REPORT OF THE

JOINT SUBCOMMITTEE ON THE

MEDICAL NEEDS OF CHILDREN

OF THE

HOUSE SUBCOMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS

AND THE

SENATE COMMITTEE ON EDUCATION AND HEALTH

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 28

COMMONWEALTH OF VIRGINIA
DIVISION OF PURCHASES AND SUPPLY
RICHMOND
1979

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Report of the

Joint Subcommittee on the

Medical Needs of Children

of the

House Committee on Health, Welfare and Institutions

and the

Senate Committee on Education and Health

To

The Governor and the General Assembly of Virginia

Richmond, Virginia

January 10, 1979

To: Honorable John N. Dalton, Governor of Virginia

and

The General Assembly of Virginia

INTRODUCTION

The Joint Subcommittee on the Medical Needs of Children was authorized to conduct its study by House Joint Resolution No. 48, agreed to by the House of Delegates and the Senate of Virginia during the 1978 Session. That resolution is as follows:

HOUSE JOINT RESOLUTION NO. 48

Requesting the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to study the medical needs of children in the custody or care of State and local agencies.

WHEREAS, the House Committee on Health, Welfare and Institutions has conducted a study on the placement of children during 1976 and 1977; and

WHEREAS, during the course of this study it was determined that gaps in medical coverage for children in the custody or care of State and local agencies present major barriers to providing appropriate placements and treatment for them; and

WHEREAS, the Medicaid plan for Virginia does not currently provide Medicaid coverage for all

income eligible children under the age of twenty-one years which is an allowable option under federal law and regulations; and

WHEREAS, an opinion of the Office of the Attorney General issued November twenty-four, nineteen hundred seventy-six interprets the federal law as excluding children in the custody of the State Board of Corrections from being eligible for Medicaid benefits while other states have come to different conclusions; and

WHEREAS, the failure of the Commonwealth to have a comprehensive medical care system for children in its custody is a major deterrent to cost effective planning for children; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health are requested to study the medical needs of children in the custody and care of State and local agencies. The study should focus upon (i) the identification of gaps in medical coverage for children in placement; (ii) mechanisms for filling these gaps and providing the needed services in an effective and economical way; and (iii) the potential for and cost of expanding Virginia's Medicaid plan to meet some or all of these needs.

The joint subcommittee shall submit its report and any legislation it deems appropriate to the Governor and the nineteen hundred seventy-nine Session of the General Assembly.

Pursuant to the direction of the General Assembly to conduct a study of the medical needs of children who are in the custody or care of State and local agencies, Delegate John D. Gray, Chairman of the House Committee on Health, Welfare and Institutions and Senator Hunter B. Andrews, Chairman of the Senate Committee on Education and Health, appointed the following delegates and senators to serve on a joint subcommittee: Delegate Norman Sisisky of Petersburg, Senator Adelard L. Brault of Fairfax, Senator John C. Buchanan of Wise, Senator A. Joe Canada, Jr. of Virginia Beach, Delegate Evelyn M. Hailey of Norfolk, Delegate Joan S. Jones of Lynchburg, Delegate Owen B. Pickett of Virginia Beach, Delegate Robert C. Scott of Newport News, Delegate Frank M. Slayton of South Boston, Delegate Warren G. Stambaugh of Arlington and Senator Edward E. Willey of Richmond. Delegate Sisisky was selected to serve as chairman and Delegate Hailey as vice-chairman.

HISTORY

During 1976 and 1977 a comprehensive study was conducted by a subcommittee of the House Committee on Health, Welfare and Institutions on the placement of children. (See House Document No. 16 - 1977 and House Document No. 22 - 1978.) Among the issues addressed by the Subcommittee on the Placement of Children are the difficulties which State and local agencies are faced with when trying to place children who have emotional and physical handicaps in treatment facilities. The 1978 Report of the Subcommittee stated: "Since agencies tend to seek placements for children for which financial support is available, the failure to provide support to meet the considerable medical needs of these special children often results in inappropriate treatment and placements." The Report further stated that: "Planning to meet the needs of children in State and local care or custody is influenced in the Commonwealth by the absence of a comprehensive medical care system." (House Document No. 22 - 1978, page 18.) The Subcommittee proposed legislation which would establish a study in 1978 to specifically address the issue of the medical needs of those children who were generally the concern of the legislative study conducted during 1976 and 1977. The Joint Subcommittee on the Medical Needs of Children and this report represent the fruits of that effort.

FINDINGS

Children in Placement.

The status of the custody of a child for whom medical services may be required is a key to whether certain financial resources such as Medicaid are available. The children with whom this

study has been concerned may be in the care or custody of:

1. A local welfare agency.

A child may be committed to the custody of a local board of welfare by a juvenile court or be entrusted to the agency by a parent and be formally placed in a foster care program. (§§ 16.1-279 and 63.1-56)

The juvenile court may place a child in the care of a local welfare agency pending a detention, adjudicatory or dispositional hearing without formally committing the child to the local board. (§ 16.1-249)

The juvenile court may return to a local welfare agency for supervision in the community a child who has been committed to the State Board of Corrections. When a child is so paroled for local supervision, he remains in the custody of the Department of Corrections even though he is the responsibility of the local welfare agency. (§§ 16.1-252 and 16.1-253)

In the case of the placement for adoption of a child in the custody of a local board, the agency retains custody and control of the child until a final order of adoption has been entered. (§ 63.1-204)

A child with special needs in the custody of a local board may be adopted with a subsidy paid to the adopting parents. The local agency may agree to continue responsibility after the final order of adoption for specified medical problems of the adopted child. (§ 63.1-238.1 et seq.)

2. The State Board of Corrections.

A child who is over ten years of age and found guilty of a delinquent act may be committed to the State Board of Corrections by a juvenile court. (§ 16.1-279 E.)

3. Community residential care facilities financed by funds from the Department of Corrections and participating local governing bodies (ex. juvenile detention homes, group homes).

A child may be held in a detention home pending a detention, adjudicatory or dispositional hearing by the juvenile court. (§ 16.1-249)

A child may be placed in a community residential care facility such as a group home as a final disposition by a juvenile court. (§§ 16.1-279 and 16.1-286)

In each of the instances enumerated above, a child who is the responsibility of a State or local agency and who may be separated from his parents or legal guardian may require medical services. The source of funding to meet the medical treatment needs of these children most often goes back to the agency having custody of the child. If this matter of custody is not clear pursuant to a court order or is clouded by agencies which have programmatic or treatment but not custodial responsibilities, major barriers to adequate medical coverage can arise.

Sources of Funding for Medical Services.

Department of Corrections - For children committed to the care of the State Board of Corrections, medical and clinical services are a budgeted item in the Department's budget.

The costs of medical services for chidren which are paid for by community residential care facilities, financed in part by funds from the Department of Corrections, are one hundred percent reimbursable by the Department.

All children in the custody of the State Board of Corrections or in community facilities financed in part by Corrections funds have been ineligible for Medicaid benefits by virtue of an interpretation of federal law by the Virginia Office of the Attorney General issued November 24, 1976.

Department of Welfare - Children in the custody of local welfare agencies through entrustment by their parents or commitment by the court are eligible for Medicaid when the child's income and

resources are insufficient to cover the cost of maintenance (room, board, clothing) and medical care.

The funding of medical care for children in foster care who are ineligible for Medicaid and for children who are otherwise in the care of a local welfare agency comes from Title XX funds, Social Services funds, Aid to Dependent Children - Foster Care funds and State - Local - Foster Care funds appropriated for the maintenance of these children.

Department of Health - The Medical Assistance Program (Medicaid) established under Title XIX of the Social Security Act is administered by the Department of Health. The Medicaid program incorporates groups of individuals and services that are both mandatory and optional. The mandatory services are those which the federal government requires be present in any Medicaid program. Optional services are those for which federal matching funds are available, but a state is not compelled to cover these services in its Medicaid program. There are several groups of individuals which a state may opt to cover as medically needy. These individuals meet the categorical requirements for public assistance but do not receive cash payments, because their income is too high to qualify. These individuals have enough income to purchase the basic necessities of life but are unable to purchase medical care.

Virginia currently opts to provide Medicaid benefits to the medically needy under twenty-one years of age as follows:

1. All persons under twenty-one for whom public agencies are assuming full or partial financial responsibility who are in foster homes or private child-caring institutions and who are in subsidized adoptions.

2. All persons under twenty-one in intermediate care facilities.

Each individual who applies for Medicaid must meet the criteria specified for one of these groups in addition to having income within Medicaid eligibility levels.

The Commonwealth does not take advantage of federal options to cover medically needy individuals under twenty-one as follows:

1. Families for the Aid to Dependent Children Program with unemployed fathers.

2. All individuals under age twenty-one placed in foster homes or private child-caring institutions by private non-profit agencies.

3. All individuals under age twenty-one.

4. All individuals under twenty-one receiving active treatment in psychiatric hospitals.

For children in the custody of local boards of welfare, Medicaid is the primary source of funding to meet the medical treatment needs of those children who are eligible. The major barriers to adequate medical coverage through Medicaid, however, have been the limitations on what children are eligible and the exclusion of some eligible children from receiving benefits when they are placed in residential treatment centers or publicly-operated group homes. It is these issues which the Subcommittee has primarily focused its attention on during this study.

SUBCOMMITTEE ACTIVITIES

At the Subcommittee's first meeting on July 19, 1978, representatives of the Departments of Welfare, Corrections and Health delineated the issues which they felt the study should address and provided background information for the Subcommittee's consideration.

A Joint Task Force for Coordination was formed in June, 1977 between the Division of Youth Services of the Department of Corrections and the Department of Welfare to facilitate the implementation of the revised laws governing juvenile and domestic relations district courts. The absence of a comprehensive and consistent system to meet the medical needs of children was a major issue addressed by the Task Force. One aspect of this problem can be illustrated as follows:

A child in a foster care program in need of the services offered by a group home financed partially by the Department of Corrections in accordance with § 16.1-313 of the Code automatically loses his Medicaid coverage as soon as he enters the group home. If the Department of Welfare, however, purchases the same services for the same foster care child from private vendors, the child retains his Medicaid coverage. The absence of a mechanism to cover medical expenses for such children has been inhibiting the use of existing group homes by local welfare agencies.

Efforts by the agencies involved to address these problems through agreements as to which agency has responsibility for medical expenses in specified cases have been less than successful. The primary obstacle to effectively resolving many of the issues surrounding financial support for medical treatment of many of the special children of concern to the agencies remained an interpretation of the federal law and regulations governing the Medical Assistance Program by the Virginia Office of the Attorney General. (See Appendix A.)

At the Subcommittee's August 22, 1978 meeting, representatives of the Philadelphia Regional Office of the Department of Health, Education and Welfare discussed the Subcommittee's request for a review (i) of Virginia's position on Medicaid eligibility for certain children in community residential care facilities (See Appendix B, Exhibit 1.) and (ii) of the availability of Medicaid reimbursement to certain private non-medical institutions for medical and psychiatric services. (See Appendix B, Exhibit 2.) Earlier testimony at the August meeting by representatives of a local social service department and a local group home administration indicated a need to clarify financial responsibility for the medical treatment of the children in their programs and to provide greater financial support for this important part of their budgets. Representatives of the Department of Health, Corrections and Welfare presented programmatic and financial data which illustrated the number of children participating in their various programs and the potential impact of any revision of Virginia's Medicaid policy.

Information presented by the Department of Health showed that a total of 132,861 individuals under age twenty-one were enrolled as active cases in the Medicaid program as of July 1, 1978. This total included 8,817 children in foster care programs. Statistics presented by the Department of Welfare indicated that 10,199 children were in foster care as of June 30, 1978, leaving approximately 1,382 children in the custody of local welfare departments who were not Medicaid eligible. None of the 2,768 children committed to the State Board of Corrections or of the 955 children receiving predispositional services funded by the Department of Corrections during 1977-78 were eligible for Medicaid benefits. Also precluded from receiving Medicaid reimbursement were 12,145 admissions to local detention homes, crisis intervention homes, detention outreach programs and local group homes in which medical expenses for the children are one hundred percent reimbursable by the State.

The Department of Health estimated that the cost of Medicaid coverage for all individuals under twenty-one, excluding inpatient psychiatric care, would have been $46,724,000 for fiscal year 1977-78 and would be $69,939,000 for fiscal year 1978-79, with 42.99% of these amounts being the cost to the Commonwealth. The Department of Corrections and Welfare enumerated their correlative expenditures for medical costs for these same periods. These figures together with more detailed statistics on the facts previously discussed can be found in Appendix C.

This background information was shared with the HEW staff in Philadelphia working to obtain a review of Medicaid law and regulations which would assist Virginia in better serving its special children. At the November 14, 1978 meeting of the Subcommittee, representatives of HEW presented an opinion of the Office of the General Counsel, Health Care Financing and Human Development Services Division, Department of Health, Education and Welfare. (See Appendix D.) The entire opinion should be read for a thorough understanding of HEW's position on Medicaid eligibility requirements for children in the care or custody of the Department of Corrections or of community facilities which it finances. The following excerpts from that opinion, however, address most specifically the issues which the Subcommittee had sought clarification of.

> "In the light of current regulations regarding inmates of public institutions the November 24, 1976 Opinion of the Virginia Attorney General has two major flaws as a guide to proper categorization, for Medicaid purposes, of juveniles in the custody of the State Department of Corrections.
>
> "The first flaw is attributable simply to the passage of time. At the time the Opinion was written, federal regulations excepted only "medical institutions" and "intermediate care facilities"

from the definition of "public institutions." As of March 10, 1978, the relevant regulations were amended to except "publicly operated community residences which serve no more than 16 residents" from the definition of public institutions. Accordingly, the Attorney General's judgment regarding the applicability of the "inmate of a public institution" exclusion to children in certain governmentally administered facilities may have to be reassessed. The factual information provided in the Attorney General's Opinion, however, is insufficient to form a basis for any meaningful judgment of the extent to which the new "community residence" exception affects the current validity of the opinion.

"The second fallacy in the Attorney General's Opinion is the assertion that certain juveniles are properly categorized as inmates of public institutions, and hence excluded from Medicaid coverage, on the basis of the fact that they are within the "administrative control," i.e., in the legal custody of, the Department of Corrections.

"As has been discussed above, federal regulations do not permit classification of an individual as an "inmate of a public institution" unless that individual may reasonably be considered to live in a facility defined as a "public institution." The regulations, moreover, absolutely preclude a "medical institution," "intermediate care facility," or "publicly operated community residence that serves no more than 16 residents" from being considered a "public institution" for purposes of excluding its inmates from Medicaid coverage. Thus, the fact that a juvenile is within the "administrative control" of the Department of Corrections cannot be determinative of status as an inmate of a public institution where the juvenile clearly does not live in such an institution. Although there may be cases in which a juvenile in the Department of Corrections' custody can be considered an "inmate of a public institution" despite physical presence in a medical facility; the rationale for such classification must be that the juvenile, at least constructively, "lives in" another facility included in the regulatory definition of a "public institution." The administrative control of the Department of Corrections is, under no circumstances, the fact determinative of Medicaid eligibility.

"... Contrary to the Attorney General's Opinion, the relevant question to be answered with respect to each category of juveniles mentioned is simply whether the involved children live in facilities classified by regulation as public institutions. Under no circumstances can the "administrative control" of the Department of Corrections be the factor that establishes a juvenile's status as an "inmate of a public institution."

The opinion of the HEW General Counsel opened the door to Medicaid benefits for children previously excluded from eligibility by clarifying the guidelines to be used in determining eligibility. The burden of establishing eligibility requirements as they relate to specific categories of children in Virginia, determining the financial impact on the Medicaid program and enrolling those eligible children fell on the Departments of Health, Welfare and Corrections. To facilitate this process the Subcommittee requested that the Virginia Office of the Attorney General review its opinion of November 24, 1976 in light of the HEW opinion of November 9, 1978 and advise the Subcommittee as to what steps needed to be taken to see that Medicaid benefits were extended to those eligible children. (See Appendix E, Exhibit 1.) Pursuant to the Attorney General's response, the Departments of Corrections, Health and Welfare began meeting early in December to identify the potentially eligible children, finalize eligibility determination procedures and develop a plan for enrolling eligible children. (See Appendix E, Exhibit 2.) On January 5, 1979 a joint information bulletin was released from the Departments of Corrections and Welfare informing pertinent local human service delivery agencies of the changes in State Medicaid policy with regard to children in their care or custody. March, 1, 1979 has been set as the date for initiating applications for Medicaid benefits for these children. (See Appendix E, Exhibit 3.)

The Departments of Corrections and Welfare have determined that approximately 1,325 additional children are potentially eligible for Medicaid benefits. The Department of Health has estimated that about ninety percent of these children will meet the financial eligibility criteria. Based on the average annual cost of medical expenses for foster children in the custody of local welfare departments of $520, the Department of Health has calculated that Medicaid expenditures to cover the new eligible children will be as follows:

1978-79 fiscal year: $176,759 federal funds
133,291 State funds
$310,050

1979-80 fiscal year: $350,605 federal funds
269,495 State funds
$620,100

The Subcommittee supports the Department of Health in its request to the 1979 Session of the General Assembly for an additional appropriation of $402,786 to the Medicaid budget to cover these increased expenditures in the 1978-80 biennium.

Previously referenced in this report was the Subcommittee's concern about the need for more extensive use of Medicaid reimbursement for medical and psychiatric services in certain private non-medical institutions. During the course of the study, it was learned that only one Virginia private, non-medical child-caring facility had applied for and been approved as a Medicaid provider since 1971. The Department of Welfare estimated that more than $650,000 per year in Title XX funds would be saved, if other such facilities could be certified as Medicaid providers. The State Departments of Health and Welfare, in cooperation with the HEW Philadelphia Regional Office, clarified the procedures to be used by private facilities in applying as Medicaid providers. (See Apppendix F, Exhibit 1.) On November 29, 1978 twenty-eight private child-caring facilities with medical services components in Virginia and out-of-state currently serving children placed by local departments of welfare were contacted concerning their potential eligibility for Medicaid contracts. (See Appendix F, Exhibit 2.) The Department of Health has indicated its willingness to work with each of these facilities to determine if it is eligible for Medicaid reimbursement, thus providing one more resource for financing private placements of troubled children.

CONCLUSIONS

During the 1978 Session of the General Assembly, Senate Joint Resolution No. 19 was agreed to by the Senate and the House of Delegates. This resolution acknowledged support of the proclamation by the United Nations General Assembly that 1979 be declared the "International Year of the Child." That resolution stated in part: "That the Virginia General Assembly will encourage the review of all State and local programs for the promotion of the well-being of children and will support national and international efforts to respond to the needs of children..." The Subcommittee is pleased to be able to report to the Governor and the 1979 Session of the General Assembly that significant barriers to the financing of appropriate medical care and treatment for many children in State and local care and custody have been removed. This has resulted from a cooperative effort by the Subcommittee, State executive departments and the United States Department of Health, Education and Welfare in reviewing Virginia's medical resources for its youngest citizens. Much remains to be done to provide the most comprehensive, yet economically feasible, medical care system for children who become the responsibility of State and local governments. Yet, this study has illustrated that intergovernmental efforts to resolve problems of mutual interest can be productive and can result in more effective resources to help children needing care outside the traditional family structure.

Children, Youth and Families in Virginia: Assessing Their Needs, published by the Virginia Division for Children in the fall of 1978, includes important data analysis concerning the health and mental health needs of the Virginia citizens interviewed. This publication along with the statistics compiled for this legislative report call for a continuing review of Virginia's resources in the human services delivery system in order to meet the health needs of the children of the Commonwealth. While the legislature will perform this role in its general oversight of State and local programs, it is incumbent upon those working on a daily basis in this field at all levels of government and in the private sector to pursue effective, quality health services for children.

The Subcommittee wishes to particularly express its appreciation to Roy T. Perez-Daple and the staff of the Philadelphia Regional Office of the United States Department of Health, Education and Welfare for their most cooperative and effective assistance during the course of the study. The efforts of the Regional Office were invaluable in securing a timely and favorable review of federal issues of concern to the Commonwealth. The Subcommittee is also appreciative of the responsiveness of the Departments of Corrections, Health and Welfare in securing the necessary data and background information for the study to proceed and looks forward to their continued close cooperation with each other in implementing the Medicaid policy revisions initiated by this study and in their daily efforts to provide effective and efficient health care for children.

Respectively submitted,

Norman Sisisky, Chairman

Evelyn M. Hailey, Vice-Chairman

Adelard L. Brault

John C. Buchanan

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APPENDIX A

Report of the Attorney General

November 24, 1976

THE HONORABLE JACK F. DAVIS, Director
Department of Corrections

This is in reply to your request for my opinion concerning the eligibility for benefits from the Virginia Medical Assistance Program (Medicaid) of twenty classes of juveniles, participating in programs or residing in facilities operated by or for the Department of Corrections. Specifically, you inquired:

> "Does the Social Security Act prohibit extension of Medicaid benefits to children in the categories set forth below who otherwise meet the eligibility criteria for such benefits?"

The twenty categories, which you enumerated, are as follows:

> "(1) Children held in locally or regionally operated secure detention homes pending disposition of status offense charges in juvenile and domestic relations district courts. A status offense, such as truancy, is one which would not be a crime if committed by an adult. A secure detention home is a highly specialized and physically restrictive facility where a child is temporarily held pending disposition of charges by the juvenile and domestic relations district court. The Code prohibits a child's being committed to a detention home as a matter of final disposition. *See* § 16.1-199, Code of Virginia (1950), as amended. The Commonwealth reimburses cities, counties and commissions for 100% of the operating expenses and ⅔'s of the personnel costs of locally operated secure detention homes in accordance with § 16.1-201 of the Code.
>
> "(2) Children held in locally or regionally operated secure detention homes pending disposition of delinquency charges in juvenile and domestic relations district courts.
>
> "(3) Children held in locally or regionally operated secure detention homes pending trial as adults on criminal charges in a circuit court after transfer to such court pursuant to § 16.1-176 or § 16.1-176.2.
>
> "(4) Children held in locally or regionally operated less secure detention homes pending disposition of status offense charges in juvenile and domestic relations district courts. A less-secure detention home provides temporary care for children, in homelike and non-secure facilities, pending disposition of charges by the juvenile and domestic relations district court. These homes normally house twelve (12) to fifteen (15) residents and provide care for those chidlren not in need of secure custody. The Commonwealth reimburses cities, counties, and commissions for 100% of the operating expenses and ⅔'s of the personnel costs of locally operated less secure detention homes in accordance with § 16.1-201.
>
> "(5) Children held in locally or regionally operated less secure detention homes pending disposition of delinquency charges in juvenile and domestic relations district courts.
>
> "(6) Children served in locally or regionally operated crisis intervention centers. Charges may or may not be pending and children are free to come and go as they wish. These facilities provide short term intensive supervision and counseling to juveniles with serious emotional, personality, or family conflicts. The Commonwealth reimburses cities, counties, and commissions for 100% of operating expenses and ⅔'s of the personnel costs of locally operated crisis intervention centers in accordance with § 16.1-201.
>
> "(7) Children served by locally or regionally operated outreach detention programs pending disposition of status offense charges in juvenile and domestic relations district courts. Outreach detention is an approach to detention which utilizes no physical facility but rather provides intensive supervision to the child in his own or surrogate home. The Commonwealth reimburses cities, counties, and commissions for 100% of the operating expenses and ⅔'s of the personal costs of locally operated outreach detention programs in accordance with § 16.1-201.
>
> "(8) Children served by locally or regionally operated outreach detention programs pending disposition of delinquency charges in juvenile and domestic relations district courts.
>
> "(9) Children held in locally or regionally operated boarding homes and/or group homes pending disposition of status offense charges in juvenile and domestic relations district courts. Boarding homes and group homes are private families with which juvenile courts have contracts to supply room and board for children. The Commonwealth pays 100% of this expense.
>
> "(10) Children held in locally or regionally operated boarding homes and/or group homes pending disposition of delinquency charges in juvenile and domestic relations district courts.

"(11) Children held in hospitals and/or psychiatric clinics pending disposition of status offense charges in juvenile and domestic relations district courts. The Commonwealth pays 100% of this expense.

"(12) Children held in hospitals and/or psychiatric clinics pending disposition of delinquency charges in juvenile and domestic relations district courts.

"(13) Children held in jails pending disposition of status offense charges in juvenile and domestic relations district courts. When no vacancy exists in juvenile facilities, children are frequently detained in jails. Such children must be fifteen years of age or older and must be held in a room or ward entirely separate from adults. *See* § 16.1-196.

"(14) Children held in jails pending disposition of delinquency charges in juvenile and domestic relations district courts.

"(15) Children committed to a locally or regionally operated group home by a juvenile and domestic relations district court. A group home is a community based single dwelling. The facility is not adjacent to or part of an institutional campus, or of a number of group homes in a single neighborhood; it is rather an intergral part of the neighborhood. It provides residential care for four (4) to fifteen (15) children. Child care and treatment staff are employed as counselors or professional houseparents. The Commonwealth reimburses cities, counties, and commissions for 100% of the operating expenses and ⅔'s of the personnel costs of locally operated group homes in accordance with § 16.1-201.

"(16) Children committed to the State Board of Corrections and undergoing a needs assessment at the Reception and Diagnostic Center of the Division of Youth Services pending a more permanent placement. The Reception and Diagnostic Center performs the functions of diagnosis and evaluation of children committed to the Department of Corrections.

"(17) Children committed to the State Board of Corrections and placed in a community based, State-operated group home. A community based, State-operated group home is defined as a single dwelling which is not adjacent to or part of an institutional campus, or of a number of group homes in a single neighborhood. It is rather an integral part of the neighborhood and provides residential care for four (4) to fifteen (15) children. Child care and treatment staff are employed as counselors or professional houseparents.

"(18) Children committed to the State Board of Corrections and placed in a foster home. A foster home is a private family with which the State has contracted to supply room and board and minimal counseling for children. A foster home is designed for children whose basic needs can best be supplied through an environment of healthy family functioning.

"(19) Children committed to the State Board of Corrections and placed in special placements. Special placements include private boarding homes, psychiatric treatment centers and specialized vocational centers. These facilities are not operated by the State.

"(20) Children committed to the Department of Corrections and placed in learning centers of the Division of Youth Services. Learning centers are State funded and operated residential treatment facilities serving children who have been duly committed to the State Board of Corrections. The purpose of a learning center is to provide learning opportunities to improve those social skills which will enable a child to function effectively in society. Academic and vocational instruction is provided for children to continue their education. Each child is approached as an individual. Individualized treatment plans are developed for each child and his/her progress in meeting the objectives in these plans determine when the child has earned the opportunity to return to his/her community. The length of stay is based on the child's progress as children are committed to the State Board of Corrections for an indeterminate period of time. *See* § 16.1-180. The average length of stay in a learning center for a child is approximately nine (9) months."

In 1965, the United States Congress enacted Title XIX of the Social Security Act, more commonly known as Medicaid, authorizing grants to the States for medical assistance programs for the benefit of the States' indigent citizens. *See* 42 U.S.C. §§ 1396 to 1396i (Supp. V, 1975). This legislation encourages a State to appropriate funds for medical care to indigents by offering the incentive of matching federal funds. The goal of Medicaid is to provide indigents access to quality medical care which they might not otherwise receive.

Two primary characteristics of Medicaid are that a State's participation is voluntary and that the degree of participation is largely within the State's prerogative to determine. *See* 42 U.S.C. §§ 1396 and 1396a(a)(10)(C) (Supp. V, 1975, *amending* 42 U.S.C. §§ 1396 and 1396a(a)(10)(B) (1970). As do all other States, the Commonwealth of Virginia participates in the Medicaid program by its own choice [*see* § 32-30.1 of the Code], and it has promulgated its own State plan. This plan details the scope of the program and prescribes how

specific needs and priorities of Virginians will be met. The Act not only requires minimum mandatory coverage for that group of persons which the federal regulations describe as being the "categorically needy" [*see* 45 C.F.R. § 248.10a(1) (1975)], but it also allows the State, at its own option, to extend the program to people "who would, except for income and resources, be eligible." *See* 42 U.S.C. § 1396a(a)(10)(C)(i) (Supp. V, 1975). This latter group of people are the "medically needy." *See* 45 C.F.R. § 248.10a(2) (1975). Moreover, the State may in its discretion provide types of care and services beyond those required as a minimum by the Act. *See* 42 U.S.C. § 1396d(a)(17) (Supp. V, 1975).

Your inquiry must be analyzed in light of the Act itself, the implementing regulations in 45 C.F.R. §§ 248 to 252 (1975), and the Commonwealth's State plan. In addition, the United States Department of Health, Education, and Welfare publishes the *Medical Assistance Manual* which provides guidance for interpretation of the language of the Act and of the regulations. Because there are no judicial decisions which provide the necessary interpretation, great weight must be accorded to the *Medical Assistance Manual* as a statement of the law by the agency charged with its administration. *See Udall* v. *Tallman*, 380 U.S. 1 (1965); *see also Shea* v. *Vialpando*, 416 U.S. 251 (1974). I am enclosing, for your benefit, copies of the pertinent parts of the Act, the regulations, the State plan, and the *Medical Assistance Manual*.

The Act defines "medical assistance" as:

> "(a) . . . payment of part or all the cost [of medical care and services required by the Act] . . . for individuals . . . who are—
> "(i) under the age of 21,
> "but whose income and resources are insufficient to meet all of such cost—
> "except . . . such term does not include—
> "(A) any such payments with respect to care or services for any individual who is *an inmate of a public institution (except as a patient in a medical institution)*. . . ." (Emphasis added.) *See* 42 U.S.C. § 1396d(a)(A) (1970).

After consideration of this definition of medical assistance, it is clear that any prohibition against the provision of Medicaid benefits to juveniles within the Department of Corrections' programs and facilities must be based upon the exclusionary language "inmate of a public institution." Consequently, the issue is whether any of the children in your twenty classifications are inmates of public institutions.

To answer this question, the definitions of the terms used in 42 U.S.C. § 1396d (a)(A) (1970) are crucial. The principal terms, defined by the federal regulations, are listed below:

> "Institution"—"an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and in addition, provides some treatment or services which meet some need beyond the basic provisions of food and shelter." 45 C.F.R. § 248.60(b)(1) (1974).
> "Public Institution"—"an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." 45 C.F.R. § 248.60(b)(3) (1974).
> "Inmate of a public institution—"a person who is living in a public institution. An individual is not considered an inmate when:
> "(i) He is in a public educational or vocational training institution, for purposes of securing education or vocational training, or
> "(ii) He is in a public institution for a temporary emergent period pending other arrangements appropriate to his needs." 45 C.F.R. § 248.60(b)(4) (1974).
> "Medical institution—"an institution which:

"(i) Is organized to provide medical care, including nursing and convalescent care;

"(ii) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

"(iii) Is authorized under State law to provide medical care;

"(iv) Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician; sufficient registered nurse or licensed practical nurse supervision and services and nurse aid services to meet nursing care needs; and appropriate guidance by a physician(s) on the professional aspects of operating the facility." 45 C.F.R. § 248.60(b)(5) (1974).

There is one apparent contradiction between the language of 42 U.S.C. § 1396d(a)(A) (1970) and 45 C.F.R. § 248.60(a) (1974), regarding the exemption of patients in medical institutions. The Act provides an exemption only for a patient in a medical institution, whereas the regulation provides an exemption not only for a patient in a medical institution but also for a "resident of an intermediate care facility." An "intermediate care facility" is a term of art in the field of medical care, and it is a type of medical institution, as defined by 45 C.F.R. § 248.60(b)(5) (1974). Thus, the variance in the language of the Act and regulation is not significant.

An application of the definitions, provided above, to your twenty classes of juveniles, and appropriate references to the Act, to the *Medical Assistance Manual*, and to the State plan, supply the answer to your question concerning the eligibility for Medicaid benefits of juveniles in those twenty classes who are otherwise eligible.

The first five Categories include children who reside in detention homes, pending conclusion of status offense charges (*e.g.*, truancy), of delinquency charges, and of trial as adults. These detention homes are, unquestionably, public institutions within the meaning of 45 C.F.R. § 248.60(b)(1) and (3) (1974) because they serve four or more juveniles, they supply a means of controlling these juveniles, which is a need beyond the basic provision of food and shelter, and they are the responsibility of a governmental unit. If such homes can be classified as medical institutions, as defined by 45 C.F.R. § 248.60(b)(5) (1974), their residents would be eligible for Medicaid benefits. *See* 42 U.S.C. § 1396d(a)(A) (1970) and 45 C.F.R. § 248.60a (1974). They are not, however, medical institutions because (1) they are not organized to provide medical care, including nursing and convalescent care; (2) they do not have the necessary professional medical personnel, medical equipment, or medical facilities; (3) they are not licensed under the Code to provide medical care as are general hospitals, skilled nursing homes, intermediate care facilities, or medical clinics; and, (4) they are not staffed by professional personnel who are responsible to the homes for providing professional medical or nursing services, including continual medical care and supervision by a physician, sufficient nurse supervision, and appropriate guidance by a physician on the professional aspects of operating the facility.

Therefore, if the juveniles within these first five Categories are to be eligible for Medicaid benefits, they would have to fall within one of the two exclusions in the definition of "inmate of a public institution." *See* 45 C.F.R. § 248.60(b)(4)(i) and (ii) (1974). The first exclusion is for the individual receiving educational or vocational training in an institution. While residence in a detention home presents a child with a learning situation about the realities of life, the detention home does not offer formal education or vocational training; rather, it is a place of confinement with the purpose of ensuring a juvenile's presence at that location until the appropriate court has made a decision in his or her case. The second exclusion in the definition of "inmate of a public institution" would cover those juveniles who are placed in a detention home "for a temporary

emergent period pending other arrangements." (Emphasis added.) *See* 45 C.F.R. § 248.60(b)(4)(ii) (1974). The important word in this phrase is "emergent," which denotes an exigency or emergency. Although routine residence in a detention home is indicative of a problem, it is not necessarily an indication of an emergency as contemplated by the regulations. The *Medical Assistance Manual*, Part 4, Para. 4-50-20F (SRS-AT-76-110 [MSA], July 8, 1976) states:

> "Persons who are temporarily placed in public facilities on an emergency basis pending other arrangements appropriate to their needs are not considered to be 'inmates'. For example, children who are in custody of a State or local agency in order that arrangements may be made for their care in a foster family home are occasionally placed in a public child care facility until such arrangements are established. Providing that such persons have been judged not to be in need of care in the facility and that other arrangements suitable to their needs are made without delay, they may be excluded from consideration as 'inmates' of the facility for purposes of Medicaid coverage."

In light of this administrative interpretation of the second exclusion under the definition of "inmate of a public institution," the ordinary resident of a detention home is not placed there for a "temporary emergent period" as contemplated by the regulation.

With these considerations in mind, I conclude that, in ordinary circumstances, juveniles in detention homes do not qualify for Medicaid benefits because they are inmates of public institutions. Thus, juveniles within the first five Categories you outlined cannot receive Medicaid benefits.

Category 6 involves children served by crisis intervention centers. You stated that attendance is voluntary and that charges may or may not be pending. Such variables are significant and they lead to different results. If such a center provides food, shelter, supervision, and counseling to four or more children, it is a public institution within the meaning of the regulations. *See* 45 C.F.R. § 248.60(b)(1) and (3) 1974). Such a center does not qualify as a licensed medical institution under 45 C.F.R. § 248.60(b)(5) (1974) for the same reasons given in the discussion of Categories 1-5. The inquiry becomes whether the juveniles who attend such a center are "inmates" within the meaning of 45 C.F.R. § 248.60(b)(4) (1974).

The first exclusion from the definition of "inmate of a public institution" does not apply to a crisis intervention center because the principal objective of such a center is to provide the juvenile with a refuge in a stable environment for the resolution of personal difficulties. The education or vocational training opportunities provided are secondary objectives of these centers. Consequently, for the same reasons given in the discussion of Categories 1-5 about the applicability of the educational or vocational training exclusion, I conclude that crisis intervention centers do not fall within that exclusion.

The more difficult situation is presented by the child who occasionally remains overnight in such a center due to family difficulties or other personal crises. The Act, the regulations, the State plan, and the *Medical Assistance Manual* are silent on this situation. The regulations, however, speak of "a person who is living in a public institution," *see* 45 C.F.R. § 248.60(b)(4) (1974). This connotes residence in the institution, rather than at the home of the juvenile's parents or guardians. Occasional, short term, voluntary residence in a crisis intervention center does not, in my opinion, necessarily preclude the juvenile from receiving Medicaid benefits. Such determinations must be made, however, on a case-by-case basis. Of course, those children who do not stay overnight in the center are not inmates, regardless whether charges are pending against them; they may, therefore, receive Medicaid benefits if they are otherwise eligible.

Categories 7 and 8 on your list refer to juveniles participating in outreach detention programs. Those children under charges for status offenses or delinquency offenses are eligible for Medicaid benefits if they live at home, because

they are not inmates of a public institution. You mentioned, however, that some include foster homes in this term. Children in foster homes, which are reimbursed by the Department of Corrections, one of its agencies, or any governmental unit or program operating under the auspices of the Department of Corrections, cannot receive Medicaid benefits. This conclusion requires explanation because certain children in foster homes, reimbursed by the Department of Welfare or one of its subordinate agencies, are eligible for Medicaid coverage. The reason for the difference in treatment of the Department of Corrections foster home care child and of the Department of Welfare foster home care child is found in the Act itself.

The Act requires that the State provide medical assistance to the categorically needy, who are statutorily defined as "individuals receiving aid or assistance under any plan of the State approved under Title I, XXIV, or XVI, or *Part A of Title IV*. . . ." (Emphasis added.) *See* 42 U.S.C. § 1396a(a)(10)(A) (Supp. V, 1975). Part A of Title IV is the Aid to Families of Dependent Children Program, in which the Commonwealth participates through the Department of Welfare (*see* §§ 63.1-36 and 63.1-105 of the Code), and one part of this program is foster home care. *See* 42 U.S.C. § 608 (1970). Furthermore, the *Medical Assistance Manual* states that "[p]rivate, non-profit child care facilities and foster family homes defined in Section 408(a) [sic] of the Act are not public institutions." *See Medical Assistance Manual,* Part 4, Para. 4-50-10 (SRS-AT-76-110 [MSA], July 8, 1976). Consequently, a specific exemption from the definition of "public institution" exists for the foster home reimbursed pursuant to Part A of Title IV of the Social Security Act, that is, a foster home which is reimbursed by the Department of Welfare. *See* 42 U.S.C. § 1396d(a)(A) (1970). A foster home which is reimbursed by the Department of Corrections or one of its agencies is not so exempted.

Some question may remain about a foster home under the Department of Corrections which serves less than four juveniles because the definition of "public institution" specifies four or more persons. *See* 45 C.F.R. § 248.60(b)(1) (1974). The definition, however, also takes into account "multiple facilities" which allows the aggression of all juveniles in all foster homes of the Department of Corrections to arrive at the determination that the standard of four or more persons is met. Because such foster homes afford a child an opportunity for counseling and supervision aside from simply food and shelter, they are "public institutions," and the juveniles residing therein are not eligible for Medicaid benefits.

The ninth and tenth Categories of children you describe are those held in boarding homes or group homes pending disposition of status offense charges or delinquency charges; for the same reasons given as to juveniles held in detention homes (Categories 1-5) or in foster homes (Category 7), juveniles in boarding and group homes are also ineligible for Medicaid benefits.

Licensed medical facilities, such as the hospitals and psychiatric clinics in which the children in your eleventh and twelfth Categories have been placed, are medical institutions within the definition of 45 C.F.R. § 248.60(b)(5) (1974). Such children are, nevertheless, ineligible for Medicaid benefits. The determining factor is one of control, rather than of location. When the Commonwealth, through her legal process, holds such a juvenile in a medical institution pending disposition of charges, that juvenile must be viewed as an inmate of a public institution. The *Medical Assistance Manual,* Part 4, Para. 4-50-20C (SRS-AT-76-110 [MSA], July 8, 1976) provides:

> "When a person is detained by legal process under the penal system, he cannot attain status as an inpatient of a medical facility for purposes of Medicaid. His status as inmate is not terminated until he is released from the institution on parole or otherwise. Specifically, a visit to a physician or

other medical practitioner outside the institution does not in any way affect his inmate status, nor does transfer to a public, or private medical facility.

"Furthermore, even if he has not been transferred from a prison or other correctional institution, but is sent directly to a medical institution (e.g., for a mental examination or because he has been found mentally incompetent to stand trial), he is not considered a patient therein for purposes of Medicaid coverage."

Children in such hospitals and psychiatric clinics are, therefore, ineligible for Medicaid benefits.

With reference to children held in jails (Categories 13 and 14), Medicaid benefits are not available because they are "inmates of public institutions." The fact that their incarceration in a jail might have been necessitated only by a lack of space in a juvenile facility does not change this result, even considering the "temporary emergent" exception, because the child would not be eligible after transfer to such a juvenile facility.

Your next category (15) is comprised of children committed to local or regional group homes. For the same reasons given in the discussion of Categories 1-5 and 9-10, these children may not receive medical assistance from the Medicaid program. Furthermore, the United States Department of Health, Education, and Welfare has included the group home in the definition of public institution. *See Medical Assistance Manual*, Part 4, Para. 4-50-10 (SRS-AT-76-110 [MSA], July 8, 1976).

Juveniles committed to the Reception and Diagnostic Center of the Division of Youth Services, your sixteenth Category, which I am advised provides food and shelter, are inmates of a public institution, as that term is defined. This Center does not fit within the definition of "medical institution," for reasons discussed above. Accordingly, these juveniles will be eligible for benefits only if they fall within one of the two exclusions from the definition of "inmate of a public institution." *See* 45 C.F.R. § 248.60(b)(4) (1974). The principal purpose of the Center is to diagnose and evaluate the juvenile in order to determine in what facility or program he should be placed. Any educational or vocational training provided is merely incidental to that diagnostic function. Eligibility, therefore, must be based upon a finding that placement in the Center is for "a temporary emergent period." The United States Department of Health, Education, and Welfare has determined that children in such centers are ineligible for benefits. *See Medical Assistance Manual*, Part 4, Para. 4-50-20C (SRS-AT-76-110 [MSA], July 8, 1976). Moreover, no emergency exists when a child is routinely sent to the Center. Children in the Reception and Diagnostic Center are, thus, excluded from Medicaid's coverage.

Children placed in group homes or foster homes, as specified in Categories 17 and 18, are not eligible for Medicaid benefits for the reasons I gave in discussion of Categories 1-5, 9, and 10 (detention, board, and group homes) and Category 7 (foster homes), respectively. Similarily, the special placements, mentioned in Category 19, are excluded from Medicaid coverage for the same reasons as are the children within Categories 11 and 12. The fact that medical services or vocational opportunities are provided in special placements is not relevant. The Department of Corrections has assumed responsibility for these children and has merely taken advantage of existing medical and vocational institutions to extend its rehabilitative capacity. These juveniles are inmates of public institutions because they are under the Department's administrative control.

Lastly, your category of children in learning centers (20) is also ineligible to receive Medicaid benefits. Although these centers provide educational and vocational opportunities, their principal purpose is rehabilitation. The determining factor is one of control by the Department of Corrections which is holding these children, by legal process, in learning centers as opposed to persons who voluntarily attend a public institution such as a school for the blind. *See* 45 C.F.R. § 248.60(b)(4)(i) (1974) and *Medical Assistance Manual*, Part 4, Para. 4-50-

20E (SRS-AT-76-110 [MSA], July 8, 1976). This approach is analogous to the one taken by the United States Department of Health, Education, and Welfare in its determination that persons detained by legal process under the penal system in a psychiatric clinic or a hospital cannot qualify for Medicaid benefits as inmates of a medical institution which was pointed out in the discussion of your eleventh and twelfth Categories of children. *See Medical Assistance Manual,* Part 4, Para. 4-50-20C (SRS-AT-76-110 [MSA], July 8, 1976).

APPENDIX B, Exhibit 1

COMMONWEALTH of VIRGINIA

JOHN A. BANKS, JR.
DIRECTOR

G. WILLIAM WHITE, JR.
DEPUTY DIRECTOR

DIVISION OF LEGISLATIVE SERVICES

General Assembly Building
910 Capitol Street

POST OFFICE BOX 3-AG
RICHMOND, VIRGINIA 23208

IN RESPONSE TO
THIS LETTER TELEPHONE
(804) 786- 1880

August 1, 1978

Mr. Roy Perez-Daple
ATTENTION: Bill Neary
P. O. Box 13716
Philadelphia, Pennsylvania 19101

Dear Bill:

I am sorry for the delay in sending you the enclosed material concerning the work of the Joint Subcommittee Studying the Medical Needs of Children. I appreciate your agreeing to provide staff and information for a meeting of this Subcommittee on Tuesday, August 22, 1978 at 10:00 a.m. in House Room 1 in the State Capitol.

Enclosed for your use in preparation for the August 22nd meeting are the following materials:

1. Staff Memorandum - July 17, 1978.
2. House Joint Resolution No. 48 - 1978.
3. House Document No. 22 - 1978, pages 17-18.
4. Opinion of the Attorney General, November 24, 1976.
5. Report on the Feasibility of Extending Medicaid Coverage to Children Served by the Division of Youth Services, Department of Corrections.
6. Presentation made to the Subcommittee on July 19, 1978 by a representative of the Department of Welfare detailing some of the issues which need to be addressed.
7. Cost figures provided the Subcommittee by the Department of Health on extending certain Medicaid benefits for children.
8. Summary of presentation made to the Subcommittee on July 19, 1978 by a representative of the Medicaid Program, Department of Health, detailing benefits available in Virginia under Medicaid.

The Subcommittee requests your assistance in this study and that your attention be given to the following:

1. Review of the enclosed opinion of the Virginia Attorney General. Item #4. Please consider the opinion on its own merits and in light of the Keyes amendment to Title 42, Part 448 (§ 448.60). This opinion has been a major stumbling block in providing medical coverage to children in State and local care. Is it the intent of the federal law that these categories of children be excluded? Do other states handle these cases differently? Does the Keyes amendment shed a different light on the status of community residential care facilities which house children placed there by juvenile courts and which may be partially funded with monies from the Department of Corrections?

2. Review of the information supplied the Subcommittee by the Department of Welfare (Item #6) and Department of Health (Items #7 and 8). Is Virginia now taking advantage of Medicaid coverage for all possible situations children may be in as the VMAP is currently written? Do the cost figures supplied by the Department of Health for extending coverage for children correspond with the cost experiences of other comparable states presently offering these options? What services do other states usually buy into that Virginia is not?

Please feel free to address any other issues which you may perceive as needing to be discussed from the material I have sent you or from the knowledge your staff has in this field. I remain open to your suggestions.

The agenda for the August 22nd meeting will involve presentations of about 15 minutes a piece by local representatives of a welfare department and of a corrections community residential care program. Representatives of the Departments of Welfare, Health and Corrections will have a total of 45 minutes to present cost data and statistics on children they have been asked to compile indicating the specific nature of the problem we are dealing with. I have allowed one hour for presentations by the HEW staff. Questions and answers from Subcommittee members would be in addition to this time. If you feel you need additional time to present the material you put together, that will be no problem. Just let me know.

I will look forward to talking with you later this week to clarify the matters I have addressed in this letter. Thank you again for your assistance.

Sincerely,

Lelia Hopper

Lelia B. Hopper
Staff Attorney

LBH/gh
Enclosures

COMMONWEALTH of VIRGINIA

JOHN A. BANKS, JR.
DIRECTOR

G. WILLIAM WHITE, JR.
DEPUTY DIRECTOR

DIVISION OF LEGISLATIVE SERVICES

General Assembly Building
910 Capitol Street

1880

August 24, 1978

Mr. Roy T. Perez-Daple
Intergovernmental and Congressional Affairs
3535 Market Street
P. O. Box 13716
Philadelphia, Pennsylvania 19101

Dear Roy:

The Joint Subcommittee Studying the Medical Needs of Children appreciated your attending its meeting on Tuesday, August 22, 1978 and the remarks made by Thelma Weiss, Michelle Gougeon and yourself. I hope you found the time you spent with us valuable. I believe we now have a clearer picture of the numbers of children, amounts of money and sources of those funds involved in this study than we previously had and that the issues surrounding the availability of Medicaid benefits have been more clearly articulated. I am enclosing for your convenience copies of all the statements and data distributed at the 22nd meeting except for that of William Lukhard's. He will send his to me next week, and I will send it along to you at that time.

As you are aware the next meeting of the Subcommittee has been scheduled for Wednesday, November 1, 1978 at 10:00 a.m. in House Room 1 at the State Capitol. The two items on the agenda for this meeting which require your attention are as follows:

1. Interpretation of the opinion of the Virginia Office of the Attorney General of November 24, 1976. (See our correspondence of August 1, 1978)

2. Procedure currently in effect for the certification by DHEW of providers of child-caring institutions as "private non-medical institutions" for reimbursement on a predetermined capitation basis for psychotherapeutic and medical treatment services pursuant to 42 CFR 449.82(a)(4). As I related to the Subcommittee on Tuesday, the Department of Health has been requested to clarify the procedure to be used at this time under this regulation and to coordinate with the Departments of Corrections and Welfare in distributing to potentially eligible child-caring institutions information about how to apply for funding under this regulation. Because the procedure for the certification of Edgemeade of Virginia in 1971 significantly

involved the Region III Office, I would anticipate your assistance will be needed in these efforts today. The three agencies have been asked to report on November lst on the progress made to make this funding mechanism more widely available. Attached is correspondence which may help clarify this issue.

If other questions are addressed between now and November which we could use your assistance on, I will certainly let you know. Please keep me posted on the progress your office makes on the above two matters. Thank you for your continuing support and interest in the work of the Virginia General Assembly.

Sincerely,

Lelia Hopper

Lelia B. Hopper
Staff Attorney

LBH/gh
Enclosures

CC: Honorable Norman Sisisky

APPENDIX C

Dr. Freeman C. Hays
Department of Health

Exhibit 1

INDIVIDUALS UNDER AGE 21 ELIGIBLE FOR THE MEDICAID PROGRAM

July 1, 1978

State and Local Foster Care	6,175	
ADC Foster Child	2,642	
ADC Categorically Needy	115,337	
ADC Medically Needy	8,704	
Subsidized Adoption	3	
	132,861	Total

Expenditures Federal Fiscal Year 1977

State and Local Foster Care	$ 2,404,000	
(ADC Foster Care accounted for approximately $800,000)		
ADC Categorically Needy	31,713,483	
ADC Medically Needy	2,813,847	
All other under age 21 (Blind, disabled, ADC mother or father under age 21)	8,019,887	
	$44,951,217	Total
Federal Funds 58.34%	$26,224,540	
State Funds 41.66%	$18,726,677	

ESTIMATED COST OF COVERAGE OF INDIVIDUALS UNDER 21

(Excluding Inpatient Psychiatric Care)

Age Under 21: Total New Potential Eligibles		=	360,000
Estimated Enrollment Cost/Enrolled Under 21 = $259	FY 77/78	=	180,400
	FY 77/78 Expenditures	=	$46,724,000
Estimated Enrollment Cost/Enrolled Under 21 = $285	FY 78/79	=	245,400
	FY 77/78	=	$69,939,000
	77/79 Biennium		$116,663,000

Federal Financial Participation 57.01%

ESTIMATED COST OF PROVIDING PSYCHIATRIC INPATIENT CARE FOR PERSONS 21 AND UNDER

Estimated Medicaid Recipients under 21		=	150,000
Estimated in Need of Psychiatric Care		=	15,540
Estimated Hospital Admissions			1,500
Estimated Average Length of Stay			300 Days
Cost Per Day		=	$120
Cost Per Admission	300 X $120	=	$36,000
1,500 Admission X $36,000		=	$54,000,000

NOTE: NEEDS ESTIMATED FROM "FINAL REPORT OF THE CHILD MENTAL HEALTH STUDY GROUP", MAY 26, 1976

APPENDIX C

Exhibit 2

Remarks of William L. Lukhard
To
Subcommittee Studying
The Medical Needs of Children

Virginia Department of Welfare
August 22, 1978

House Joint Resolution No. 48 requesting a study of the medical needs of children was jointly recommended by the Department of Welfare, the Division of Youth Services of the Department of Corrections and the Virginia League of Social Services Executives. This year the Department of Welfare received nearly a dozen legislative recommendations regarding inadequate medical services from localities across the Commonwealth. This Subcommittee's work is of great and longstanding interest to the Department of Welfare. I am here today to re-affirm that interest and to facilitate the work of the Subcommittee in any way possible.

Following the first meeting of the Subcommittee held on July 19, 1978, Ms. Hopper, on behalf of the Subcommittee, requested additional information from the Department of Welfare. Specifically, you wanted a profile of foster care children in Virginia; you also asked how much the Department of Welfare paid for medical services for children from non-Medicaid sources.

An Annual Report of Virginia's Foster Care Program is now being prepared and will be submitted to the General Assembly in the fall. However, I am prepared today to discuss with you the medically related characteristics of foster care children:

1. There are fewer children in foster care today than previously.

   The total population has declined from 11,303 in June 1976 to 10,827 in June 1977 to 10,199 in June, 1978.

2. There is little difference in the age of children in foster care today than in previous years.

   In June, 1977, 39% of the foster care population was between the ages of 15 and 21; as of June, 1978, 40% of the foster care population was between 15 and 21 years of age. For the period of time June 1977 and June 1978, the percentage of children age 19-21 remained at 5.3%.

3. The sexual and racial composition of the foster care population has remained fairly constant. Approximately 53% are male; 46% female; 51.8% white; 46.6% black; and 1.6% other. These figures have remained fairly constant for the period June 1976 - June 1978.

(more)

4. Slightly more foster care children are mentally retarded, physically impaired, emotionally disturbed, multiply handicapped, or otherwise handicapped than previously.

   In June, 1977, 35.6% of foster care children were reported to have one or more disabilities requiring treatment. Even though the number of children in foster care has declined, the percentage of disabled children increased slightly to 37.3% by June of 1978. Also, 37.3% represents the same percentage reported for the period March 1978.

5. Children with handicapping conditions are more likely to have, in order of priority as of June 1978 goals of "Continued Foster Care, 48%," or "goal yet to be determined, 45.6%," or "Permanent Foster Care, 36.7%" and have a lower probability of achieving permanency.

   The children with the goals of "Return Home, 36.1%" and "Adoption, 29.4%" have fewer handicaps than the general foster care population.

6. Approximately 5% of the children were in adoptive placements in June 1977 compared to 6% in June 1978, 70% in foster homes in June 1977 compared to 70% in June 1978, 13% in residential programs in 1977 compared to 13% in June 1978, 8% in their own homes in June 1977 compared to 9% in June 1978, 4% in independent living status or runaway in June 1977 compared to 4% in June 1978.

The profile of foster care program is complex and slowly changing. These are only a few of the key characteristics; I'm sure the Annual Report will answer your questions more completely.

But, now I must turn to the matter of how much the Department of Welfare is paying for medical services for children from non-Medicaid sources.

The foster care program is a multi-million dollar operation more than $18 million in federal, State and local funds supported the program in 1977-78. Virginia has a locally administered, State supervised welfare system with 126 local welfare agencies. Given that structure and the amount of money involved, it is not possible to say, on such short notice, exactly how much is expended on any one aspect of the program. We can make reasonable estimates, however.

It is estimated that the State-Local Hospitalization program expended more than 1.3 million dollars to provide medical services including psychiatric care to children in foster care during the fiscal year ended in June, 1977. More than $532,000 of this was for In-patient Care; nearly $850,000 was for Out-patient Care.

(more)

In addition, it is estimated that more than $130,000 in State/Local Foster Care funds, Title XX funds and ADC/FC funds, were expended in fiscal year 1977-78 for medical services to children in foster care.

Another significant block of non-Medicaid funds were expended in the Child Protective Services program. There were 1224 protective services cases during 1977-78 which required medical services for children; the cost for the medical services provided children in the Protective Services program is estimated to be more than $60,000 per year.

In July, Mr. Sirry told you that children's treatment centers are not approved as medicaid providers -- and this is accurate with one exception. Edgemeade of Virginia is approved as a Medicaid provider and receives approximately $242 per month per child from Medicaid. If facilities similar to Edgemeade were certified as Medicaid providers, it is estimated that more than $650,000 in Title XX funds per year would be saved.

In summary, it is estimated that the Department of Welfare expended more than 2.1 million dollars in non-Medicaid funds to provide medical services to children during 1977-78. A significant amount of this was from State and local funds.

This concludes my presentation; I will attempt to answer any questions you may have.

APPENDIX C

Exhibit 3

Mr. William E. Weddington
Department of Corrections

The Joint Subcommittee to Study the
Medical Needs of Children

August 22, 1978

As the result of your meeting of July 19, 1978, the Department of Corrections was asked for specific information concerning the Medical and Psychiatric expenditures for it's programs serving juveniles. These programs are varied and have relatively low medical expenditures since 97% of all children are served in their local community with parents retaining responsibility for most basic medical and psychiatric care. The 3% of the children who are committed to the State Board of Corrections represent higher per capita medical and psychiatric costs.

The data concerning these programs for juveniles will be presented by program type with the costs identified for each.

The first is the juvenile detention and group homes funded under Title 16.1-313. In fiscal year 1977-78 these forty-four programs were reimbursed $69,080 for direct medical care to children. This figure does not include salary reimbursement of approximately $84,000 for fourteen nurse positions in secure detention homes.

Other predispositional services are for boarding care provided under 16.1-314 and for physical and mental examinations and treatment under 16.1-275. In fiscal year 1977-78 these programs expended $2,455 in medical costs and $23,043 in psychiatric costs.

Another program established under 16.1-286 permits the Department to pay a per diem allowance for the cost of children placed by the Court Service Units in lieu of commitment to the State Board of Corrections. Medical and Psychiatric costs for this program are not available for the

past fiscal year. These costs are usually incorporated in a flat fee and are extremely difficult to break out in terms of the source of funding. There is usually a complicated formula of second and third party funding necessary to contract these often expensive placements. In these placements, as in the special placement of State Wards the flat fees of the placement facility are usually met with Department money, supplemented by parents, special education funds, CHAMPUS, Insurance, Social Service Bureau, etc.

Unlike the community based programs where parents and community resources assume primary responsibility for medical costs, the Department's programs for committed children bear a much greater responsibility for these costs. The direct cost for medical services in the Reception and Diagnostic Center and Learning Centers was $235,859 and $55,135 for psychiatric cost during fiscal year 1977-78. These figures are for services delivered and do not include personnel costs. The combined cost for medical and psychiatric costs was $8,967 in the state-operated Group (4) Homes.

For committed children who are not placed in learning centers and are supported under 53-325 - 327 those in Foster Homes accrued a combined medical and psychiatric cost of $31,664. In addition to this, payments of $63,000 were made on two children who were injured in automobile accidents. A determination of the cost of medical services for children in special placements, as explained earlier in this presentation, is not possible. The medical costs for special placements are routinely incorporated in a monthly fee which is usually met through Department funding in combination with second and third party funding.

DEPARTMENT OF CORRECTIONS

Program Serving Juveniles

1977-78

Medical Costs

Detention and Group Home Program		Medical
		$69,080
14 Secure Detention Homes - incidents of admissions	8,659	
3 Less Secure Detention Homes - incidents of admissions	567	
6 Crisis Intervention Homes - incidents of admissions	1,459	
5 Detention Outreach Programs - incidents of admissions	843	
16 Local Group Homes - incidents of admissions	617	
Sub-Total	12,145*	
Other Predispositional Services		$ 2,455
		Psychiatric
		$23,043
Children held in boarding or shelter homes predispositionally	717	
Children receiving medical or psychiatric evaluations predispositionally	238	
Sub-Total	955	
TOTAL		$94,578

*This is the number of separate admissions to the home and not the number of individual children entering the programs during the year. If a child is detained more than once during the report period or is transferred from one program to another s/he will be recounted with each admission.

Services to Children Committed To The State Board of Corrections			$394,625
Children received at the Reception and Diagnostic Center		(1,215)	
Medical	$21,156		
Psychiatric	$55,135		$76,291
Children placed in Learning Centers		(1,165)	
Medical	$214,703		
Psychiatric Costs are in Reception and Diagnostic Center expenditure			$214,703
Children placed in State Operated Group Homes		(151)	
Medical	$ 8,967	(includes psychiatric costs)	$ 8,967
Children placed in Foster Homes or Special Placements		(237)	
Foster Care Medical (an additional $63,000 was spent on two children who were injured in automobile accidents. Psychiatric - these costs are usually included in the total cost of the placement and are not retrievable at this point in time. In situations where they are not included, private insurance funds, CHAMPUS, or other second or third party funding is used.	$31,664		$94,664
			$ 94,578
Grand Total			$489,203

APPENDIX D

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
OFFICE OF THE GENERAL COUNSEL
Health Care Financing and Human Development Services Division

DATE: NOV 9 197

TO : Alwyn Carty Jr.
Regional Medicaid Director

FROM : Galen D. Powers
Assistant General Counsel

SUBJECT: Application of Regulations Concerning the Exclusion of "Inmates of Public Institutions" from Medicaid Coverage to Certain Juveniles in the Custody of the Commonwealth of Virginia's Department of Corrections.

This is in response to memoranda received from both the Regional Attorney and the Principal Regional Official in Region III 1/ requesting clarification from this office of Medicaid eligibility requirements applicable to juveniles in the custody of the Virginia Department of Corrections. The Chief of the Medicaid Eligibility Policy Branch in the Central Office, Mr. Eshelman, has recommended that we respond directly to you with regard to this issue.

As we understand the inquiries that we have received, the principal question raised is whether an Opinion of the Virginia Attorney General, dated November 24, 1976, 2/ correctly interprets Medicaid law and regulations with respect to eligibility criteria applicable to certain categories of juveniles.

Although much of this opinion appears to correctly apply Medicaid law and regulations to the circumstances of institutionalized juveniles, it naturally fails to consider the effect of regulations promulgated subsequent to the date of its writing, and also contains certain major inaccuracies in the statement of Medicaid eligibility criteria. Evidently, the primary source of misunderstanding that has resulted in these inaccuracies is a section of the Medical Assistance Manual which purports to clarify the definition of an "inmate" of a public institution in the specific context of "Commitment to Public Institutions Under the Penal System." 3/

1/ Dated August 23, 1978 and October 10, 1978 respectively.

2/ Attached at Tab A.

3/ See Part 4, Para 4-50-20C of the Medical Assistance Manual. (SRS-AT-76-110 [MSA], July 8, 1976)

Because this section of the Manual contains language that has, understandably, led to confusion on the part of the tate, it is important that the substance of these guidelines be examined and explained in the light of the provisions of law and regulations to which they relate. This memorandum will analyze the provisions of the administrative guidelines concerning "Commitment to Public Institutions Under the Penal System" in relation to the regulations which those guidelines purport to restate and clarify. The inconsistencies with federal regulations that are inherent both in the Virginia Attorney General's Opinion and the administrative guidelines upon which that opinion is apparently based will be discussed. Finally, the specific areas with respect to which the Attorney General's Opinion is of questionable validity will be pointed out.

The Relevant Statutory and Regulatory Language.

§1905(a)(17)(A) of the Social Security Act excludes from the definition of "medical assistance" payments for care and services rendered to any individual who is an "inmate of a public institution" unless that individual is a "patient in a medical institution." 4/ This statutory language has been interpreted by the Secretary in regulations at 42 C.F.R. §432.1009, as well as in administrative guidelines intended to clarify the meaning of those regulations.

The language of §1905(a)(17)(A) is relatively simple and direct. The broad standards to be applied in implementing this provision of law are inherent in the statutory language. Valid regulations and guidelines relative to the "public institution" exclusion from Medicaid coverage must be directed towards answering four principal questions:

(1) What is an inmate?

(2) What is a public institution?

(3) What is a medical institution?

4/ The relevant portion of §1905 states:

"Sec. 1905 For purposes of this title -- (a) The term "medical assistance" means . . . (17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary; except as otherwise provided in paragraph (16), such term does not include --

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

(4) When is an individual a "patient" in a medical institution?

Federal regulations address these questions straightforwardly in a definitional section relating to institutional status. 5/ The terms, "inmate," "institution," "public institution," "medical institution," "patient," and "in an institution," are all separately defined.

In regulations, the Secretary, has used similar approaches in defining the terms "inmate" and "public institution" for Medicaid purposes. In both cases, a simple general rule is provided as the basic test of whether a person or institutional facility falls under the rubric of the defined term. The basic definitional rule relative to each term, however, is expressly made inapplicable to certain situtions.

An "inmate" of a public institution is defined as "a person who is living in a public institution" unless that person

(1) "is in a public educational or vocational training institution for purposes of securing education or vocational training," or

(2) "is in a public institution for a temporary period pending other arrangements appropriate to his needs."

Under this definition, it is clear that the broad areas of inquiry relevant to the determination of "inmate" status are:

1. the nature of the physical placement of an individual, i.e. is he actually living in the institution considered to be a public institution?

2. the purpose of the placement, i.e. is the reason for residence in the institution the goal of securing education or vocational training?

5/ These regulations formerly appeared at 42 C.F.R. §448.60(b), but have recently been rewritten and redesignated at 42 C.F.R. §435.1009. See 43 F.R. 45217 (September 29, 1978) The definitions relevant to status as an "inmate of a public institution" are attached to this Memorandum at Tab B.

3. the expected duration of the placement, i.e. is the individual's residence in the institution purely a temporary arrangement intended to continue only until other more satisfactory arrangements can be made?

The primary criterion of inmate status is the nature of the involved individual's physical placement. The educational purpose or anticipated temporary duration of a placement, however, may bring an individual within one of the narrow exceptions to the basic rule that a person who lives in a public institution is an "inmate" for purposes of Medicaid eligibility determinations. Thus, the nature of physical placement, the purpose of placement, or the expected duration of placement, may be sufficient to eliminate an individual from categorization as an inmate of a public institution. However, all three factors must be considered in order to positively identify an individual as a public institution "inmate". Furthermore, the sine qua non of inmate status is the fact of an individual's residence in a public institution. Although other factors may provide a basis for removing an individual from the "inmate" category, it is not possible for a person to be an "inmate" under the regulatory definition at 42 C.F.R. §435.1009 unless he lives in an institutional facility considered to be a "public institution."

Current regulations define a "public institution" simply as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." However, specifically excluded from the definition of the term "public institution" are "medical institutions," "intermediate care facilities," and "publicly operated community residences that serve no more than 16 residents."

Under these regulations, the basic contours of the standards to be applied, and the steps to be taken, in identifying inmates of public institutions are reasonably clear. Nevertheless, certain judgmental or policy decisions are unavoidable in applying the regulatory standards. For example, in a given instance, it may be unclear whether a person's institutional placement is "temporary" in the sense that brings him within the second exception to the definition of "inmate" status, applicable to those who live in institutions pending more suitable arrangements; or it may be difficult to establish where an individual should be considered to "live."

The Secretary has attempted to settle certain policy questions and judgmental issues in administrative guidelines contained in Part 4 of the "Medical Assistance Manual." 6/

6/ The guidelines relative to inmates of public institutions are attached at Tab C.

Particular confusion has arisen over the provisions of the Manual addressed to "Commitment to Public Institutions Under the Penal System." 7/

7/ This portion of the guidelines states:

Definition of An "Inmate" of a Public Institution (45 C.F.R. 248.60(b)(4))

C. Commitment to Public Institutions Under the Penal System

When a person is incarcerated under the penal system because he has been accused or found guilty of a criminal offense his status as an inmate is not terminated until he is released from the institution on parole or otherwise. Inmates of penal institutions, whether during the period before trial or other disposition of the charges or after conviction, are totally excluded from Medicaid coverage; by the act of incareceration, the State assumes full responsibility for the prisoner's care, wherever provided. His "inmate" status continues until the indictment is dismissed or he is released from custody either as "not guilty" or for some other reason (e.g., bail, parole, pardon). An individual who is on furlough from a prison (e.g., under a rehabilitation program) is still under the custody of the penal system and remains an "inmate" until he is released or pardoned.

A person is considered an inmate of a penal institution if he is incarcerated under process of the penal system, whether the offense is a misdemeanor or a felony or is a delinquent act; for example, if he is serving a sentence in a prison or other correctional institution, or if while serving his sentence, he is transferred to a mental or other medical facility.

When a person is detained by legal process under the penal system system, he cannot attain status as an inpatient of a medical facility for purposes of Medicaid. His status as inmate is not terminated until he is released from the institution on parole or otherwise. Specifically, a visit to a physician or other medical practitioner outside the institution does not in any way affect his inmate status, nor does transfer to a public or private medical facility.

(Continued)

In general, these guidelines are responsive to questions that would predictably arise in applying the regulations at 42 C.F.R. §435.1009 to persons placed in penal institutions.

The Manual establishes the initial point that penal institutions are considered "public institutions" for purposes of Medicaid coverage. 8/

A second, and far less obvious, point is made by the statement,

> "Inmates of penal institutions, whether during the period before trial or other disposition of the charges, or after conviction, are totally excluded from Medicaid coverage;"

From this language, it is clear that an individual is considered an "inmate" of a penal institution even during a pretrial period when the basis for his placement is only accusation, and not conviction, of a crime. Clarification of this point is necessary because it is at least arguable that a period of incarceration pending disposition of charges against an individual falls within the category of placement "for a temporary period pending other arrangements appropriate to his needs," and thus within the second exception to the §435.1009 definition of an "inmate." The guidelines represent the Secretary's discretionary

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7/ (Continued)

Furthermore, even if he has not been transferred from a prison or other correctional institution, but is sent directly to a medical institution (e.g., for a mental examination or because he has been found mentally incompetent to stand trial), he is not considered a patient therein for purposes of Medicaid coverage. However, if the court commitment to a mental institution were to follow a verdict of "not guilty by reason of insanity," the individual is not in custody as an accused nor as a convicted criminal and so may be entitled to Medicaid coverage (if he is eligible).

Children who have been committed by the court to a correctional institution for detention in connection with a violation of the law are considered inmates of a penal institution and are not eligible for Medicaid, nor are children who are temporarily sent to diagnostic or evaluation centers (which are administered by a government agency) for a determination of the most appropriate institutional placement resulting from a court order for commitment under the penal system.

8/ Although not expressly stated, the point is implicit in the Manual's discussion of exclusion from title XIX coverage of "inmates of penal institutions." Here, "penal institutions" is used essentially as a synonym for "public institutions."

judgment that this ambiguous situation, wherein it is as yet unclear whether an individual's placement is of a long-term or purely temporary nature, does not qualify as a "temporary" arrangement under the meaning of §435.1009.

Since neither of the exceptions to "inmate" status apply to an individual imprisoned because accused of a crime, 9/ the general definition of an "inmate" is controlling. There is no doubt that such an individual is living in a penal institution, which fits the regulatory definition of a public institution. Thus the individual is an inmate of a public institution and is excluded from Medicaid coverage.

The Manual continues on the subject of prisoners with the following information:

> "by the act of incarceration, the State assumes full responsibility for the prisoner's care, wherever provided. His "inmate" status continues until the indictment is dismissed or he is released from custody either as "not guilty" or for some other reason (e.g., bail, parole, pardon). An individual who is on furlough from a prison (e.g. under a rehabilitation program) is still under the custody of the penal system and remains an 'inmate' until he is released or pardoned."

The language is addressed to a situation in which it is ambiguous where an individual should be considered to "live." The guidelines establish that an individual imprisoned in a penal institution is not considered to cease "living" in that institution just because he may be physically removed from that environment on a short-term basis. The fact that an individual is on furlough from the institutional setting in which he otherwise resides is not considered to change the location of the individual's residence. Temporary physical whereabouts notwithstanding, the individual has been placed in a particular institutional facility. He constructively "lives in" that facility, even though he is spending a certain amount of time outside its institutional walls.

9/ A penal institution is clearly not a "public educational or vocational training institution," which persons attend "for purposes of securing education or vocational training."

As will be seen, it is this nexus with having "lived in" a particular public institution which, under the regulation, is the only test that may be applied in this regard. Control by the penal system cannot be used as an alternative test.

Thus, it is important to recognize here that the guidelines concerning a furloughed prisoner do not and cannot introduce a new exception to the basic regulatory definition of an "inmate." The statement

> "An individual who is on furlough from a prison (e.g., under a rehabilitation program) is still under the custody of the penal system and remains an 'inmate' until he is released or pardoned"

cannot, consistent with current regulations, refer to being "under the custody of the penal system" as the determining factor of "inmate" status. Rather, the statement must be viewed to reflect an administrative judgment that an individual still within the custody of the penal system and simply on "furlough" from confinement to an institutional setting continues constructively to "live in" that institutional facility. Inmate status in such a case, however, is still established under the basic regulatory standard, that is, under the general rule that only a person who "lives in" a public institution is an "inmate" thereof.

The next paragraph in the guidelines associated with 42 C.F.R. §435.1009 reads as follows:

> A person is considered an inmate of a penal institution if he is incarcerated under process of the penal system, whether the offense is a misdemeanor or a felony or is a delinquent act; for example, if he is serving a sentence in a prison or other correctional institution, or if while serving his sentence, he is transferred to a mental or other medical facility.

The word "incarcerated" as used here implies confinement to a physical placement or institutional facility. Thus a facility in which a person is confined "under process of the penal system" is to be considered a "penal institution." Since the immediately preceding paragraph of the guidelines effectively categorizes "penal institutions" as "public institutions," the point is of some importance.

The paragraph also makes it clear that a person's status as an inmate of a penal institution, and thus of a public institution, is unaffected by distinctions of degree or quality of the offense committed

by the individual. Thus an individual is an inmate of a penal institution whether the reason for his incarceration is a felony, a misdemeanor, or an act of delinquency. The relevant criterion, as dictated by the regulations, is not why he has been incarcerated, but simply whether he presently "lives in" a facility defined as a "public institution."

Moreover, not only prisons, but "correctional institutions," such as those to which juveniles adjudicated to be delinquent might be assigned, are covered by the term "penal institutions." Because correctional institutions within the juvenile justice system are, theoretically, dedicated towards a purely rehabilitative goal rather than a punative or "penal" purpose, confusion as to whether a facility such as, for example, a reformatory is included in the term "penal institution" could arise. The administrative guideline is responsive to this potential confusion.

The guidelines further state that a person incarcerated in a public institution under process of the penal system retains his "inmate of a public institution" status even

> "if while serving his sentence, he is transferred to a mental or other medical facility."

Like the provision relating to an individual on furlough from a prison, this language concerns the concept of a constructive residence. An inmate of a penal institution who, while serving his sentence, is transferred to a mental or other medical facility is still considered to "live in" the public institution in which he was incarcerated under the penal system. That such an individual is considered an "inmate of a public institution" despite the fact of his physical presence in a medical facility does not conflict with the general rule that a patient in a medical institution is not defined as an "inmate of a public institution."

A medical institution cannot, consistent with the Medicaid Act, be categorized as a public institution for purposes of excluding its patients from Medicaid coverage. However, the statutory language exempting a "patient in a medical institution" from public institution inmate status is properly interpreted with reference to the regulatory definitions of the phrase "in an institution" as well as of the word "patient."

It is also important to resolve any potential ambiguity concerning, (a) whether an inmate of a public institution loses that status by being transferred to a medical institution, and (b) whether an individual could be considered to be both an inmate in a public institution and a patient in a medical institution, and, if so, which set of regulations govern in that case.

Regulations state that a

> "Patient" means an individual who is receiving needed professional services that are directed by a licensed partitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illiness, disability, or pain.

and that

> "In an institution" refers to an individual who is admitted to live there and receive treatment of services provided there that are appropriate to his requirements. (emphasis added).

Thus, an individual is not a "patient in a medical institution" under the Medicaid statute unless he has been admitted to "live" in a medical institution. The Manual provisions indicate that a prisoner who is transferred from a penal institution to a medical facility is not considered to commence "living in" the medical facility; and thus is not considered a "patient" "in" that facility for Medicaid purposes. Rather, he is considered to continue to "live in" the penal institution to which he has been sentenced. Such an individual is an "inmate of a public institution" because he "lives", albeit constructively, in a penal institution; not because he is in the custody of the state or because he is "detained by legal process under the penal system."

The Manual is unfortunately phrased in a manner which, read out of context, appears to indicate that an individual's status under the legal system is a criterion upon which exclusion from Medicaid coverage may be based. 10/ However, such an interpretation must be rejected because it lacks an adequate foundation in the Medicaid statute and

10/ This misconception could easily result from an out-of-context reading of the statement:

> "When a person is detained by legal process under the penal system, he cannot attain status as in inpatient of a medical facility for purposes of Medicaid"

The statement is a valid interpretation of the law only if it is understood that the involved individual has been, at least initially, detained by legal process under the penal system in a penal institution. When read in conjunction with the succeeding sentences, the statement quite apparently refers to instances of temporary absence or transfer from penal institutions to which individuals have been confined.

its implementing regulations. Absent specific circumstances which are clearly set forth in regulations as exceptions to the general rule, the test of exclusion from Medicaid coverage as an "inmate of a public institution" is whether an individual "lives in" a public institution other than a medical institution. The Medical Assistance Manual does not have the legal authority to substitute for this clearly articulated regulatory standard, a different standard revolving around whether or not the state has custody of an individual as an accused or convicted criminal.

Such an interpretation would also potentially exclude from Medicaid individuals on parole whose conditions of parole contain stringent restrictions on where they can live and travel; such individuals could easily be considered "detained by legal process under the penal system."

The next paragraph of the Manual, however, is even more misleading in regard to the application of the "inmate of a public institution" exclusion.

The Manual states:

> Furthermore, even if he has not been transferred from a prison or other correctional institution, but is sent directly to a medical institution (e.g., for a mental examination or because he has been found mentally incompetent to stand trial), he is not considered a patient therein for purposes of Medicaid coverage. However, if the court commitment to a mental institution were to follow a verdict of "not guilty by reason of insanity," the individual is not in custody as an accused nor as a convicted criminal and so may be entitled to Medicaid coverage (if he is eligible).

Thus it is asserted that "a person detained by legal process" 11/ is not to be considered a "patient" in a medical institution for Medicaid purposes. By emphasizing this policy in connection with individuals sent directly to a medical institution for a mental examination, diagnosis, or psychiatric treatment pending a determination of competence to stand trial, the Manual implies that these individuals are necessarily excluded from Medicaid coverage as "inmates of public institutions." This con-

11/ As referred to in the preceeding paragraph.

clusion oversteps the bounds of reasonable interpretation of the relevant statutory and regulatory provisions. Living in a medical institution as a patient does not, under the Medicare statute, qualify as living in a public institution for purposes of Medicaid coverage. According to the Manual, persons "detained by legal process under the penal system" are not to be considered patients in medical institutions. Such a policy, applied to persons who otherwise fit the regulatory definition of a "patient," could be justified on the basis that such individuals are not considered to "live in" the medical facilities to which they are admitted. However, in order to meet the regulatory definition of an "inmate of a public institution," such individuals would nevertheless have to live, actually or constructively, in some "public institution." The fact that these individuals are not considered to live in medical facilities to which they have been admitted does not necessarily establish that they do live in public institutions other than these medical facilities. Without some identifiable public institutional residence, they cannot be categorized as "inmates of public institutions" consistent with the regulatory definition of that term. Nor do we believe that a present intent by the state to transfer the individual to a specific public institution at some later date supplies the requisite nexus.

When an individual's physical presence in a medical institution interrupts, or follows transfer from, incarceration in a penal institution, there is at least an identifiable institutional facility, other than the medical institution, in which that individual may legitimately be considered to continue to live. If a person detained by legal process is sent directly to a medical institution, however, there is no other "public institution" of which he may be considered, even constructively, to be an inmate. Irrespective of such a person's status under the penal system, he cannot be considered an "inmate of a public institution."" Insofar as the administrative guidelines imply that, by virtue of being "detained by legal process under the penal system," an individual may be excluded from Medicaid coverage as an "inmate of a public institution", even though he does not live in a facility defined as a public institution, the guidelines are directly in conflict with 42 C.F.R. §435.1009 and are therefore invalid.

The final paragraph of the Medical Assistance Manual concerning "Commitment to Public Institutions Under the Penal System" could also be misleading without clear recognition of this principle, i.e., that an inmate of a public institution must in some sense "live in" a governmentally administered institutional facility that is not excluded by regulations from the definition of a "public institution." This paragraph states:

> Children who have been committed by the court to a correctional institution for detention in connection with a violation of the law are considered inmates of a penal institution and are not eligible for Medicaid, nor are children who are temporarily sent to diagnostic or evaluation centers (which are administered by a government agency) for a determination of the most appropriate institutional placement resulting from a court order for commitment under the penal system.

The first portion of this paragraph merely clarifies the point that children are not exempted from categorization as "inmates of public institutions" for purposes of the statutory exclusion from Medicaid coverage. Neither the Medicaid statute nor its implementing regulations, in fact, provide a basis for excepting children from the otherwise applicable provisions of the law and regulations concerning "inmates of public institutions." 12/ However, the statement that Medicaid coverage is denied to "children who are temporarily sent to diagnostic or evaluation centers (which are administered by a government agency) for a determination of the most appropriate institutional placement resulting from a court order for commitment under the penal system" is misleading in its breadth.

It is probably within the bounds of valid administrative discretion to determine that, as a matter of policy, the children described here are not excepted from the Medicaid definition of "inmates of public institutions" as individuals living in public institutions for only "temporary" periods." If these children are to be committed to institutional placements under the penal system, their period of residence in public institutions may legitimately be viewed as more than "temporary" under the meaning of §435.1009. Such a view is rationally supportable even if a child's initial placement in a public institution is predictably short-term. Although the child may be in a particular public institution on a purely temporary basis, he will clearly be living in a public institution of some type for more than a "temporary" period.

12/ Although we note that a bill was introduced in the House of Representatives which proposes to amend the Medicaid statute to mandate Medicaid eligibility for certain children in juvenile institutions. See §14 of the "Child Health Assurance Act of 1978" (H.R. 13611) Introduced July 26, 1978.

However, the rule set forth in this paragraph of the guidelines is valid only where the diagnostic or evaluation centers to which children are initially sent are legitimately categorized as "public institutions" for Medicaid purposes. If any of these facilities are actually "medical institutions" as defined by §435.1009, children placed in those facilities who have never resided in any other institutional placements cannot as yet be considered to "live in" public institutions, or consequently be said to have "inmate" status.

As in the case of adults, the primary test of status as an inmate of a public institution must be, as dictated by federal regulations, whether an individual "lives in" a facility defined as a public institution. If an individual cannot rationally be viewed as "living in" some identifiable public institution, his inmate status is legally insupportable. The fact that such an individual is in state custody and is destined to live in such a facility at a later time does not alter his current lack of status as an "inmate of a public institution."

In summary the valid provisions of the guidelines that appear in the Medical Assistance Manual under the heading "Commitment to Public Institutions Under the Penal System" primarily serve to clarify the question of where individuals are considered to "live" under certain ambiguous circumstances. Under the Secretary's interpretation of the regulations, persons "detained by legal process under the penal system" may be considered to "live in" penal institutions even during periods of physical absence from those facilities. Although some may disagree with the rationale behind this policy, it is not inconsistent with the law and regulations. In general, the guidelines are addressed to situations in which an individual is associated with a particular public institution to an extent that at least arguably implies "resident" status in that institution. In such situations, it is within the Secretary's discretion to determine that involved individuals are covered by the regulatory language referring to persons who "live in" public institutions, even though the "inmates" may be, for a time, physically located outside of those particular institutional facilities. In addition, these guidelines are to some extent directed towards clarifying the circumstances in which an individual's institutional residence is considered to be "temporary" in the sense that precludes "inmate" status under Medicaid regulations.

Insofar as the guidelines merely clarify the administrative interpretation of terms that are not further defined in regulations (such as the concept of "living in" an institution, or public institutional residence for a "temporary period pending other arrangements"), they represent valid and meaningful administrative rules. Insofar as they impliedly set forth alternative tests of public institutional inmate

status that are inconsistent with the regulatory definition of that status, the guidelines are incorrect interpretations of law and should not be followed.

The Opinion of the Virginia Attorney General

In the light of current regulations regarding inmates of public institutions the November 24, 1976 Opinion of the Virginia Attorney General has two major flaws as a guide to proper categorization, for Medicaid purposes, of juveniles in the custody of the State Department of Corrections.

The first flaw is attributable simply to the passage of time. At the time the Opinion was written, federal regulations excepted only "medical institutions" and "intermediate care facilities" from the definition of "public institutions." As of March 10, 1978, the relevant regulations were amended to except "publicly operated community residences which serve no more than 16 residents" from the definition of public institutions. 13/ Accordingly, the Attorney General's judgment regarding the applicability of the "inmate of a public institution" exclusion to children in certain governmentally administered facilities may have to be reassessed. The factual information provided in the Attorney General's Opinion, however, is insufficient to form a basis for any meaningful judgement of the extent to which the new "community residence" exception affects the current validity of the opinion. 14/

The second fallacy in the Attorney General's Opinion is the assertion that certain juveniles are properly categorized as inmates of public institutions, and hence excluded from Medicaid coverage, on the basis of the fact that they are within the "administrative control," i.e., in the legal custody of, the Department of Corrections. 15/

13/ See 43 F.R. 9816.

14/ The regulations also exclude from the definition of a "publicly operated community residence for 16 or fewer residents"
(iii) Correctionalor holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

15/ See Attorney General's Opinion at pg. 136: "These juveniles are inmates of public institutions because they are under the Department's (i.e., Corrections) administrative control."

As has been discussed above, federal regulations do not permit classification of an individual as an "inmate of a public institution" unless that individual may reasonably be considered to live in a facility defined as a "public institution." The regulations, moreover, absolutely preclude a "medical institution," "intermediate care facility," or "publicly operated community residence that serves no more than 16 residents" from being considered a "public institution" for purposes of excluding its inmates from Medicaid coverage. Thus, the fact that a juvenile is within the "administrative control" of the Department of Corrections cannot be determinative of status as an inmate of a public institution where the juvenile clearly does not live in such an institution. Although there may be cases in which a juvenile in the Department of Corrections' custody can be considered an "inmate of a public institution" despite physical presence in a medical facility; the rationale for such classification must be that the juvenile, at least constructively, "lives in" another facility included in the regulatory definition of a "public institution." The administrative control of the Department of Corrections is, under no circumstances, the fact determinative of Medicaid eligibility.

It is apparent that this error in the Attorney General's Opinion concerning institutionalized juveniles is the product of misleading language in the Administrative Assistance Manual. As has previously been discussed, Part 4, Para 4-50-20C of the Manual implies that individuals in medical institutions are nevertheless "inmates of public institutions" because they are "detained by legal process under the penal system." On the basis of these administrative guidelines, the Attorney General's conclusion that for certain children in medical institutions "the determining factor is one of control, rather than of location" is understandable. Nevertheless, administrative guidelines notwithstanding, the Attorney General's conclusion in this regard is incorrect because it is inconsistent with the regulatory definitions applicable to institutional status. Contrary to the Attorney General's Opinion, the relevant question to be answered with respect to each category of juveniles mentioned is simply whether the involved children live in facilities classified by regulation as public institutions. Under no circumstances can the "administrative control" of the Department of Corrections be the factor that establishes a juvenile's status as an "inmate of a public institution."

On the basis of the fact that the 1976 Attorney General's Opinion does not address the effect of recently promulgated regulations concerning publicly operated community residences and since the Attorney General was apparently laboring under a misconception of the relevant criterion to be applied in determining "inmate of a public institution" status in certain circumstances, the validity of the conclusions reached in that opinion must be reassessed. The limited facts provided in the Attorney General's Opinion, however, are not adequate to serve as a

basis for final determinations of the eligibility status of each of the groups of juveniles mentioned therein. At this point, therefore, it is impossible to do more than note that the validity of the Attorney General's conclusions regarding categories 6 - 12, 15, and 17 - 20 is at least questionable. Many of these conclusions could conceivably be altered by the application of regulations concerning "publicly operated community residences." The Attorney General's conclusions regarding children in categories 11, 12, 19, and 20, moreover, were apparently not based upon application of legally correct eligibility criteria, and thus should be re-evaluated in light of the relevant regulatory definitions.

cc: James C. Eshelman
James F. Mellody
Stephanie Naidoff

APPENDIX E, Exhibit 1

NORMAN SISISKY
P. O. BOX 4010
PETERSBURG, VIRGINIA 23803

COMMITTEE ASSIGNMENTS
HEALTH, WELFARE AND INSTITUTIONS
LABOR AND COMMERCE
CHESAPEAKE AND ITS TRIBUTARIES

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

THIRTIETH DISTRICT

November 17, 1978

Honorable J. Marshall Coleman
Attorney General of Virginia
Supreme Court Building
4th Floor
Richmond, Virginia 23219

Dear Mr. Coleman:

During the 1978 Session of the General Assembly, House Joint Resolution No. 48 directed that a study be conducted of the medical needs of children in State and local care and custody. I have chaired that study this year. One of the primary issues considered during this study has been the nature of Medicaid eligibility requirements applicable to juveniles in the custody of the State Board of Corrections or in community-based residential care facilities funded with Corrections monies. An opinion of the Office of the Attorney General issued November 14, 1976 ruled that these children are ineligible for Medicaid benefits.

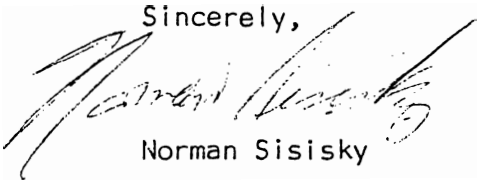
The legislative subcommittee which I chair requested and has received a review of the November, 1976 opinion by the Office of General Counsel of the Department of Health, Education and Welfare. The Philadelphia Regional Office of HEW has been most cooperative in representing Virginia's interests in this regard by seeing that this matter received expeditious review and favorable action.

At a November 14th meeting of the Joint Subcommittee, representatives of the Philadelphia Regional Office of HEW presented the opinion of the Office of General Counsel which is enclosed and which has determined that Virginia's practices in this area are not in conformity with applicable provisions of federal law and regulations in several significant respects. The Subcommittee asked that I request you to review this opinion and report to this legislative study on what steps will now be taken to see that Medicaid benefits are now extended to those children eligible under the guidelines set out in HEW's opinion. The Subcommittee is anxious for the barriers which exist in Virginia to adequate medical coverage for children in State and local care and custody to be removed expeditiously.

It is crucial that we receive a quick reply on this matter in order for the Subcommittee to formulate its recommendations to the 1979 Session of the General Assembly which may include additions to the budget of the Medicaid Program to cover the costs of the new eligible children.

Thank you for your prompt attention to and assistance in this matter.

Sincerely,



Norman Sisisky

Enclosures

CC: Jean L. Harris
Don Terrell Hutto
J. B. Kenley
William L. Lukhard
Roy T. Perez-Daple
Hunter B. Andrews
John D. Gray
H. Selwyn Smith

Commonwealth of Virginia

MARSHALL COLEMAN
ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL
SUPREME COURT BUILDING
1101 EAST BROAD STREET
RICHMOND, VIRGINIA 23219
804-786-2071

November 22, 1978

The Honorable Norman Sisisky
Member, House of Delegates
P. O. Box 4010
Petersburg, Virginia 23803

Dear Delegate Sisisky:

The letter opinion of the General Counsel's Office of the United States Department of Health, Education and Welfare concerning medicaid eligibility of children in the custody of the Department of Corrections has been reviewed. The opinion indicates that the November 24, 1976, opinion of the former Attorney General is no longer accurate because of recent amendments to the medicaid regulations and because of misleading language in the Medical Assistance Manual.

In my judgment, the letter of the General Counsel's Office has delineated with sufficient specificity the factors which the Commonwealth must consider in determining eligibility for these juveniles, assuming that they otherwise meet the income eligibility standards for medicaid. That being the case, it is my advice that the Department of Corrections take the appropriate steps to apply for medicaid benefits for these juveniles with the Department of Welfare, which performs the eligibility determinations for medicaid.

I have some reservations, in view of the letter of the General Counsel, about stating categorically that all the juveniles in any one of the particular classes of juveniles, previously held to be ineligible, is now eligible. Rather, it appears that the Department of Welfare will have to consider each case on its own merits. Consequently, I would suggest that the Departments of Corrections and of Welfare with the assistance of the Department of Health re-evaluate the situation. If any uncertainties remain after their re-evaluation, my office is, of course, ready to assist in any way that it can.

With kindest regards, I remain

Sincerely,

Marshall Coleman

Marshall Coleman
Attorney General

4:26:142

cc: Jean L. Harris
Don Terrell Hutto
J. B. Kenley
William L. Lukhard
Roy T. Perez-Daple
Hunter B. Andrews
John D. Gray

COMMONWEALTH of VIRGINIA

January 2, 1979

Information Bulletin (79-5)

Distribution: Judges, Juvenile and Domestic Relations Court
Directors, Court Services Units
Superintendents/Directors of Public Welfare/Social Services

Subject: MEDICAID ELIGIBILITY OF CERTAIN CATEGORIES OF JUVENILES

Currently, certain categories of children in the juvenile justice and welfare systems are excluded from medical coverage under Title XIX, Medicaid. A recent opinion from the Office of The General Counsel, Department of Health, Education and Welfare has resulted in a re-interpretation of Medicaid eligibility criteria applicable to these juveniles.

The General Counsel opinion stipulates that administrative control of a child by the Department of Corrections is not a factor in determining eligibility for Medicaid. Placement in publicly operated community residences which serve no more than 16 persons is, also, not a consideration as long as the residence is not a correctional or holding facility for individuals who are prisoners, have been arrested or detained pending disposition of charges or are held under court order as material witnesses or juveniles. This modification to the definition of publicly operated community residences continues to exclude from Medicaid eligibility children placed in jails, learning centers and secure and less secure detention facilities.

Children residing outside of their own homes who will be eligible for determination of Medicaid eligibility as a family unit of one, include:

1. Children residing in facilities serving no more than 16 persons operated by cities, counties and/or commissions pursuant to Section 16.1-315, Code of Virginia. These facilities include crisis intervention centers, outreach programs, group homes, and family oriented group homes;

2. Children committed to the Department of Corrections and residing in State operated foster homes and group homes serving no more than 16 persons;

3. Children in custody of the Department of Corrections placed in private facilities pursuant to Section 16.1-286, Code of Virginia;

4. Children for whom local boards of welfare have been assigned responsibility for aftercare supervision pursuant to Section 16.1-293, Code of Virginia;

5. Children in joint custody of a component of the juvenile justice system and a local welfare board if not placed in a precluded facility.

Determination of eligibility for Medicaid for children in their own homes, under court ordered supervision or aftercare, is based on the income of the total family unit.

This Bulletin is for information purposes only. Staff of the Virginia Departments of Health, Welfare and Corrections are working cooperatively to develop policy for implementation of these new regulations. The date for initiating applications will be March 1, 1979. More detailed instructions and procedures will be issued prior to that time. Unpaid medical bills will be covered for a period of 90 days prior to the date of application for children determined Medicaid eligible.

Local Welfare Departments should retain this Bulletin until these changes are incorporated in the Social Services Manual, Chapter 5000 - Foster Care and Chapter 200 of the Medicaid Manual.

William L. Lukhard

Terrell Don Hutto

Virginia State Department of Health
109 Governor Street
Richmond, Virginia
23219

October 6, 1978

Mr. William L. Lukhard, Commissioner
Department of Welfare
8007 Discovery Drive
Box K-176
Richmond, Virginia 23288

Dear Mr. Lukhard:

At the request of Mr. Ray Sirry, we have prepared an informational letter about the potential for residential facilities to enter into contract with the Virginia Medical Assistance Program for payment of the medical and psychiatric component of the care of children placed by local departments of social services. Such a contract has been in effect several years with Edgemeade. Mr. Sirry believes that other facilities may wish to make similar contracts with the Virginia Medical Assistance Program.

Federal regulations provide for certain state contracts for the provision of or payment for medical and remedial services under Title XIX of the Social Security Act. The provisions for these contracts are enumerated in 42 CFR 449.82. A "contractor" may be one of several kinds of organizations providing care on a prepaid capitation basis. Included are private nonmedical institutions, such as a child-care institution or a maternity home, which provides medical care through contracts or other arrangements with medical providers, and which receives payments on a prepaid capitation basis through contract with the Medicaid single State agency.

The institution must be willing and able to identify the medical and psychiatric treatment component of the cost of care of program recipients. The Virginia Medical Assistance Program can then enter into contract to pay a monthly rate for the anticipated cost of these services at a fixed rate per resident.

The kinds of services that may be included in these contracts include individual and group psychotherapy, psychological evaluation, social work evaluation, medication, and physician services. The residential facility should continue to secure medical care not available at the facility from physicians and other medical facilities in the community. For these services, the Virginia Medical Assistance Program will arrange for reimbursement directly to the provider.

Further details will be worked out directly with any facilities desiring to explore such a contract. Facilities interested in exploring this potential source of reimbursement should contact Malcolm Perkins, Administrator, Professional Services, Virginia Medical Assistance Program, 109 Governor Street, Richmond, Virginia 23219. His telephone number is (804) 786-7781.

Sincerely,

F. C. Hayes, M.D.
Director

cc: Mr. Ray Sirry
Ms. Lelia Hopper
Mr. Bill Baker
Mr. Malcolm Perkins

APPENDIX F, Exhibit 2

Virginia State Department of Health
109 Governor Street
Richmond, Virginia
23219

November 29, 1978

Dear Service Provider:

It is our understanding that one or more children have been placed in your facility by the Virginia Department of Welfare. This letter is to acquaint you with a means of financing certain of the needs of these children and to ascertain your interest in entering into a contract with our Virginia Medical Assistance Program (Medicaid).

Federal regulations provide for state contracts for the provision of or payment for medical and remedial services under Title XIX of the Social Security Act. The provisions for these contracts are enumerated in 42 CFR 449.82. A "contractor" may be one of several kinds of organizations providing care on a prepaid capitation basis. Included are private non-medical institutions, such as a child-care institution or a maternity home, which provide medical care through contracts or other arrangements with medical providers, and which receive payments on a prepaid capitation basis through a contract with the Medicaid single State agency.

The institution must be willing and able to identify the medical and psychiatric treatment component of the cost of care of program recipients. The Virginia Medical Assistance Program can then enter into a contract to pay a monthly rate for the anticipated cost of these services at a fixed rate per resident eligible for medical assistance.

The kinds of services that may be included in these contracts include individual and group psychotherapy, psychological evaluation, social work evaluation, medication, and physician services. The residential facility should continue to secure medical care not available at the facility from physicians and other medical facilities in the community. For these services, the Virginia Medical Assistance Program will arrange for reimbursement directly to the provider.

Further details will be worked out directly with any facilities desiring to explore such a contract. Facilities interested in exploring this potential source of reimbursement should contact Mr. M. O. Perkins, Administrator, Professional Services, Virginia Medical Assistance Program, 109 Governor Street, Richmond, Virginia 23219. His telephone number is (804) 786-7781.

Sincerely,

F. C. Hays, M.D.
Director
Virginia Medical Assistance Program

cc: Mr. William L. Lukhard
Ms. Lelia Hopper
Mr. M. O. Perkins