at: http://www.cdcr.ca.gov/ReportsResearch/docs/research/POPOVER2005.pdf.

[20] California Department of Justice, Division of California Justice Information Services, *Juvenile Justice in California 2004*, pp. 85 and 87.

Services for California's Children in Foster Care Task Force, and public health professionals conducted a series of Symposia in Sacramento (June 2005), Fresno (October 2005), and Los Angeles (April 2006) to help county probation, public health, mental health, and eligibility staff learn about Medi-Cal policies that apply to youth in the juvenile justice system, share best practices, and discuss ways to overcome the problems they encounter in providing health care services to the youth they serve.

The Youth Law Center conducted a preliminary survey of probation, public health, and other county staff to identify current practices, promising ideas, and barriers to health care coverage. Eighty-seven individuals from 53 counties responded; 42 participants worked in probation, and 45 were public health nurses. Before each Symposium, the Youth Law Center collected additional data from participants as part of the registration process to identify the level of familiarity participants had with Medi-Cal issues and the questions that most concerned them. The results were shared with Symposium presenters to permit speakers to research questions and adjust their presentations to meet the needs of the participants. Results were also shared with staff at the California Department of Health Services (CDHS.) The Youth Law Center and the presenters prepared a conference notebook with extensive written resources, including federal and state statues, regulations, and policies; forms, flow charts, and other practical materials developed by county staff; and background policy and advocacy materials. (*See,* Lists of Materials, Attachment 1.)

More than 300 individuals from 40 counties participated in the Symposia. (*See,* Participants Lists, Attachment 2). Youth Law Center attorneys provided an overview of the juvenile justice system and Medi-Cal, and county panels provided information about strategies and programs that they had put into practice to increase access to health care. (*See,* Agendas, Attachment 3.) After the presentations, participants met in county groups to discuss what they had learned and how it could be applied in practice. Each county group completed a county discussion form that identified what they planned to do next and what help they needed. At the end of each Symposium, participants completed a written evaluation.

After each Symposium, the Youth Law Center and county experts provided technical assistance to participants upon request. Participants were also urged to contact CDHS for clarification of state policy questions. During the Sacramento Symposium participants kept a running list of unanswered policy questions, which was shared with CDHS. (*See*, Questions/Topics of Particular Concern to Symposium Participants, Attachment 4.)

Three months after each Symposium, the Youth Law Center conducted a follow-up survey of participants to identify what had been accomplished, whether the Symposium and written materials were helpful in practice, and what challenges

remained. The Youth Law Center received 70 responses representing 32 counties.

Youth Law Center attorneys, CPOC, and Probation Youth Subcommittee members also met several times with staff from the California Department of Health Services to discuss barriers to Medi-Cal coverage for youth in the juvenile justice system, and confusion about Medi-Cal policies, particularly those implementing the inmate payment exception. CDHS staff was invited to participate in all three Symposia and to respond to the questions about Medi-Cal policy raised by Symposia participants.

The Youth Law Center also provided assistance to staff of the Division of Juvenile Justice (formerly the California Youth Authority) to help DJJ improve access to Medi-Cal for youth residing in and transitioning out of DJJ facilities.

On October 5, 2006, the Youth Law Center convened a final meeting to solicit comments on a draft of this report and discuss proposed recommendations. Forty-five individuals from eleven counties (including probation, health, and/or social services departments), the California Department of Health Services, the California Department of Mental Health, the California Department of Social Services, the Chief Probation Officers of California, the California Welfare Directors Association, the California Legislature, and Maximus Inc., California Health Care Options attended. (*See*, Attachment 5 - Oct. 5 Meeting List of Attendees and Agenda.)

IV. Key Findings

1. Training, information sharing, and discussion of the issues have improved knowledge in the field about barriers to health care coverage and funding for incarcerated populations.

Pre-meeting surveys revealed differing levels of knowledge about Medi-Cal coverage for youth in the juvenile justice system and about implementation at the county level. Some staff were not aware of county practices to establish or terminate Medi-Cal coverage, and some were not familiar with the inmate payment exception or how it worked in their county. Several respondents voiced a belief that Medi-Cal was not available for incarcerated youth at all.

Symposium evaluations indicated that 67% of respondents increased their awareness of barriers to Medi-Cal coverage, 76% had a better understanding of the Medi-Cal eligibility process, and 81% gained information that they will be able to use immediately. Project activities, including distribution of the Inmate Exception Paper, planning and conducting the Symposia, and presentations to other audiences[21] raised the general level of awareness about these issues in

[21] For example, Youth Law Center staff made presentations at the National Juvenile Defender Leadership Summit in Los Angeles on October 21, 2005, and Beyond the Bench, a statewide

the community. Three bills, SB 1469, SB 1616, and AB 2004, designed to improve Medi-Cal coverage for youth in the juvenile justice system, were passed by the California Legislature in 2006. The Governor signed SB 1469[22] but vetoed SB 1616 and AB 2004. [23]

2. Improved knowledge about Medi-Cal and new relationships among professionals serving youth in the juvenile justice system have increased the capacity of county probation and health personnel to utilize Medi-Cal services.

Evaluations indicate that participants found the Symposia useful. Ninety-three percent of respondents said they were glad they participated and would recommend that others attend similar Symposia. Participants gained practical information that they could put to use and met individuals they could work with or call upon for help. As noted above, 81% of respondents said they gained new information that they could use immediately; 70% thought that they could use the information they learned to reduce barriers to health care coverage for youth in the juvenile justice system; 63% met a new person from their county; and 56% met a new person outside their county that they planned to contact for assistance.

Participants expressed some skepticism that systemic change could be accomplished. Only 49% of respondents expressed confidence that their counties will change policies/practices to reduce the barriers to Medi-Cal for youth in the juvenile justice system. Nevertheless, county plans developed at each of the Symposia identified specific actions that the participants could take to improve policy and practice in their county.

3. Some counties have improved their ability to leverage federal resources for Medi-Cal eligible youth in the juvenile justice system; however, differences among counties still exist.

The three month follow-up surveys show continued value from the Symposia but mixed success in making progress toward improvement. Almost all of the

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multidisciplinary conference for California dependency and delinquency professionals, in San Diego on December 16, 2005.

[22] SB 1469 (Cedillo) requires county probation and welfare departments to take steps to insure that Medi-Cal eligible youth committed to a juvenile hall, ranch or camp for 30 days or longer are able to establish Medi-Cal eligibility before their release. Youth who are not eligible for Medi-Cal will be referred to the Healthy Families program.

[23] AB 2004 (Yee) would have required CDHS to (1) suspend benefits rather than terminate Medi-Cal eligibility for youth while they are considered inmates of the public institution for Medi-Cal purposes, (2) ensure that youth receive all health care benefits for which they are eligible immediately on release from incarceration; and (3) expedite new Medi-Cal applications to enable eligible youth to receive Medi-Cal covered services immediately upon release. SB 1616 (Kuehl), modeled on the Bazelon Model Act, would have addressed Medi-Cal and SSI applications for youth with disabilities transitioning out of a Division of Juvenile Justice facility.

participants found at least some of the presentations and materials especially helpful, and 91% said that the county discussions were useful. Many participants followed up with specific actions such as speaking with someone else about Medi-Cal coverage for youth in the juvenile justice system, holding meetings about the issue, or discussing Medi-Cal issues for youth in the juvenile justice system at ongoing meetings. Some respondents contacted CDHS for assistance, and CDHS reported that calls from probation departments increased after the Sacramento Symposium.

Some counties reported progress, particularly with interagency communication and resolution of specific problems. For example:

> Prior to the symposium, it took longer for me to get a response from when I applied for residents' Medi-Cal to when I received a reply. Now, it appears this process is a lot faster.
>
> Because of my contact with a…County eligibility worker during the training, I have found it easier to collaborate with the eligibility program, especially when working with barriers to accessing Medi-Cal coverage when working with children returning from runaway status.
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> One particular issue was inter-county Medi-Cal approval, and we have had some success with getting that implemented.
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> … Behavioral Health is going to use Prop 63 dollars, the Mental Health grant dollars, for more programs services with case management services on 602 wards of the court. Better linkage with Probation by the Health Dept. and Behavioral Health in servicing our youth is also occurring.
>
> The Probation Dept. is exploring opportunities to collaborate with Certified Application Assistors to ensure that all probation locations (camps, juvenile halls, and area offices) have scheduled days where probationers can and their families can enroll in health insurance (many of whom will be Medi-Cal eligible).
>
> We've been able to add on to and finalize our guidelines in processing Expedited Medi-Cal, including the youths who are considered foster children and who are in juvenile hall awaiting placement. The ability to process the MC application while the foster child is in juvenile hall means less hesitancy to provide service due to cost to county, and more timely processing of Medi-Cal prior to placement, which leads to more timely access to health services once [the] child is physically placed in the group home.
>
> [The juvenile court judge] called a meeting with probation to discuss moving up placement screening timelines and [violation of probation] /new

> file decision making. … Some progress has been made, such as decisions as to whether or not to file a new crime [when a youth is accused of violating probation], which would have the effect of stopping coverage.
>
> [We have created] "priority" appointment slots for probation minors who have recently been released from camp or juvenile hall.

Others reported little or no change. The barriers most frequently reported by respondents, including both those who had and those who had not experienced progress, were state and federal policies particularly concerning the inmate payment exception; systems issues, such as coordination among agencies; and difficulty in changing the attitudes or practices of individual workers. Other barriers included problems in maintaining continuity of care when youth are placed out of county, access to mental health services, Medi-Cal policies on substance abuse treatment, and lack of funding for additional public health nurses.

Several respondents mentioned specific things that would make it easier to make improvements. For example:

> I would like to find out how I can get a Meds Screen here at juvenile probation for us in the clerical placement unit. We work with DPSS/Foster Care on a daily basis to ask them questions on minors regarding their Medi-Cal status and it would be easier and faster to have access to it ourselves.
>
> We need more money to fund Public Health Nurse (PHN) time in Probation. HCPCFC [Health Care Program for Children in Foster Care] funds have remained the same for the last 5 years. With cost of living adjustments, in effect the counties have had to cut back on PHN time with Probation.
>
> Assistance with grant funding sources and information on creating a database where [probation], school districts, office of education, medical and dental providers can share responsibility for entering information concerning the foster youth's health, dental, education in a secure and accessible county-wide system. Similar to the San Diego system.
>
> Someone to pay the salary for a Project Coordinator and a professional evaluation team.

Some cited a need for more training and technical assistance or listed specific policy questions that troubled them. For example:

> Would really like to see the Symposium done again locally!

> I believe this Symposium should be given to all DSS workers, eligibility and county administrators.
>
> Another regional Symposium to emphasize the points that were made previously, allow attendance to those who could not attend the previous one, address the Medi-Cal CIV system, allow former attendees to ask questions re implementation attempts, learn from other counties who have been successful in implementation.
>
> Clarification if once a minor is ordered placed out of home, whether probation can submit paperwork in part to get MC approved by the time the minor leaves for placement.

Others pointed to a need for improved policy or leadership. For example,

> … the changes have to come from the State or Federal Government when it comes to Medi-Cal coverage.
>
> The hardest thing to change is the people in power who have the power to change the system but they don't or don't care.
>
> We need more interest and involvement from our political leaders.

4. Data is not available to identify services provided or to measure gaps in mental health and health care services for youth in the juvenile justice system.

State and county juvenile justice systems do not routinely collect information about health care coverage of youth entering the juvenile justice system, track mental health services, evaluate continuity of care, or determine the efficacy of services they provide. Project surveys indicate that counties differ on whether and when anyone identifies a youth's health care coverage or eligibility for coverage. No aggregate data are available on the number of youth in the juvenile justice system who are covered by Medi-Cal, Healthy Families, or other health insurance programs. Most counties do not routinely collect information about the services provided to youth in the juvenile justice system, and no statewide data system tracks the delivery or effectiveness of these services.

Data from the Healthy Returns Initiative (HRI) may help to fill in some of this picture in the five participating counties (Humboldt, Santa Clara, Santa Cruz, Los Angeles, and Ventura). Funded by The California Endowment, HRI is designed to strengthen the capacity of probation departments to improve access to mental health and health services for adolescents in detention facilities and to ensure continuity of care upon their release. The National Council on Crime and Delinquency (NCCD), which is conducting the HRI evaluation, will be collecting

data on health services and health outcomes for youth served over four years beginning in 2005.

Data gathered for the Juvenile Justice Data Project[24] may also help. The Project is made up of a coalition of individuals representing probation, education, mental health, counties, and others, is headed by the California Department of Corrections and Rehabilitation, and is funded by the JEHT, Walter S. Johnson, and Evelyn and Walter Haas Foundations. The goal of the Project is to develop a set of measurable indicators and outcomes that will be collected on a statewide basis and used by macro-level decision makers at the county and state level to identify indicators/markers within our juvenile justice system. This will make it possible to examine particular areas or issues (trends, positive outcomes, disparities, discrepancies, variances, etc. across counties or within individual counties) that might be worth further exploration and/or explanation. So far, the data collection has included information about what caused a juvenile to encounter the criminal justice system, how the system handled the youth, services provided by each county, and risk assessment instrument used by each county. The final report on this data collection will be released January 2007, with the report on outcomes to follow at a later date.

5. Individual CDHS staff members provide helpful information when county staff seek answers to specific questions, but CDHS could provide additional leadership and assistance in helping counties access Medi-Cal for youth in the juvenile justice system.

County staff and advocates who have contacted CDHS Medi-Cal eligibility staff members report that they receive helpful information when they ask specific questions about Medi-Cal policy. However, CDHS has not yet provided written answers to questions raised at the Symposia and has not revised Medi-Cal policy in response to concerns raised by project participants. Project evaluations indicate that Medi-Cal policies and unanswered questions are of concern. Although 76% of those completing symposium evaluations said they understood the Medi-Cal eligibility process better after the Symposium, only 63% said that the majority of their questions about Medi-Cal eligibility for youth in the juvenile justice system have been answered. In the three month follow-up surveys, several respondents mentioned state policies as a barrier to improvement, and participants have reported to the Youth Law Center that additional guidance and training from CDHS would be very helpful. At the October 5 meeting, participants from the counties and state departments agreed that interdisciplinary training and technical assistance would be helpful in explaining all the resources that are available for youth in the juvenile justice system.

[24] The Juvenile Justice Data Project operates through a collaborative of stakeholder agencies led by the Division of Juvenile Justice and Chief Probation Officers of California. Foundation funding for the project was secured by Youth Law Center, and the research has been conducted by a team led by Karen Hennigan at the Center for Research on Crime and Social Control, Department of Psychology, University of Southern California.

6. Medi-Cal policies impede access to Medi-Cal for eligible youth and create additional work for county probation, public health, and eligibility staff.

Results from the preliminary survey revealed that 74.4% of respondents felt Medi-Cal policies create barriers to health or mental health services for youth,[25] and 73.5% felt that Medi-Cal policies made their jobs more difficult.[26] These results were confirmed in the three month follow-up surveys in which many respondents cited Medi-Cal policies as a barrier to improving health care coverage for youth in the juvenile justice system.

Respondents in the preliminary surveys who cited problems mentioned complicated Medi-Cal eligibility requirements, frequently changing policies, and cumbersome paperwork. Eligibility issues were specifically mentioned as burdensome.

Many respondents singled out the inmate payment exception as a particular problem, and some respondents provided narrative descriptions of the difficulties caused by terminating Medi-Cal eligibility. For example,

> … the stopping and restarting of Medi-Cal all the time is extremely disruptive to the youth receiving services, as well as time consuming for the department. If the youth's Medi-Cal services remained active when s/he were in the juvenile hall, many of the delays in services could be avoided. Many youth go from a group home back to juvenile hall and then back to group home placement within a short period of time. Starting and stopping the youth's Medi-Cal services causes a lapse in services for the youth and an enormous amount of paperwork for the probation and eligibility departments.
>
> Minors in detention status lose their health care coverage (except for those awaiting placement), creating not only a local burden for providing required medical treatment, but a lack of continuity in care since many of these minors are in and out of detention on a regular basis. Minors could then lose eligibility requiring them to reapply and causing there to be periods of no coverage. This is a very cumbersome process for both the family and those of us working within the system to try to maintain the coverage and provide needed health care services.

[25] Some respondents who cited no Medi-Cal barriers said that Medi-Cal does not cover services to youth in detention, indicating that the county may not be taking advantage of Medi-Cal coverage for youth who are eligible under current state policy, such as youth awaiting placement in a nonsecure setting such as a group home.

[26] Some respondents who said Medi-Cal does not make their jobs more difficult said that management of Medi-Cal was not their responsibility.

> For minors with serious mental health needs released from juvenile hall, it takes too long for them to get reestablished on their Medi-Cal plan and to obtain intensive services even if the parents apply right away.
>
> For minors who are returned home after being in custody for a long time, the parent must reapply for coverage. Many parents either are not aware they must reapply or do not get around to it, so the medical and mental health needs of the minor go unaddressed.
>
> Kids in placement who go back to relative placements. Medi-Cal gets terminated for kids who remain wards, but are not in a group home or foster care placement. Although they are still a ward of the court, the relative must go and apply for Medi-Cal.

Retroactive Medi-Cal coverage does not solve the problem. For example,

> ... even when the Medi-Cal coverage is active, many dental and mental health providers will not see youth until the youth has received their BIC card.
>
> Many doctors' offices say they are not reimbursed for treatment of Medi-Cal patients. Because of this, they require proof of eligibility just to make an appointment. Since it can take up to 4 weeks to secure Medi-Cal eligibility, it is sometimes difficult to comply with required physicals within 30 days of placement per 16010 WIC.

Three month follow-up surveys indicate only limited success in addressing these barriers. For example,

> The biggest barrier to our breaking down barriers is lack of certainty on the DHS position regarding suspension of benefits for children in Juvenile Hall.
>
> We must be able to get these children eligible for dental and physical promptly after ordered to placement even if not in a specific placement that day. Goal is to get services to minors placed out of home fast and not be bogged down in process because minor placed in a "bad part of month."
>
> The main barrier in obtaining MC coverage for the probation youth in our county is the lag time in MC activation when the youth go from Juvenile Hall to a group home placement

Survey respondents and participants in the Symposia also identified other problems that impede access to care. They include: problems and delays in enrolling and disenrolling youth in managed care plans; difficulties in accessing

services in a timely manner (or at all) when youth are placed out of county; problems in using Medi-Cal coverage when a youth has other health care coverage or a child support order requires coverage; limitations on services that Medi-Cal will cover; restrictions on eligibility for immigrant youth; a shortage of providers willing to accept Medi-Cal primarily as a result of billing problems and low reimbursement rates; and limited resources for mental health services and substance abuse treatment.

7. Some counties have developed practices to expedite Medi-Cal coverage and maintain continuity of care; however, challenges remain.

Counties responding to the preliminary survey varied in the amount of assistance probation departments provided in reestablishing Med-Cal eligibility for youth leaving secure care. Survey responses indicate: in forty-one counties, probation staff assists with Medi-Cal applications for youth going into placement (such as a group home.) In eight counties, probation staff provides information or referral when a youth returns home. In sixteen counties, probation staff provides assistance (beyond information and referral) when a youth goes home or to a relative placement, although some counties provide assistance only when requested by the parent, and some provide assistance only when a youth is in a probation program, such as day reporting or day treatment.

Public health nurses (PHN) play a crucial role in obtaining appropriate health care services for youth, but they are not funded to serve all youth who need this assistance. The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program located in county child welfare service agencies and some probation departments that uses the Child Health and Disability Prevention Program (CHDP) model to provide public health nurse expertise in meeting the medical, dental, mental, and developmental needs of children and youth in foster care. While all county child welfare agencies have a PHN to serve foster children, only some counties have PHNs in probation, and even these professionals may be restricted in their ability to serve youth unless the youth is in or ordered to a foster care placement, leaving youth in juvenile hall and youth returning home or to a relative without PHN assistance.

Several counties reported mechanisms to speed or streamline Medi-Cal procedures, such as using expedited Medi-Cal, and some were able to solve problems by developing good relationships among probation, public health, and eligibility staff to speed up the reapplication process, particularly for youth going to a foster care placement. At each Symposium county teams presented their approaches to solving problems or addressing issues that interfered with

continuity of health care.[27] Several themes emerged from these presentations, including:

- Coordinating efforts through strong interagency and interdepartmental relationships and communication to ensure that all staff with responsibility for the care of youth are working together;

- Maximizing Medi-Cal coverage by beginning the Medi-Cal enrollment before a youth leaves secure confinement and by establishing Medi-Cal coverage as soon as a youth is eligible;

- Improving health care information by completing the Health and Education Passport and beginning the HEP process early; and

- Developing and maintaining connections with placement or community resources to ensure continuity of care when a youth leaves secure confinement and providing follow up after a youth is released.

However, even these counties continue to face challenges, including the termination of Medi-Cal eligibility when youth enter juvenile hall and the need to reestablish eligibility, delays in disenrolling youth from managed care plans, delays in obtaining proof of Medi-Cal coverage when youth leave juvenile hall, difficulty in maintaining coverage for youth placed out of county, and access to services particularly dental care and mental health treatment.

8. Some counties have used Medi-Cal and other funding sources to develop evidence-based programs and services to avoid unnecessary incarceration.

Several counties have used Medi-Cal coverage and other funding sources, such as Title IV-E foster care, to support evidence-based practices and to fund innovative programs for youth in their juvenile justice systems.[28] These programs also help to reduce incarceration of youth who can be served in the community. For example, in the preliminary survey, respondents from twenty-three counties indicated that Wrap-Around Services are available for youth in the juvenile justice system, sixteen reported using Therapeutic Behavioral Services (TBS), and seven reported using Multi-Systemic Therapy (MST). Others reported using nonsecure residential programs, day treatment programs, and day reporting centers. Twelve reported collaboration with mental health or other agencies, and two counties cited the use of mental health courts.

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[27] Some of these presentations are summarized in Attachment 8. The presenters provided helpful forms, flow charts, and other practical materials. Copies of the materials are available from the Youth Law Center or the county.

[28] County presentations at the Fresno Symposium included information about Functional Family Therapy and Wrap-Around Services.

9. Some professionals in the juvenile justice system recommend elimination of the inmate payment exception altogether.

The advisability of eliminating the inmate payment exception altogether is still a matter of debate among mental health and juvenile justice experts. Although additional Medicaid funds could improve health and mental health services provided in institutions, federal funding of these services could also increase the development of institution-based treatment services and remove an incentive to keeping youth in the community. The Council of Juvenile Correctional Administrators has urged Congress to make Medicaid funds available for youth in juvenile institutions.[29] Some project participants echoed that recommendation. For example,

> Students should continue to be eligible for their Medi-Cal while in the juvenile system. Students should receive comprehensive evaluations and treatment while detained and should be connected to appropriate resources prior to release and perhaps continuing in treatment should be a condition of their probation.
>
> Laws regarding Medi Cal eligibility for minors in juvenile hall need to be changed or get designated monies for behavioral health that should be made available by the state and federal government.
>
> Advocacy to make Medi-Cal available to all adolescents is always appreciated.
>
> Getting Behavioral Health care for detained youths that are not Medi-Cal billable, currently unless [youth] have been ordered by the court into placement [there is no ability to bill], [resulting in] few services. This needs to change [so] minors in custody can receive Medi-Cal billable services regardless of time in Juvenile Hall or if they are going to placement.
>
> I believe the core issue for me is MC eligibility for inmates without exception.

However, some advocates remain concerned about the effects of increasing resources for institutional care.[30]

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[29] Council of Juvenile Correctional Administrators, *Position Paper on: Mental Health Services for Young Offenders,* (2003). Available at: http://cjca.net/photos/content/documents/Mental%20Health.pdf

[30] For a more complete discussion of these issues, *see,* the Inmate Exception Paper, *supra*, pp. 24-28.

V. Recommendations

1. CDHS should revise Medi-Cal policies to (1) implement the inmate payment exception without terminating Medi-Cal eligibility; (2) clarify provisions that have caused confusion; and (3) make policies more consistent with the juvenile justice system and easier to understand.

A key finding of this project is that the termination of Medi-Cal eligibility for detained youth interrupts continuity of care and creates additional work for probation, public health, and eligibility staff.[31] Termination of eligibility is also inconsistent with federal law.[32] In 2004, CMS said:

> As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD[33] ***does not affect the eligibility of an individual for the Medicaid program***. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affect only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.
>
> Thus ***states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents*.** Instead, states should establish a process under which an eligible inmate or resident is ***placed in suspended status*** so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continued to meet all applicable eligibility requirements). ***Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility.*** If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take

[31] The experience of project participants clearly demonstrates that proposed solutions, such as retroactive payment for services, do not fully address the gaps in coverage because many providers simply will not provide services or medication without proof of Medi-Cal coverage.
[32] The California Department of Health Services and the California Department of Mental Health believe that California's policy directives in this area are consistent with federal law.
[33] Institution for Mental Disease. This applies only to adults.

> whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility.[34]

In addition, CDHS could resolve many of the questions raised by project participants by revising Medi-Cal policy to use terminology and examples that are consistent with the way that the juvenile justice system works. CDHS should sit down with juvenile justice professionals, eligibility workers, health care providers who are familiar with the juvenile justice system, and staff from other state departments involved with the juvenile justice system to identify specific areas of inconsistency and confusion and develop written policies that are easier for individuals in the field to understand and follow.

2. **A mechanism should be developed to provide ongoing training on Medi-Cal issues and to facilitate sharing of information and best practices to individuals who work with youth in the juvenile justice system. CDHS and other state agencies should expand the technical assistance provided to county probation departments and other professionals working with youth in the juvenile justice system by providing on-site training, consultation, and problem solving.**

Many individuals who participated in the Symposia expressed a need for follow-up training and/or additional training for others in their county with information provided by the state agency staff responsible for implementing state policy. Participants in the October 5 meeting suggested that multiple agency training would be more effective than a single agency training. Comments provided after the meeting suggested involvement of CDHS, CDMH, the California Department of Social Services (CDSS), the California Department of Developmental Services (CDDS) , the California Department of Corrections and Rehabilitation (CDCR), and the California Department of Education (CDE). For example, mental health providers and individuals responsible for administration of Medi-Cal mental health services are critical players in training, problem solving, and policy development. Symposium evaluations indicate that this training would be most productive if the training follows the Symposium interdisciplinary participation model of bringing together probation, public health, eligibility, mental health, and other appropriate staff from each county, and the training reaches key people such as program administrators and court officers, as well as line workers.

Additional groups, such as juvenile defenders, should also be included. At the October 5 meeting participants pointed out that newly enacted California Rule of Court 1479 provides for the post-dispositional involvement of juvenile defenders, which may include helping to access needed services to carry out

[34] Centers for Medicare and Medicaid Services, State Medicaid Directors Letter Re: Ending Chronic Homelessness (May 25, 2004.) (Emphasis added.) Available at: http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/SMDLetter.pdf.

the court's dispositional orders. Understanding Medi-Cal policies can also enhance advocacy for youth at earlier stages in the proceedings.

A successful training model is "Bridging Professional Cultures Between Public Health Nurses, Child Welfare Workers, and Probation Officers," a multidisciplinary training held in Oakland in 2002. The Child Welfare Training Academies are well equipped to design and deliver this ongoing training in consultation with the Chief Probation Officers of California (CPOC), public health nurses, the California Welfare Directors Association, and other interested parties, if funding can be secured.

Participants in the October 5 meeting also suggested creation of a tool kit on services for youth in the juvenile justice system that would include information about funding streams, program requirements, and best practices that have been implemented in some counties.

3. **Counties and the Division of Juvenile Justice should increase health care coverage and continuity of care for youth in the juvenile justice system by: (1) identifying sources of health care coverage for youth as early as possible; (2) making health care coverage part of services, disposition, and transition planning; and (3) assisting youth to establish eligibility for Medi-Cal, Healthy Families, and other programs.**

The failure to identify and obtain health care coverage for youth interferes with the ability to plan and provide appropriate services to youth. The intake process for youth entering the juvenile justice system should include identification of existing health care coverage and eligibility screening for Medi-Cal and Healthy Families for youth who do not have coverage. This information should be updated at appropriate points, such as when making a disposition plan, recommending an initial placement or a placement change, and preparing to discharge a youth from a facility or other placement. As discussed below in Recommendation 5, interdepartmental collaboration will be important to effectively implement improved policies and practices.

SB 1469 will require counties and CDHS to begin this process. Starting January 1, 2008, county facilities must provide the county welfare department with information about any youth committed to a juvenile hall, ranch, or camp for 30 days or longer, including the youth's release date, known information about the youth Medi-Cal status prior to disposition, and available information that will allow the welfare department to begin to determine Medi-Cal eligibility. When the youth is a minor, the facility must notify the youth's parents and give them an opportunity to opt out of the Medi-Cal eligibility determination. Unless the parents have chosen not to proceed, the welfare department must determine the youth's Medi-Cal eligibility and provide the youth with sufficient documentation to enable the youth to obtain necessary

medical care upon release. When a youth is expected to be released in fewer than 45 days, the welfare department must expedite the Medi-Cal eligibility determination process. Youth determined to be ineligible for Medi-Cal are to be referred to Healthy Families or another appropriate program. By June 1, 2007, CDHS, in consultation with Chief Probation Officers of California and the County Welfare Directors Association, must establish protocols and procedures necessary to implement these requirements.

The SB 1469 planning and implementation process provides an opportunity for state and county officials to improve continuity of care for all youth affected by the inmate payment exception. Medi-Cal eligible youth should receive all necessary services that can legally be covered. However, counties differ on whether they initiate coverage for eligible youth, such as those awaiting placement in a group home or foster care setting, and whether they ensure that previously covered youth can receive Medi-Cal services as soon as they leave secure confinement. Ensuring that coverage is provided to eligible youth will not only support appropriate care but also provide additional resources for treatment.

Although he differs with some advocates on the way to achieve continuity of care, the Governor recognizes the importance of ensuring that youth continue to receive health services upon release, and he directed CDHS and the Department of Corrections and Rehabilitation to coordinate on the state level. In his veto message to AB 2004, the Governor said:

> A more effective way of ensuring youth continue to receive health services when they are released is through coordination of discharge planning at the local level. This is why I signed SB 1469, which would create a collaborative effort between state and local agencies to ensure that a minor receives appropriate services when being released. I am also directing the Department of Health Services and the Department of Corrections and Rehabilitation to develop and implement a memorandum of understanding that will establish a process for achieving this coordination at the state level.[35]

4. All counties should fully implement the Health and Education Passport (HEP) for youth in the juvenile justice system, and the Child Welfare Services/Case Management System (CWS/CMS) should be accessible to probation staff.

All youth in foster care placements, including those supervised by probation, should have a health and education passport that includes the names of the youth's health and dental care providers, a record of the youth's

[35] AB 2004 veto message, 9/30/06. Available at: http://info.sen.ca.gov/pub/bill/asm/ab_2001-2050/ab_2004_vt_20060930.html.

immunizations and allergies, the youth's known medical problems, the youth's current medications, past health problems and hospitalizations, a record of the youth's relevant mental health history, the youth's known mental health condition and medications, and other relevant mental health, dental, and health information.[36] However, recent data from the Child Welfare Services/ Case Management System (CWS/CMS) indicate that not all counties are in compliance with this requirement.

In some counties, the public health nurse assigned to probation has taken steps to ensure full compliance for youth supervised by probation. However probation staff does not have access to the information that has been entered. This makes the CWS/CMS system useless to probation officers and creates a disincentive to enter data into the system. The Youth Law Center, CPOC, and the California Department of Social Services are working on a legislative initiative that would make CWS/CMS available to Probation.

5. Interdisciplinary teams that include probation, public health, eligibility, mental health, and other relevant professionals should meet regularly to resolve problems, review and improve practices, and make policy recommendations at the county and state level.

The Symposia and the work done by many counties afterwards demonstrates that interagency communication and cooperation is essential to smoothing out difficulties encountered in obtaining health care coverage for youth and that these interagency efforts can be effective in identifying areas where policy change is needed. On the county level, these interdisciplinary teams can resolve specific problems and adjust county policy and practice in response to recurring difficulties. At the state level, interdepartmental cooperation is needed to address issues that fall within the authority and responsibility of the Department of Health Services, the Department of Social Services, the Department of Mental Health, the Division of Juvenile Justice, the Department of Alcohol and Drug Programs, the Department of Education, the Department of Developmental Services, and others.

Participants in the October 5th meeting agreed that interdepartmental and interagency problem solving is crucial. Staff from the relevant agencies and departments (which may differ from county to county) should form collaborative, ongoing relationships and get the training needed to facilitate best practice. SB 1469 implementation provides an opportunity to create or strengthen these interdisciplinary working groups to plan implementation of specific SB 1469 provisions and identify ways of improving health care coverage and continuity of care for youth in the juvenile justice system generally.

[36] Calif. Welf. & Inst. Code § 16010.

6. **California should collect and track health care data, including health care coverage, for youth in the juvenile justice system and use it to identify trends, evaluate the effectiveness of programs and services, and improve the system overall.**

State and county juvenile justice professionals are discussing ways to improve accountability for juvenile justice interventions and services. This accountability system should include information about health care coverage to allow policy makers to evaluate whether and to what extent the existence and type of health care coverage affects the services provided to youth in the juvenile justice system, the effectiveness of interventions, and health and rehabilitation outcomes. The Juvenile Justice Data Project, described on page 12, is bringing together a wide variety of state, county, and local officials; researchers; advocates; and community partners to identify ways of recording and tracking the delivery and effectiveness of services and outcomes for youth in the juvenile justice system. The January 2007 project report on data should help to identify what data should be collected, who should be responsible for collecting it, and how information should be shared across state and county systems.

7. **California should expand the Health Care Program for Children in Foster Care (HCPCFC) to provide public health nurses in all county probation departments and to provide services to youth in juvenile detention facilities, regardless of placement recommendation, and to youth returning to the community.**

HCPCFC has been effective in improving health care services for children and youth in foster care placements, including some placements that are supervised by probation. It should be expanded to provide public health nursing support for all youth in out-of-home placements through the juvenile justice system and to allow public health nurses to continue to provide services to youth after they return to the community.

8. **The California Health and Welfare Agency should resolve problems that inappropriately terminate Medi-Cal coverage, interfere with continuity of care, and/or create additional work for county staff in obtaining health and mental health services for eligible youth.**

Project participants identified many problems that are not unique to youth in the juvenile justice system, including difficulty in obtaining services when youth are placed out of county, termination of coverage when youth leave a placement, and complications when youth have other health care coverage. Though some of these issues have been discussed for years,[37] they have not

[37] *See, e.g.,* K. Karpilow, L. Burden, T. Carbaugh, *Code Blue: Health Services for Children in Foster Care*, Institute for Research on Women and Families, Center for California Studies (1998). Available at: http://www.ccrwf.org/publications/codeblue.pdf.

been resolved. Addressing these issues promptly is an essential part of improving health care coverage for youth in the juvenile justice system.

9. **Counties and the Division of Juvenile Justice should use Medicaid and other funds to develop and expand alternatives to secure confinement for youth who can safely live in the community. Medicaid can help to support evidence-based practices such as Wrap-Around services, multi-systemic therapy, and therapeutic foster care.**

The inmate payment exception does not apply to youth living at home, in small community-based residential programs, or child care institutions funded by Title IV-E foster care funds, and community-based programs are more successful than institutional settings in providing treatment and long-term rehabilitation for many youth. Several California counties have used Medi-Cal and other funding sources to implement evidence-based practices,[38] such as Multidimensional Treatment Foster Care and Functional Family Therapy, and promising practices, such as Aggression Replacement Therapy.[39] Increasing, more counties are using Wrap-Around services to reduce the need for out-of-home placement. Although one agency or department may take the lead, counties that have successfully implemented these programs have found interagency collaboration and good communication to be essential. Other counties can learn from these experiences and develop alternatives to secure confinement for youth who can live safely in the community.

10. **Juvenile justice and mental health professionals, advocates, and others involved with the juvenile justice system should continue the discussion about the advisability of the inmate payment exception policy and the best ways to provide adequate mental health services to youth in the least restrictive setting.**

Given the fiscal implications, elimination of the federal inmate payment exception is not on the immediate horizon. Nevertheless, it continues to be the subject of debate in the juvenile justice and mental health communities. Although additional federal funds[40] could be used to improve health care services to incarcerated youth, they could also create an incentive to rely on

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[38] *See*, e.g., R. Barnoski, *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders* (Washington State Institute for Public Policy, January, 2004). Available at: http://www.wsipp.wa.gov/rptfiles/04-01-1201.pdf. Fight Crime Invest in Kids, *From Promise to Practice: Mental Health Models that Work for Children* (2005). Available at: http://www.fightcrime.org/ca/toolkit/fcikcatoolkit.pdf.

[39] California Institute for Mental Health, *Bulletin: A Snapshot of Values-Driven Evidence-Based Practices (VEP) Implementation in California* (October 13, 2005).

[40] At least one state (Massachusetts) has made state funds available to cover all Medicaid eligible youth affected by the inmate payment exception.

institution-based treatment rather than community-based alternatives.[41] These differences of opinion generate productive discussion about the best ways to serve youth and should continue, whether or not everyone can agree on the best policy.

VI. Immediate Next Steps

At the October 5, 2006 meeting and in subsequent comments, participants identified some immediate next steps:

1. Work together to effectively implement the provisions of SB 1469.

2. Use SB 1469 as an opportunity to discuss other ways of improving continuity of health care for youth in the juvenile justice system.

3. Develop a tool kit that includes information about Medi-Cal and other resources for serving youth in the juvenile justice system.

4. Create a mechanism for interdepartmental and interagency training and technical assistance, which may include California Department of Health Services, California Department of Mental Health, California Department of Social Services, California Department of Developmental Services, California Department of Education, California Department of Corrections and Rehabilitation, California Department of Alcohol and Drug Programs, and experienced staff from the counties. Coordinate with existing training resources such as the regional Training Academies.

5. Begin a dialogue to identify and amend Medi-Cal policies that create barriers to health care services for youth in the juvenile justice system.

6. Continue current efforts such as the Juvenile Justice Data Project and the dialogue with CDSS to make CWS/CMS more accessible to probation departments.

VII. Conclusion

This project has demonstrated that a great many individuals care deeply about youth who are involved in the juvenile justice system and are dedicated to seeing that they receive the health care and other services they need. While confirming the importance of communication and cooperation in maximizing health care coverage and appropriate care for youth, the project also shows the limits of individual efforts in the absence of policies that support best practice. The recommendations and immediate next steps, which address both policy and

[41] For a more complete discussion of the debate, *see,* the Inmate Exception Paper, pp. 24-28.

practice issues, have been developed by project participants who work directly with youth to provide a roadmap to help dedicated professionals accomplish their goals and improve health care for youth in the juvenile justice system.

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ATTACHMENT 1

LISTS OF SYMPOSIA MATERIAL

Sacramento Medi-Cal Symposium Handouts

Agenda
Participants List
Evaluation Form
Inmate Exception Report

1. Glossary
2. Rep. Waxman Report
3. YLC Powerpoint/CMS Letter
4. Placement Delay Report
5. Summary of Medi-Cal Survey
6. All County Letters
7. Senate Bill No. 543
8. Health Care Program for Children in Foster Care (HCPCFC)
9. Managed Care Models by County
10. Contra Costa County Handouts
11. Solano County Handouts
12. San Mateo County Handouts
13. Alameda County Power Point Presentation
14. Humboldt County Power Point Presentation
15. Resource List

Fresno Medi-Cal Symposium Handouts

Agenda
Participants List
Evaluation Form
Inmate Exception Report

1. Glossary
2. Rep. Waxman Report
3. YLC Powerpoint/CMS Letter
4. Fair Hearing Decision re Furlough
5. Placement Delay Report
6. Summary of Medi-Cal Survey
7. All County Letters
8. Health Care Program for Children in Foster Care (HCPCFC)
9. Managed Care Models by County
10. Contra Costa County Handouts
11. Fresno County
12. Kern County
13. San Luis Obispo County Handout
14. Humboldt County Powerpoint Presentation
15. Resources

Los Angeles Medi-Cal Symposium Handouts

Agenda
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Evaluation Form
Inmate Exception Report

1. Rep. Waxman Report
2. YLC Powerpoint/CMS Letter
3. Fair Hearing Decision re Furlough
4. Placement Delay Report
5. Summary of Medi-Cal Survey
6. All County Letters
7. Health Care Program for Children in Foster Care (HCPCFC)
8. Managed Care Models by County
9. Contra Costa County Handouts
10. Los Angeles County Powerpoint Presentation
11. San Bernardino County
12. San Diego Obispo County
13. Ventura County Powerpoint Presentation
14. Humboldt County Powerpoint Presentation
15. Resources/DHS Contacts/Glossary

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Stan Einhorn, Ph.D
Santa Cruz Dept. of Health

Laura Garnette, Division Director
Santa Cruz Probation

Elke Hams, RN
Santa Cruz County

Terry Pohle
Division Director for Juvenile Hall
Santa Cruz Probation

Shasta County

Venessa Vidovich
Supervising Public Health Nurse
Shasta County Department of
Children and Family Services

Solano County

Laura Fraser
Solano County Probation

Marsha Lucien
Senior Deputy Probation Officer

Earl Montilla
Senior Deputy Probation Officer

Bridget Oduni
Senior Public Health Nurse
CHDP

Elizabeth Reeves
Probation/HCPCFC/CHDP

Donna Robinson
Supervising Deputy Probation Officer

Jacqueline Smith
Supervising Mental Health Clinician
H&SS Children's Mental Health

Sonoma County

Jean Abel, EWII
County of Sonoma

Lisa Hernandez
Placement Coordinator
Sonoma County Probation

Pat Mullooly
FC/Prob PHN
C/o CHDP

Stanislaus

Emily Boyd
DPOIII, Placement Unit
Stanislaus Co. Probation

Julie Campbell, LVN
CFMG c/o Stanislaus Juvenile Hall

Mike Hamasaki
Probation Manager – Juvenile Hall
Stanislaus Co. Probation

Shawn Kiely, Coordinator
Stanislaus Co. BHRS

Leta Love, PHN
Health Care Program for Children in
Foster Care
Mitzi Whitworth, RN
Juvenile Hall

Sutter County

Debra DeAngelis Campbell
Deputy Chief Probation Officer
Sutter County Probation

Beverly Siemens
Deputy Probation Officer
Sutter County Probation

Tulare

Christine K. Davis
Program Specialist
Tulare County HHSA

Madeleine Pitts
Office Manager
Karis House, Inc.

Maria L. Sanchez
Mental Health Case Manager III
Tulare Co. Mental Health

Bobbi Schnell
Supervising Probation Officer
Tulare County Probation

Lisa Sidelinker, Supervisor
Karis House, Inc.

Dan Weaver
Supervising Nurse – CWS
Tulare County Health & Human Services

Tuolumne

Linda Downey
ILP & Licensing
Health and Human Services

Shirley Juhl, Chief Probation Officer
Tuolumne County Probation

Sue McGuire
Managed Care/Quality Improvement
Tuolumne County Behavioral Health

Kathleen Olson
Eligibility
Health and Human Services

Leanna Salazar
Asst. Chief Probation Officer
Tuolumne County Probation

Ventura

Barbara Holdsworth
Public Health Nurse II
Healthy Returns Unit
Ventura County Public Health

Kattya Manning
Marriage/Family Therapist-Intern
Healthy Returns Unit
Ventura County Behavioral Health

Elizabeth Plazola-Jones, PHNII
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Sandra Priebe
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Leonard Salinas
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Yolo County

Debra Gable
Supervising Probation Officer
Yolo County Probation

Jessica Hilligoss
Administrative Clerk
Yolo County Probation

Youth Law Center

Neelum Arya
Soros Fellow
Youth Law Center

Sue Burrell
Staff Attorney
Youth Law Center

Alice Bussiere
Staff Attorney
Youth Law Center

Mamie Yee
Paralegal
Youth Law Center

ATTACHMENT 3

SYMPOSIA AGENDAS

Symposium on Medi-Cal Coverage for Youth in the Juvenile Justice System
Sierra Health Foundation, Sacramento
June 28, 2005
Agenda

9:30 - 9:45	Registration and Coffee
9:45 - 10:15	Welcome and Introductions. Objectives of the Symposium - Alice Bussiere, Youth Law Center and Norma Suzuki, Executive Director, Chief Probation Officers of California
10:15 - 11:00	Overview of the issues and systems • Juvenile justice system - Sue Burrell, Youth Law Center • Medi-Cal and the Inmate Exception - Alice Bussiere
11:00 - 11:15	Break
11:15 - 12:00	The Contra Costa Experience • Paula A. Hines, CHDP Deputy Director • Dave Ellis, Contra Costa Co. Probation Placement Supervisor • Kira Faulkner, Contra Costa Co. Probation Placement Specialist • Donna Harbaugh, Contra Costa Co. EHSD Foster Care Eligibility Supervisor • Nancy Hayes, CHDP/Probation PHN
12:00 - 12:30	Lunch
12:30 - 1:45	County solutions on specific issues • Health and Education Passports (HEP) - Elizabeth Reeves, Solano County • Probation Database and HEP - Jean Jacquemet, San Mateo • The GPO Exception - Medical Services for GPO Minor's in Juvenile Hall - Shelley Neal, Alameda County • Humboldt County Northern California Regional Facility New Horizons Program – Connie Hudelson and Tim Toste, Humboldt County
1:45 - 2:00	Break
2:00 - 2:30	County discussions: • What are we doing now? • What else do we want to do? • What help/information do we need?
2: 30 - 3:30	Reports from county discussions and Next Steps • Information • Training and Technical assistance • Policy issues

Symposium on Medi-Cal Coverage for Youth in the Juvenile Justice System
Four Points Sheraton, Fresno
October 19, 2005
Agenda

8:30 - 9:30 Registration and Coffee

9:30 - 10:00 Welcome and Introductions. Objectives of the Symposium
Alice Bussiere, Youth Law Center
Norma Suzuki, Executive Director, Chief Probation Officers of California

10:00 - 10:45 Overview of the Issues and Systems
- Juvenile Justice System - Sue Burrell, Youth Law Center
- Medi-Cal and the Inmate Exception - Alice Bussiere

10:45 - 11:00 Break

11:00 - 12:00 Interagency Collaboration - The Contra Costa Experience
- Paula A. Hines, CHDP Deputy Director
- Dave Ellis, Probation Placement Supervisor
- Kira Faulkner Brown, Probation Placement Specialist
- Donna Harbaugh, EHSD Foster Care Eligibility Supervisor
- Nancy Hayes, CHDP/Probation PHN

12:00 - 12:30 Lunch

12:30 - 2:30 County Solutions on Specific Issues:

- Making the Medi-Cal Connection and Using Medi-Cal for Services and Case Management - Jim Salio, San Luis Obispo, Probation

- Functional Family Therapy - Fresno County
  - Phil Kader – Probation
  - Laurie Haberman and Nancy McCart, Division Managers, DCFS Children's Mental Health

- Wrap Around - Kern County
  - Amanda Parker – Mental Health
  - William Dickinson – Probation
  - Monique Moreland – Health Unit, Human Services

- Humboldt County Northern California Regional Facility New Horizons Program –
  - Connie Hudelson - Mental Health
  - Tim Toste - Probation

2:30 - 2:45 Break

2:45 – 3:30 County Group Discussions:
- What are we doing now?
- What else do we want to do?

- What help/information do we need?

3: 30 - 4:30 Reports from County Discussions and Next Steps

- Information
- Training and Technical Assistance
- Policy Issues

Symposium on Medi-Cal Coverage for Youth in the Juvenile Justice System
Center for Health Communities
The California Endowment
Los Angeles
April 13, 2006

8:30 - 9:30 Registration and Coffee

9:30 - 10:00 Welcome and Introductions. Objectives of the Symposium
Gwen Foster, The California Endowment
Jean Miao, Program Officer, Center for Health Communities
Alice Bussiere, Youth Law Center
Norma Suzuki, Executive Director, Chief Probation Officers of California

10:00 - 10:45 Overview of the Issues and Systems
- Juvenile Justice System - Sue Burrell, Youth Law Center
- Medi-Cal and the Inmate Exception - Alice Bussiere

10:45 - 11:00 Break

11:00 - 12:00 Interagency Collaboration - The Contra Costa Experience
- Paula A. Hines, CHDP Deputy Director
- Dave Ellis, Probation Placement Supervisor
- Nancy Hayes, CHDP/Probation PHN

12:00 - 12:30 Lunch

12:30 - 2:30 County Solutions

- The Role of the Public Health Nurse in Probation: Los Angeles County Public Health Children's Medical Services, CHDP/Health Care Program for Children in Foster Care/Probation
  - Esther Feng – PHN
  - Boonrat Chantorn – PHN
  - Monette McCullough – PHN Supervisor
- Health Information and Health and Education Passports
  - Phyllis Byrnes SPHN, San Bernardino County
  - Nancy Dobson, PHN, MSN, San Bernardino County
  - Violeta Mora, SDCOE Foster Youth Services Program, San Diego County
  - Annamarie R. Iraci, PHNIII, San Diego County
- Ventura County Healthy Returns Unit
  - Barbara Holdsworth, RN, BSN, PHN
  - Kattya Manning, Marriage/Family Therapist-Intern
  - Leonard Salinas. Senior Deputy Probation Officer
- Humboldt County Northern California Regional Facility New Horizons Program –
  - Connie Hudelson - Mental Health
  - Tim Toste – Probation

2:30 - 2:45 Break

2:45 – 3:30 County Group Discussions:

- What are we doing now?
- What else do we want to do?
- What help/information do we need?

Breakout Rooms -

Orange County	Sierra
San Diego County	Sequoia
San Bernardino County	Mojave
Los Angeles County	Yosemite B
Riverside County	Cabrillo

3: 30 - 4:30 Reports from County Discussions and Next Steps

- Information
- Training and Technical Assistance
- Policy Issues

ATTACHMENT 4

QUESTIONS/TOPICS OF PARTICULAR CONCERN TO SYMPOSIA PARTICIPANTS (Compiled at Symposium in Sacramento, June 28, 2005)

Questions/Topics of Particular Concern to Symposium Participants

Who is eligible?

Do youths qualify if they are not in the foster care system?

What factors determine eligibility for youth in placement? Wraparound?

What are the differences between Social Security Medi-Cal eligibility and general Medi-Cal eligibility?

Are furloughed youth eligible even though their names are on a correctional facility's roster?

It is my understanding that minors in custody don't qualify for Medi-Cal. Does electronic supervision or ranch programs count?

For placement youths qualifying for Medi-Cal, at what point does Medi-Cal coverage begin? After court? During waiting period for placement?

How do youth qualify for Minor Consent Services?

Does a kid released for a medical appointment fall within the inmate exception?

Prop 21 kids -- can they be released to the hospital? For youth in the juvenile j system, they normally get a juv. ct. order for a suspension of proceedings. Do you get the same thing for a youth in the adult system?

Are there differences in Medi-Cal eligibility when a kid returns to the juvenile hall from a GPO, for a new offense? a violation of court order? Or a probation violation? How does the status make a difference?

Since youth have continuing Medi-Cal eligibility for the month, how does that fall into the inmate exception?

More policy guidance for kids returning home on a placement order (a stayed order). Are they eligible? What forms? What type of Medi-Cal do they get? CEC?

What is required to enroll a minor?

Is there a difference in processing Medi-Cal for 300 versus 602 cases?

What forms are needed to be filled out, and by whom (can it be the PO or parent?)

What additional paperwork, documentation is needed (birth certificate, social security number)?

Can you sign up through the phone? If so, how does that work?

Is there a specific person assigned to contact regarding obtaining Medi-Cal for juveniles who are incarcerated?

Is there a way to get the MC250 processed even through the minor is no longer in the juvenile hall, but when the MC250 was faxed in a timely manner when the minor was in the hall?

Since youth have continuing Medi-Cal eligibility for the month, how does that fall into the inmate exception?

Questions about termination:

Who is responsible for notifying social services when a minor is admitted into the juvenile hall? Do the benefits stop?

When are benefits interrupted and how may they be restored?

Suspension/Disenrollment? Who do you notify? How?

What services are they entitled to if granted Medi-Cal?

What mental health services are available?
Can we get a list of providers?

Can Medi-Cal pay for drug/alcohol treatment for minors?

Do counties have any creative programs in place to maximize the use of Medi-Cal to pay for mental health services when clients return home after the placement, i.e. support, groups, deterrents to resuming gang ties, etc.

Do youth awaiting placement under a GPO qualify for full-scope Medi-Cal services? Or are the services limited in some way?

There was a question about the ban on having a primary diagnosis of "substance abuse problem", services aren't covered. Why? Where is the source of the problem? Is it State or Federal?

Can Medi-Cal pay for TBS services in the hall?

Funding/Billing Questions:

How do we access Medi-Cal coverage and receive payment for services when minors are in custody on a GPO?

Understand all of the windows of time that can be Medi-Cal billable,
are there mechanisms/methods to track them to maximize the availability?

Can the Medi-Cal funds disappear by actions from the Governor/State Legislature?

How does the state view the releasing of inmates/juveniles from custody for costly procedures and treatment so they can be paid for by Medi-Cal only to readmit them after the procedure or treatment?

If a county receives Minor Consent services as a block, and if they aren't used on minor consent services, what can they be used for? And will it's intended use supercede the use of those funds in other Medi-Cal programs?

Managed Care

How do we expedite coverage for youth moved from managed care to FFS?

How to deal with Managed Care and Other Health Coverage Issues?

There are problems being part of Value Options because there are a very limited number of psychiatrists.

Reducing the barriers with Healthy Families -- share of cost, managed care vrs FFS parents have to disenroll from Healthy Families

MEDS Access Screen/Aid Codes

Since Geographic Managed Care is a voluntary option for foster care, why isn't the GMC code taken out as the foster care code is entered into the aid code?

Is there a way of automatically removing Kaiser from the MEDS Access as the primary insurance for kids placed in group homes where Kaiser is not accessible? The "K" code causes delays, and prevents us from meeting the 30-day physical exam requirement. I understand that we currently have to request a denial letter from Kaiser before accessing services from non-Kaiser providers. Can't there be an exception to this rule?

With an "A" code listed under the Other Health Coverage section of the MEDS screen, providers are able to bypass the private insurance and bill straight to Medi-Cal. Most of our eligibility workers don't seem to know what the "A" code means either. Is there a way to get a copy of that to fax to the providers that are refusing to offer services?

Rather than using the code in which the youth is placed, why don't we use the code of the county that has jurisdiction? Then as the youth moves between juvenile hall and placements he will always remain eligible.

How does Medi-Cal work when a foster care child has "other" insurance? Medi-Cal is always considered the payor of last resort, but is that the case for a foster care child?

CHDP and Gateway:

Clarify the Gateway process and CHDP for in-custody youth

Why are CHDP exams required at each placement? Frequently wards are in 3 or 4 group homes a year and have had 3 or 4 CHDP exams which is expensive.

Concerns over Changed placements:

How do you maintain access as the youth cycles in and out of group homes?

Concerns over Minors Placed Out of County

Concerns over Timing:

How to expedite Medi-Cal enrollment?

How to expedite application for/reactivation of Medi-Cal eligibility for youth being released from the juvenile hall?

How do you obtain coverage for the day of placement?

Questions about Medi-Cal for Youth "Aging Out":

What is the process for youth eligibility following their 18th birthday?

What are the laws and regulations regarding Medi-Cal coverage for youth aging out of the system, if in juvenile hall at the time youth ages out, but the youth in not under a GPO?

Questions about the linkage between Medi-Cal and other programs:

What are the differences between Social Security Medi-Cal eligibility and general Medi-Cal eligibility?

Is Medi-Cal a prerequisite for any other possible funding sources?

Are there other federal/state programs that are available if youth are not eligible for Medi-Cal?

Parents

If the minors parents do not have medical coverage, can the probation officer apply for the child?

Sometimes parents don't apply for Medi-Cal, is there any other way to access Medi-Cal for minors?

How can I (probation officer) or the minors parents sign up for Medi-Cal while the minors are in custody so that when they are released the minors can obtain necessary services?

How does a minor sign up for Medi-Cal when parents are not eligible but they don't have private insurance for services?

Who can we refer parents to when children are released from the correctional facility?

Questions about immigration issues:

How to get services for undocumented minors, including placement monies, mental health services, etc.

How does a family's citizenship status affect Medi-Cal and other assistance? What if parents have a different status than their children?

Resources Wanted:

References to learn eligibility/ineligibility

Phone numbers of State Medi-Cal Representatives

Phone numbers to Help Lines
Phone numbers to help trouble-shoot particularly difficult situations

How can a PHN get an orientation to learn how to process a foster child into Medi-Cal?

SB 163 funds

List of Education Liaisons

Continuous Eligibility for Children letter

ATTACHMENT 5

OCT 5TH MEETING LIST OF ATTENDEES AND AGENDA

October 5, 2006 Medi-Cal Meeting Attendees

Vince Ariz
Deputy Probation Officer
Fresno Co. Probation

Pat Arthur
National Center for Youth Law

Karen Bantique, SDPO
Solano County Probation Department

Jeff Bidmon
Assistant Division Director
Santa Cruz Probation Department

Alex Briscoe, Assistant Director
Alameda Health Care Services Agency

Carol Brown
CHDP Deputy Director
City of Berkeley

Sue Burrell, Staff Attorney
Youth Law Center

Alice Bussiere, Staff Attorney
Youth Law Center

Phyllis Byrnes, SPHN
San Bernardino County Public Health
HCPCFC

Mary Cardenas
Program Manager
Children's Health Initiative
County of Santa Clara SSA

Donna Davis
Enrollment Service Representative
Supervisor II
MAXIMUS Inc. California Health Care Options

Rosie Estrada
Lead Medical Unit Clerk
Medical Clinic
Santa Clara County

N. Kathleen Finnegan
Principal Consultant
Assemblyman Leland Yee, Ph. D.
Speaker Pro Tempore

Nancy Hayes, PHN
CHDP/Probation
Contra Costa County

Barbara Holdsworth, PHN II
Healthy Returns Unit
Ventura County Public Health

Annamarie R. Iraci, PHN III
County of San Diego HHSA

M. Elena Lara, Program Analyst
CA Department of Health Services

Suzanne Latimer, PHN, MS
Nurse Consultant III
Children's Medical Services Branch

Cindy Lawrence
CHDP Gateway Analyst
Medi-Cal Eligibility Branch
CA Department of Health Services

Chia-Chen Lee, Nurse Manager
Children's Shelter & Juvenile Fac.
Medical Clinic
Santa Clara County

Kattya Manning
Marriage/Family Therapist-Intern
Healthy Returns Unit
Ventura County Behavioral Health

Caitlin McCann, Intern
Youth Law Center

Roxanne Morales
Enrollment Service Supervisor I
Maximus Health Operations Group
Western Region Division

Shelley Neal
Placement PHN
Alameda County Probation

Dave Neilsen, Chief
Community Services and Supports Branch
Department of Mental Health

Janeen M. Newby, Associate
Governmental program Analyst
Medi-Cal Eligibility Branch, MS4608
CA Department of Health Services

Karen Pank
Incoming Executive Director for CPOC

Elizabeth Plazola-Jones, PHNII
Public Health/CHDP/Health Care
Program for Children in Foster Care
Ventura County

Judy Quinn, RN, PHN
Nurse Consultant
CHDP Foster Care Program Supvr.
Health & Human Services Agency
San Diego County

Elizabeth Reeves
Probation/HCPCFC/CHDP
Solano County

David Ruiz
Probation Services Manager
Fresno Co. Probation

Cynthia Rutledge
Staff Mental Health Specialist
California Department of Mental Health

Leonard Salinas
Senior Deputy Probation Officer Healthy
Returns Unit
Ventura County Probation Agency

Jim Salio, Division Manager
San Luis Obispo Probation

John Sanfilippo
California Department of Social Services
Foster Care

Cathy Senderling-McDonald
Senior Legislative Advocate
County Welfare Directors Association of
California

Lori Smeenge PHN
Foster Care/Probation
Santa Clara County

Jack Stroppini, Manager
Children and Family Services Division
Foster Care Support Services Bureau

Norma Suzuki, Executive Director
Chief Probation Officers of California

Tim Toste, Detention Services Director
Humboldt County Probation

Alice Turney, Program Coordinator
Department of Employment and
Benefits Services
County of Santa Clara SSA

Flavia B. Walton, Ph.D.
Consultant
Walton and Associates

Lois A. Williams
Prevention and Early Intervention
California Department of Mental Health

Debora Wong-Kochi
Managed Care Liaison
Medi-Cal Eligibility Branch
CA Department of Health Services

Mamie Yee, Paralegal
Youth Law Center

Improving Access to Medi-Cal for Youth in the Juvenile Justice System
Sierra Health Foundation
Sacramento, California
October 5, 2006

10:00 – 10:15	Welcome, Introductions, and Goals of the Meeting
10:15 – 10:30	Brief Review of Current Medi-Cal Policy
10:30 – 11:00	Project Overview Project Activities Project Findings Related Developments Recent Legislation CPOC Initiatives
11:00 – 11:30	Discussion of Best Practices and Remaining Barriers
11:30 – 12:00	Overview of Project Recommendations; Discussion
12:00 – 12:30	Lunch
12:30 – 1:00	Finalize Recommendations
1:00 – 1:45	Identify Next Steps What is needed? How should those needs be addressed? How do we make it happen?
1:45 – 2:00	Break
2:00 – 3:00	Develop Implementation Strategy Final Report and Recommendations Dissemination of Report Training and Technical Assistance Policy Development

ATTACHMENT 6

SHORT OVERVIEW OF MEDI-CAL AND THE INMATE PAYMENT EXCEPTION

MEDI-CAL OVERVIEW AND THE INMATE PAYMENT EXCEPTION

Medi-Cal, California's Medicaid program, is a significant source of health insurance for children served by the juvenile justice system.[1] Children and youth can qualify for Medi-Cal based on their income[2] or participation in programs such as Supplemental Security Income (SSI), CalWORKS, Aid for Dependent Children Foster Care, Adoption Assistance, or Refugee Medical Assistance or Refugee Cash Assistance.[3]

California has participated in Medicaid since its inception over forty years ago.[4] The purpose of Medi-Cal is to provide eligible individuals health care and related remedial or preventive services, including related social services.[5] The California Department of Health Services (CDHS) is the single state agency responsible for administering Medi-Cal in accordance with federal requirements.[6]

1. EPSDT

An important component of Medicaid is Early and Periodic Screening Diagnosis and Treatment (EPSDT), a comprehensive child health program that covers health screening, diagnosis, preventive care, and medically necessary treatment, including mental health services. States that participate in the Medicaid program must provide EPSDT services.[7]

EPSDT is not just a passive health insurance program. States must help children obtain coverage and appropriate services to meet their needs. 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

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[1] *See, e.g., Health Care for Our Troubled Youth,*, *supra* at pp. 10-12; B. Kamradt, *Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities*, p. 2, National Center for Mental Health and Juvenile Justice (December 2002). Available at: http://www.ncmhjj.com/pdfs/publications/Funding_Mental_Health_Services.pdf

[2] Medi-Cal covers youth up to age 19 whose family income is at or below the Federal Poverty Level, children 1-6 years old whose family income is at or below 133% of the FPL, and children under 1 whose family income is at or below 200% of the FPL. Calif. Welf. & Inst. Code §§ 14148, *et seq.*, 22 Cal. Code Regs. §§ 50262, *et seq.*

[3] Calif. Welf. & Inst. Code §§ 14005, *et seq.* 22 Cal. Code Regs 50201, *et seq.*

[4] The statute creating Medi-Cal, California's Medical Assistance program, was passed in 1965 and became operative on March 1, 1966. Calif. Welf. & Inst. Code §§ 14000, *et seq*. (Added by Stats.1965, 2nd Ex.Sess., c. 4, p. 103, § 2, eff. Nov. 15, 1965, operative March 1, 1966.)

[5] Calif. Welf. & Inst. Code § 14000.

[6] Calif. Welf. & Inst. Code §§ 14100.1 & 14061-14062.

[7] 42 U.S.C. § 1396a (a) (43).

> 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.[8]

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

- 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.[9]

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;

[8] http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/
[9] 42 U.S. Code §§ 1396d(r) (1), 1396a (a) (43) (B).

- 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.[10]

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.[11] States must also inform eligible individuals about EPSDT services and the benefits of preventive care,[12] provide assistance with scheduling and transportation,[13] coordinate EPSDT services with other related agencies and programs, and refer children for needed services that are not covered by Medicaid.[14]

2. EPSDT in California

California law specifically incorporates EPSDT in the definition of health care services covered by Medi-Cal.[15] California provides EPSDT services through two programs. Screening services are generally provided through the Child Health and Disability Prevention (CHDP) program;[16] diagnosis and treatment services are generally provided through Medi-Cal.

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.[17] 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. Medi-Cal mental health services are provided primarily through mental health managed care.[18]

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[10] 42 U.S. Code §§ 1396d(r) (2)-(5), 1396a (a) (43) (C).
[11] 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.
[12] 42 U.S. Code § 1396a (a) (43) (A), 42 Code of Fed. Regs. § 441.56.
[13] 42 Code of Fed. Regs. § 441.62.
[14] 42 Code of Fed. Regs. § 441.61.
[15] Calif. Welf. & Inst. Code § 14132(v).
[16] California Health and Safety Code §§ 124025, *et seq.*
[17] CHDP covers all children eligible for Medi-Cal and many low income children who are not Medi-Cal eligible. California Health & Safety Code §§ 124,090 & 104,395.
[18] 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 .

3. The Inmate Exception: Federal Law

Federal law prohibits federal financial participation (FFP) "with respect to care or services for any individual who is an inmate of a public institution."[19] This provision has been part of the Medicaid statute since the program's inception. 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.[20]

Federal 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."[21] The federal regulations provide the following definitions:

> "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
> (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.[22]
>
> "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;

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[19] 42 U.S. Code § 1396d (a) (27) (A); 42 Code of Fed. Regs. § 435.1008(a) (1).

[20] *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).

[21] 42 Code of Fed. Regs. § 435.1008(b).

[22] 42 Code of Fed. Regs. § 435.1009.

(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.[23]

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.[24] 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,[25] and in 2004, the Centers for Medicare and Medicaid Services (CMS), the successor agency to HCFA, issued a memorandum reminding states that that the inmate exception affects coverage of services, not eligibility.[26] The following pertinent points were addressed:

a. Eligibility Not Affected

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.[27] Thus federal law does not require that an individual's Medicaid eligibility be terminated upon incarceration.[28]

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[23] *Id.* Title IV-A no longer covers foster care.
[24] 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"].
[25] 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.
[26] Memorandum from Glenn Stanton, Acting Director, Disabled and Elderly Health Programs Group (DEHPG) to State Medicaid Directors and CMS Associate Regional Administrators for Medicaid, "Ending Chronic Homelessness," May 25, 2004 [hereafter CMS Memorandum, May 25, 2004].
[27] *Id.*
[28] *Id*.

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.[29] 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.[30]

iii. The 2004 Memorandum

The 2004 CMS memorandum reminds states that the inmate exception does not affect eligibility

> As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affect only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate for a public institution or a resident of an IMD.
>
> Thus states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continued to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible

[29] Letter from Donna E. Shalala to the Honorable Charles E. Rangel; letter from Sue Kelley, Kathryn Kumerker.
[30] Letter from Donna E. Shalala to the Honorable Charles E. Rangel.

> individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge form the facility.[31]

The Memorandum went on to encourage states to coordinate with parole officers and other social service provides to "assure that eligible persons are enrolled in Medicaid prior to release and…create an ongoing continuum of care for these individuals…"[32]

b. Application to Juveniles

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."[33]

c. Criteria for the Prohibition on Federal Financial Participation (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."[34] A public institution is one "under the responsibility of a governmental unit, or over which a governmental unit exercise administrative control."[35] 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

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[31] CMS Memorandum, May 25, 2004.
[32] *Id.*
[33] HCFA Memorandum, Dec. 12, 1997.
[34] *Id.*
[35] *Id*

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.[36]

c. 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 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.[37]

4. The Inmate Exception: California Implementation

The California Legislature intended to maximize access to health care services consistent with federal Medicaid coverage through California's Medi-Cal program. However, state regulations terminate Medi-Cal eligibility for inmates, and County practices are widely divergent with respect to Medi-Cal billing for

[36] *Id.*
[37] *Id.*

youth in institutions. As a result, when youth move in and out of secure facilities, they experience gaps in health care coverage because of the way that the inmate exception is applied in California. This means, for example, that Medi-Cal coverage is not immediately available to many children in need of medication or mental health treatment upon release from secure confinement. This delay in access to care may result in a worsening of conditions or illnesses, and, particularly when mental health services are unavailable, may precipitate problems causing a return to custody.

a. State Statutes: Maximizing Coverage and Federal Financial Participation

The California Medi-Cal statute concerning inmates follows federal law. It 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.[38] However, 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.[39] Counties, cities and the Division of Juvenile Justice, formerly the Youth Authority, are specifically authorized to claim Medi-Cal reimbursement for services that are eligible for FFP.[40]

b. State Regulations and Medi-Cal Policy

State regulations do not provide any further definition of "inmate" or "public institution."[41] 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:

> 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.

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[38] Calif. Welf. & Inst. Code § 14053(b).
[39] Calif. Welf. & Inst. Code § 11016.
[40] California Penal Code § 4011.1(a).
[41] 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 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.[42]

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.[43]
>
> 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.[44]

The *Medi-Cal Eligibility Procedures Manual* adds further guidance. 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,[45] but an individual released due to a medical emergency who would otherwise be incarcerated but for the medical emergency is not covered.[46] The *Manual* also notes that facilities eligible for Title IV-E foster care payments and community care facilities (*e.g.*, foster family homes, group homes, and community treatment facilities) do not come within the definition of "public institution." [47]

c. Fair Hearing: Furloughed Youth

Youth who are furloughed from an institution into the custody of a parent are not considered inmates for Medi-Cal purposes because they are no longer residents of the institution. A state fair hearing decision by the California Department of

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[42] 22 Calif. Code of Regs. § 50273(a) (5)-(8).
[43] 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.
[44] 22 Calif. Code of Regs. § 50273(c)(6)-(8)
[45] *Medi-Cal Eligibility Procedures Manual*, Section No. 50273, Manual Letter No. 241 (April 18, 2001), Article 6C-2(c) & (d).
[46] *Id.,* Article 6C-1(e).
[47] *Id.,* Article 6B.3, Section No. 50273.

Health Services said that a youth who had been furloughed from juvenile hall to attend a funeral was not an inmate.[48] The youth's mother obtained a one-day Temporary Release from juvenile hall for the youth into her custody. However the youth had a seizure during the time he was released and was taken to the hospital where he received outpatient services. The mother got a bill for $4,850. The Probation Department argued that it was not responsible for payment because the youth was in the mother's custody, and Medi-Cal denied coverage because the youth was an inmate of the juvenile hall.

The hearing officer agreed with the Probation Department and disagreed with the Medi-Cal determination, saying that the youth was not an inmate of juvenile hall. Even though the mother agreed to return the youth to juvenile hall and the youth signed an agreement to obey the rules of probation and the direction of his parents, and return to juvenile hall within 24 hours, he was in his mother's custody, not the custody of the institution. Therefore Medi-Cal coverage was available to pay the outpatient hospital bill.

[48] California Department of Health Services, Hearing No. 2004099002 (May 25, 2004).

ATTACHMENT 7

SHORT OVERVIEW OF THE JUVENILE JUSTICE SYSTEM IN CALIFORNIA

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.[1] 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.[2] 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.[3]

At the juvenile court detention hearing, the petition is read, and the minor admits or denies the allegations.[4] 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.[5] The jurisdictional hearing for children detained in juvenile hall must take place within 15 judicial days of the court's initial detention order.[6] 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.[7] 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.[8] 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.[9]

At the disposition hearing, the court decides whether the child will be released on probation, or placed in some form of institutional custody.[10] 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.[11] The statutory timelines for detained juvenile justice cases envision that the adjudication and disposition of the case will occur in approximately six weeks.[12] Post-disposition time in

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[1] Calif. Welf. & Inst. Code §§ 626, 626.5.
[2] Calif. Welf. & Inst. Code §§ 628, 628.1, 629, 629.1, 636.2.
[3] Calif. Welf. & Inst. Code §§ 631, 632.
[4] Calif. Welf. & Inst. Code §§ 633, 657.
[5] Calif. Welf. & Inst. Code §§ 636, 636.2.
[6] Calif. Welf. & Inst. Code § 657(a)(1).
[7] Calif. Welf. & Inst. Code §§ 701, 702.
[8] 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.
[9] Calif. Welf. & Inst. Code § 702.
[10] Calif. Welf. & Inst. Code §§ 727, 731.
[11] Calif. Welf. & Inst. Code § 737.
[12] In practice, it may take much longer for cases to reach disposition because of continuances (Calif. Welf. & Inst. Code § 682). Also, in cases where the prosecutor has filed a petition to have the minor found unfit for treatment in the juvenile justice system, or the minor is detained pending

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.[13] 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,[14] 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.[15] Further, youth involved in juvenile justice cases may receive a disposition committing them to the Division of Juvenile Justice (DJJ) (formerly the California Youth Authority.)[16] DJJ operates a state-wide system of institutions and camps. California law also allows for the establishment of regional facilities for seriously emotionally disturbed wards.[17]

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trial in the adult criminal system (Calif. Welf. & Inst. Code §§ 602(b), 707), the length of stay in detention may be much longer.

[13] Calif. Welf. & Inst. Code § 727(a).

[14] Calif. Welf. & Inst. Code § 850.

[15] Calif. Welf. & Inst. Code §§ 628; 636(a); 730(a); and 880.

[16] Calif. Welf. & Inst. Code § 731.

[17] Calif. Welf. & Inst. 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.

ATTA CHMENT 8

PROMISING PRACTICES

Alameda County

Objective

Facilitate access to Med-Cal for youth in juvenile hall with moving to foster care placements and improve coordination of health services for youth moving into placement.

Solution

Alameda County placed a Public Health Nurse (PHN) in the County Probation Office to facilitate communication among agency staff and ensure that the health needs of the youth are addressed.

The PHN coordinates the elements of the youth's medical history, insurance coverage, and ongoing health care and assists staff at the youth's placement with meeting those needs, particularly for youth who will require ongoing secondary care.

When a General Placement Order is issued, the process of enrolling the child in expedited Medi-Cal is begun immediately, and the PHN communicates with juvenile hall nurses, eligibility workers, and placement officers to compile the youth's health and medical records. The PHN reviews the results of medical exams conducted at juvenile hall and identifies youth who are likely to require ongoing secondary health care. The PHN meets with the youth before they enter placement to discuss their health needs and to keep them informed of their insurance status.

Once a youth enters placement, the PHN remains in contact with placement staff to ensure that the youth continues to receive follow-up care and to assist staff with any issues or concerns arising out of the minor's health needs, including any Medi-Cal enrollment issues that arise post-placement. The PHN also provides a tracking form so that placement and other relevant staff members can document any issues they are having with Medi-Cal enrollment.

Specific staff at the county Medi-Cal Eligibility Office handle eligibility for this particular population of youth. A Medi-Cal technician comes to the Probation Office twice a week to assist the PHN and others in ensuring that Medi-Cal enrollments/eligibility procedures are on track. The technician hand delivers Medi-Cal applications from the Probation Office to Eligibility. Having face-to-face contact on a weekly basis has been important in developing stronger working relationships between staff at the probation and eligibility offices, as well as staff at group placement homes.

Every quarter, all staff involved in the Medi-Cal eligibility process, including Probation placement staff and supervisors, the PHN, eligibility clerks, and the Medi-Cal eligibility specialists and technicians, meet to discuss current issues.

Positive Outcomes

- Particularly for youth with ongoing health care needs, interviewing the individual minor gives the youth a chance to connect with the PHN and provides a contact to whom the minor can turn when he or she is having difficulties with health care.

- Although all youth who enter placement receive the CHDP exam as mandated by law, the ongoing role of the PHN with group placement staff increases the likelihood the youth will continue to receive appropriate follow-up services beyond the required CHDP screening.

- Health issues are becoming a more visible and important part of the placement process in the county.

- Stronger relationships among staff at probation, eligibility and group placements ensure better health care for youth (particularly those requiring extended medical services).

- The PHN is now working to have the Medi-Cal technician become full time at the Probation Office to facilitate on-site eligibility and to track the youth until the Medi-Cal enrollment is secure, as well as expanding the current placement system to include more formalized roles for the creation of Health and Education Passports.

For more information, contact:

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Placement PHN
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2200 Fairmont Drive
San Leandro, CA 94577
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ShNeal@acgov.org

Contra Costa County

Objectives

Obtain Medi-Cal coverage for eligible youth in juvenile hall who are awaiting placement and eliminate disruption in continuity of care and additional administrative work caused by terminating and reestablishing Medi-Cal when a change occurs (such as when a youth runs from placement and is returned.)

Solutions

Contra Costa County Probation Placement Officers, Health and Educational Liaisons, Eligibility Workers, Juvenile Hall Nurses, and a Public Health Nurse (PHN) work together to ensure that youth receiving General Placement Orders (GPO) are enrolled in Medi-Cal before they arrive at their placements and that youth in placement have continuous Medi-Cal coverage.

A multi-disciplinary committee meets each Wednesday to interview youth from juvenile hall and recommend placement orders for youth the committee feels would benefit from a group treatment/rehabilitation program. A specifically designated staff member in each department (Education Liaison, Health Liaison/Public Health Nurse, Eligibility worker, and Placement Specialist), deals specifically with youth from juvenile hall determined by the committee to benefit from group home placement.

After the committee makes its recommendations, the court issues a General Placement Order (GPO). The GPO sets in motion four different processes simultaneously: compilation of education information (Education Passport-created by the Education Liaison), compilation of health information (Health Passport - created by the Public Health Nurse), determination of appropriate group placement home (determined by the Placement Specialist), and a Medi-Cal application.

As soon as the court orders the GPO, the initial Deputy Probation Officer notifies the Placement Unit and the Eligibility Office. The Deputy transfers the educational and medical files (in collaboration with Juvenile Hall nurses) to the placement unit, and the Placement Supervisor notifies the Health and Education Liaisons, who begin compiling the Health and Education passports, while the Placement Specialist determines which group home will be most appropriate for the youth.

At the same time, an eligibility worker is working on the youth's Medi-Cal application. Upon completion, an aid code is granted (45 - children supported by public funds). (Note that undocumented youth will receive only emergency Medi-Cal and will be under a different aid code (58)).

However, if the youth has been not been placed within two months of the Medi-Cal determination, the Probation Department is notified that the youth may be discontinued. This is designed to ensure that the youth is still Medi-Cal eligible, and if it turns out that the youth in question is simply still awaiting placement, the Medi-Cal will remain in place.

While the youth is awaiting a placement assignment, the process of compiling all records is already occurring. Beginning the eligibility proceedings at this stage means that staff identifies and deals with Medi-Cal problems early on. During this period, staff from each department are in communication with one another to ensure accurate and timely processing.

By the time the group home is ready to accept the youth, the youth has Medi-Cal coverage, as well as the necessary health and education passports, so there is no waiting time after the youth has been received in the home. The whole process is expedited by notifying all appropriate departments as soon as the GPO has been ordered.

If a youth's placement status changes, Contra Costa County authorizes continued Medi-Cal coverage through Continuous Eligibility for Children (CEC) until their next re-determination ("re-investigation"). Because this whole process never takes more than 60 days, youth in this population are no longer facing the "revolving door" of Medi-Cal termination and re-enrollment.

Positive Outcomes

- Youth placed in group homes do not have to wait before obtaining medication or treatment from a local health provider.
- Youth have continuous Medi-Cal coverage.
- Unnecessary administrative work is greatly reduced.
- Staff members in different departments now have stronger working relationships.

For more information, contact:

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Humboldt County: Healthy Returns Initiative (HRI)

Objective

Identify undiagnosed or improperly treated mental health, physical health, and/or dental problems when youth enter juvenile hall and improve access to follow-up services after their release.

Solution

Using an evidenced-based mental health screening tool (MAYSI-2) for each youth who enters the hall, Humboldt County creates an appropriate mental health treatment plan for youth in custody, and ensures follow-up services through the Healthy Returns Initiative (funded by The California Endowment), facilitating connections with community-based organizations and/or other County services for continued treatment after release.

When youth enter Juvenile Hall, the clinician and/or probation officer administer the MAYSI-2 to determine the youth's mental health needs. The clinician reviews the MAYSI-2 and determines whether an additional assessment is necessary. Youth with more acute and persistent mental and emotional problems can be recommended for placement in the Northern California Regional Facility New Horizons Program, if the Probation Department Staffing Committee determines no other treatment programs are adequate to meet the youth's treatment needs**.** Based on the assessments, the HRI clinician makes appropriate referrals, and/or consults with other staff at the Juvenile Hall facility (such as the probation officer and Juvenile Hall clinician) to develop a treatment plan. If a case plan is needed, the probation officer works with the clinician to incorporate the youth's mental health needs. The clinician determines whether the youth is already receiving treatment services (with the appropriate releases in place), and if so, works with the current provider to ensure continuity of care. If gaps in service remain, staff provide additional services to meet all the youth's needs.

Beginning with the youth's entry to Juvenile Hall, culturally appropriate services (especially for Native American Youth) are available at each step. For example, staff at Juvenile Hall and probation have developed close relationships with United Indian Health Services and Two Feathers Child and Family Services (a family services/case management agency), and contact these agencies immediately when appropriate. The clinician has also met with all of these organizations to ensure that all potential resources and treatment options in a community are considered for a youth. Staff from these outside organizations (such as Two Feathers, for example) are involved in every step of the planning process as needed, and are also involved in broader policy making decisions at Juvenile Hall.

During intake, youth are asked what kind of health coverage they have, and if needed, parents/guardians are referred to the Medi-Cal application process. The clinician has a good working relationship with an on-site analyst who can determine whether a youth has or is eligible for Medi-Cal. Staff advise parents if their child is Medi-Cal eligible and inform them that Medi-Cal may not be billed for services while the child is still considered an inmate (*e.g.*, if parents choose to utilize providers outside of the Juvenile Hall's contract). The HRI program allows staff to provide ongoing services regardless of Medi-Cal coverage but encourages everyone who is eligible for Medi-Cal to obtain it.

Once youth are released from Juvenile Hall, the clinician and other probation staff follow up at 30, 60 and 90 days after release. At each point, staff assess barriers the family is facing in obtaining services indicated in the referrals. Staff then work with the family and the youth to address those barriers; for example, providing transportation or counseling the youth so that treatment becomes a priority. The clinician also oversees youth on Medi-Cal who are placed in foster care or group homes, and works with their placements to assist the youth in accessing appropriate care.

Positive Outcomes

- Probation's ability to hire a full-time clinician via HRI has greatly improved coordination and provision of juvenile services within the department.

- The clinician and probation juvenile intake and field units have developed close working relationships and consult to ensure an integrated treatment plan is developed to address all the youth's issues.

- Mental health is an important area of assessment and consideration in determining the youth's needs for ongoing treatment and rehabilitation.

- Probation, the clinician, and community organizations have developed close working relationships to facilitate re-entry of the youth into the community whenever possible. These relationships ensure that youth are able to continue treatment outside the Hall and that systems of care are in place before the youth is released.

- All possible treatment options are evaluated and considered with the goal of the youth's successful re-entry back into their family and/or the community.

- Staff also focus on providing assistance to the youth's family.

For more information, contact Tim Toste, Division Director, whose contact information follows the next example.

Humboldt County: New Horizons

Objective

Provide appropriate treatment for emotionally disturbed juvenile offenders with co-occurring disorders who do not meet criteria for hospitalization. These youth lack the criminal behavior and sophistication for commitment to the California Division of Juvenile Justice (formerly California Youth Authority) but require intensive mental health services and more structure and supervision than is provided in foster or residential care.

Solutions

Staff from Probation, Mental Health, Social Services, the County Office of Education, and United Indian Health Services work together to run the New Horizons program, which provides four-and-a-half to six months of intensive, in-facility mental health treatment to youth in this population, followed by a six-month local aftercare program.

Youth in Juvenile Hall are screened for eligibility in New Horizons, and after a variety of assessments, eligible youth can be immediately placed in the program to facilitate treatment even before disposition.

Staff from across multiple agencies work together to provide services for the youth while in the New Horizons program: Humboldt County Probation Department; Humboldt County Department of Health and Human Services - Mental Health Branch - Children, Youth, and Families Services Division; and the Humboldt County Office of Education. These agencies also work closely with local Native American treatment agencies to provide additional and culturally appropriate services to Native American children.

New Horizons uses a multi-disciplinary approach to address the youth's physical, mental and educational needs. When a youth enters the program, a case plan is developed by interdisciplinary staff. Youth are provided with structured behavior management, individual/group and family counseling, alcohol/drug assessment and counseling, independent living skills, and Aggression Replacement Training (ART). Treatment is developed from evidence-based practices. Individualized strength-based child and family case plans are developed using the Family Unity Model. Staff encourage family involvement throughout the program. Educational curriculums are designed, which are consistent and supportive of the youth's treatment objectives, including both educational and social development. During the program, youth attend monthly meetings to discuss the program and participate in extra-curricular activities.

After four-and-a-half to six months of in-custody treatment, youth are placed in a six-month after care program. As youth approach the end of the six months, in-

facility treatment phase, staff meet (along with family members when possible) to develop an after care plan that meets the youth's needs. Youth entering the aftercare program are connected with Medi-Cal Services. Aftercare includes intensive supervision and treatment programming, a coordinated educational plan, and active case management services. In addition, youth often receive mental health services from the same clinicians they worked with during the in-facility treatment phase. Minors who transition from the Regional Facility (RF) into the community are supervised by a field probation officer, sometimes by a PO from the Probation System of Care (P-SOC). The minor's treatment plan, education, and placement are worked out during his/her stay in the RF using the family team meetings (Family Unity Model) facilitated by a trained facilitator.

Positive Outcomes

- Average length of stay in the regional facility for both males and females has declined.
- Rates of arrest and institutional commitments during the intervention and follow-up period are lower.
- Functioning levels for youth has increased.
- The multi-disciplinary approach allows the program to tap into a variety of different funding streams.

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San Bernardino

Objective

Improve coordination of medical histories and current health needs of probation youth entering placement and ensure they receive necessary follow-up health care, particularly psychotropic medications.

Solutions

San Bernardino placed Public Health Nurses (PHNs) in the Probation Department to provide oversight and assistance on the youth's medical needs.

The county brought PHNs into the Probation Department in July 2001. The PHNs have created a screening tool and referral form for probation officers to help them understand when consultation with or referral to a PHN would be helpful.

PHNs compile the youth's medical history and relevant information, including any information from health records at juvenile hall, for the Health and Education Passport (HEP). They also work with staff at Probation and from various placements to educate them about the importance of the HEP as well as the HEPs of individual youth.

Once a youth enters placement, the PHN works with Probation to ensure follow-up care takes place. This is especially important if the youth takes psychotropic medications or has any other special health care needs. Part of this follow-up work involves assisting staff at the youth's placement with Medi-Cal issues. The PHNs document any issues with Medi-Cal via the Child Health Care Access Problem Identification Form, and send it to the appropriate Medi-Cal overseers, and the Probation Department fiscal staff are working on developing a good relationship with the local Eligibility Worker.

The PHNs are also active in the Independent Living Program (ILP). PHNs provide training on various health issues such as differentiating between emergency and routine personal health needs, parent education (and understanding the needs of babies), and accessing health insurance.

The co-location of the PHN and Probation has helped to establish a strong working relationship to ensure the best possible care for the youth. The first step was to explain the role of the PHN (including differences from an RN) to Probation staff and to distinguish the role of the public health nurse from the role of an RN. The PHN started to consult with Probation staff on health issues and eventually developed in-service trainings for Probation and placement staff. Training topics include confidentiality and privacy concerns (e.g., what information should Probation disclose to placement staff), immunizations, and psychotropic medications. PHNs are also available to respond to specific needs,

for example, group home staff concerns about youth tattooing each other with pens.

Positive Outcomes

- Probation staff and the public health nurses are developing a good working relationship in order to improve health outcomes for youth in need.

- Placement staff are beginning to consult public health nurses more directly and are becoming better able to deal with the follow-up medical needs of the youth.

- The co-location of public health nurses and probation staff in the same building facilitates better communication.

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San Diego County

Objective

Ensure that Health and Education Passports (HEPs) are current and include all necessary information.

Solution

San Diego created a centralized database for the youth health and education information called the Foster Youth Student Information System (FY-SIS).

As part of its Foster Youth Services program, the County Office of Education created a Foster Youth Services Advisory Committee that included staff from the Juvenile Court, Probation, Health and Human Services, Child Welfare Services, County Office of Education, Schools, and the Public Defenders Office. The Committee identified the lack of current information about foster youth as a major issue and decided to create an effective database that would include health and education records. In addition to basic identifying information about each youth, the system includes educational records, such as educational assessments; grade level; attendance; health records such as immunization history; current medical conditions and medications; and a placement summary.

The Committee sought advice from legal professionals with different areas of expertise (education, health, etc.) for help in determining how to meet privacy concerns and confidentiality protections, and overcome any legal barriers to sharing health and education information. They also analyzed which agencies and staff members needed access to the database and why in order to determine which staff members or agencies needed the ability to input or change information and which needed "read-only" clearance. For example, only identified probation, court, and public health staff are able to input or change information while specific placement and school staff members have "read only" access.

The Advisory Committee continues to meet to identify and address educational and health barriers for foster youth.

Positive Outcomes

- Youth, particularly youth placed out of county, are much more likely to receive the services they need.

- Staff have immediate access to a foster youth's records when a youth transfers to a new school, or needs services at another agency. For example, when a youth enters a new school, staff can verify that immunizations are in place and determine the youth's grade level without having to delay the

process while waiting for appropriate records to be located and sent to the school.

- School placements are expedited, the youth's educational and health needs are better coordinated, and more immediate and appropriate services provided for the youth.

- Working together on the database has strengthened the working relationships among agencies, increasing their ability to provide integrated services and ensure that each youth receives the best possible care and treatment.

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San Luis Obispo

Objective

Increase Medi-Cal coverage of eligible youth to increase resources available for comprehensive mental health services.

Solution

Because youth held in Juvenile Hall after receiving a general placement order (GPO) to be placed in a non-secure setting such as a foster home or group home are not “inmates” for purpose of the inmate payment exception rule, Medi-Cal coverage is available to pay for health services provided when youth are awaiting placement. San Luis Obispo County begins the Medi-Cal enrollment process as soon as a GPO is made by the court.

When a GPO is issued, the legal clerk (who is located in the same office as county social work and eligibility staff) starts the Medi-Cal application process. Health assessments conducted by the Juvenile Hall Nurse indicates the youth’s treatment needs. The type of treatment most frequently needed by youth awaiting placement is mental health treatment. Juvenile Mental Health is located in the same building as Probation, and this facilitates communication.

In conformity with Medi-Cal provisions, San Luis Obispo bills Medi-Cal for rehabilitation services provided by a probation officer. Under EPSDT, probation officers are able to bill Medi-Cal for rehabilitation services provided to youth in need of mental health services from County Mental Health. These services may include assisting youth with truancy problems at school, helping the youth with hygiene issues, employment training, and other services that are necessary for rehabilitation.

To effectively work with Medi-Cal, the Probation Department designates specific probation staff to provide Medi-Cal services and provides training so that the probation officer understands how to record procedures and document activity consistent with Medi-Cal billing. The process involves documenting services under particular aid codes, so that County Mental Health can distinguish those Medi-Cal reimbursed services that were provided by a probation officer and transfer the corresponding reimbursement to the Probation Department.
This process requires extensive time and training; therefore, qualified probation staff are assigned a significant number of cases (generally about half of a given officer’s caseload) of youth receiving mental health treatment who are Medi-Cal recipients.

Positive Outcomes

- Having a baseline of strong relationships between probation and mental health nurses, as well as probation and eligibility staff, increases the capabilities of these agencies to work together.
- Having staff at the agencies working in close proximity to one another enhances ability to serve youth.
- Being able to bill Medi-Cal means that the savings the county accumulates over time may be utilized to broaden the number of health services it can provide to these youth.

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Solano County

Objective

Complete Health and Education Passports (HEPs) for all probation supervised foster and reduce delays in access to crucial health and educational services, including medication for potentially life-threatening illnesses, such as diabetes, and psychotropic medications.

Solution

Solano County placed a public health nurse (PHN) in the probation office where she is co-located with the Juvenile Placement Officers.

As soon as the judge issues a GPO, the PHN begins the process of compiling the youth's health and education records. At the same time, the Juvenile Placement Probation Officer initiates expedited enrollment in the Medi-Cal program. Because she has developed a strong relationship with the Foster Care Medi-Cal Eligibility Office, the PHN is able to ensure that immediate enrollment take place.

The PHN works closely with probation placement officers, foster care Medi-Cal eligibility staff, Juvenile Hall nurses, and Child Protective Services staff to ensure that the youth's HEP is completed and that all important health and education information is included as soon as a general placement order is entered. Staff members from different departments collaborate to ensure that the youth's HEP is completed before the youth arrives at the placement. In addition, the PHN has documented the steps in each process so that other staff members can ensure that the proper actions are begun in the PHN's absence.

Once the youth is placed, the placement staff receives additional follow-up information on the importance of health check ups, CHDP services, and updating the HEP.

Solano County recently held a Symposium on Medi-Cal coverage and HEPs for county staff including the Juvenile Probation Placement Unit. Staff found it so helpful that the County is considering making the training mandatory for all new employees, and adult probation units are planning to develop a similar training.

Positive Outcomes

- Every youth who receives a General Placement Order (GPO) has a complete HEP when the youth arrives at his or her placement. This decreases the likelihood that youth will fall through the cracks or experience delay in access to needed educational and health services.

- When youth arrive at a placement, they are already enrolled in the Medi-Cal program and/or have primary insurance coverage and can access needed medications and treatment they need from local providers.

- Immediate enrollment in Medi-Cal also results in lower expenditures for the county because Medi-Cal can be billed for services to the youth as soon as the youth enters his/her placement.

- Stronger working relationships have developed among staff from the different departments, increasing their ability to provide effective services for youth.

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Ventura County

Objective

Maintain improvements in mental and physical health conditions when youth are released from juvenile hall.

Solution

Through a grant from The California Endowment, the Ventura County Probation Agency established the Healthy Returns Unit (HRU), comprised of a probation officer, public health nurse (PHN) and behavioral health therapist. The members of the Healthy Returns Team are located together at the Juvenile Facility.

Through the Healthy Returns Initiative, funded by The California Endowment, the PHN assists with all aspects of follow-up care as the youth transitions into the community. Although the PHN focuses primarily on health services, including assistance with Medi-Cal, the Healthy Returns team also supports the client with transportation, housing issues, employment resources, and other needs.

Youth are screened upon arrival at Juvenile Hall through use of the MAY-SI and other assessment instruments. Based on these screenings, the behavioral health clinician makes appropriate recommendations for services, which may include referral to HRU. HRU referrals may also take place after youth have spent time in Juvenile Hall via a referral form created specifically for the Medical Unit by the PHN.

When youth are referred to HRU, the PHN begins to cultivate a relationship with the youth that will continue once the youth leaves the facility and transitions back to home and community. (The PHN also maintains contact with other youth who have specific medial needs but have been referred to more intensive programs for mental health concerns or drug/alcohol abuse to ensure that the youth are receiving the services they need). The behavioral health therapist also establishes a therapeutic relationship with the youth prior to his or her release home, and continues to work with the youth and family while the referral to community therapist is established, which can sometimes take up to two months.

Ventura is also working on improving its ability to help youth begin the Medi-Cal application process before they leave Juvenile Hall because access to immediate Medi-Cal upon release to a placement is a crucial part of the youth's ability to continue treatment. The Healthy Returns team is developing a close working relationship with local eligibility workers, and other agencies. During the time the youth is in Juvenile Hall, or immediately upon their release, the Healthy Returns

Team also assists in compiling additional identifying information such as a birth certificates, drivers licenses, and social security numbers.

The team follows the youth, from 30-90 days after release, sometimes having contact as frequently as once a week, depending on the case. The PHN also works to educate family members/guardians about the youth's needs. The behavioral health therapist makes home visits to continue the youth's individual or family behavioral therapy.

Positive Outcomes

- Throughout this process, the Healthy Returns team members have been developing relationships with outside community providers to ensure availability of health services and other resources when the youth is released.

- Stronger relationships mean that all involved agencies and organizations are able to better serve the needs of youth.

- The HRU team members are now also being asked to assist in other situations involving youth in the community (i.e., crisis intervention, etc.).

- Overall, increased integration of services has led to better health outcomes for youth, and increased likelihood that youth are able to continue to receive the medical/dental and behavioral health services they need to succeed and reduce recidivism.

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