



COLORADO LAWYERS COMMITTEE

January 14, 2010

VIA U.S. MAIL

Ms. Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Individuals Residing in Colorado Community Corrections Facilities Have Been Denied, But Are eligible for Health Care Services Funded with Federal Financial Participation.

Dear Ms. Sebelius:

I am writing to seek your help with a critical problem which has resulted in the denial of health care for seriously ill individuals in Colorado's community corrections. This denial of health care affects anywhere from one to four thousand individuals a year. It is our understanding that Congresswoman Diana DeGette would like your assistance on this issue as well.

I am the Chair of the Mental Health Task Force ("Task Force") of the Colorado Lawyers Committee. The Colorado Lawyers Committee and the Mental Health Task Force are described on page 1 of the enclosed policy paper titled "Access to Medical Benefits For Individuals in Community Corrections." Our Task Force is comprised of attorneys and advocates attempting to resolve legal issues relating to access to quality mental health and health services. We are writing to obtain your prompt guidance to the Denver Regional Office of the Centers for Medicare & Medicaid Services ("Denver CMS"). Your Department's guidance would help to avoid further denials of mandated health care as well as delays resulting from imminent costly litigation.

Last year, the Mental Health Task Force learned that residents in Colorado's community corrections program have been systematically excluded from the Colorado Indigent Care Program ("CICP") since the state regulations for that program were amended in 2005. As a result, these individuals have virtually no access to basic medical care, including psychotropic medication. CICP funding includes disproportionate share dollars that share the same restriction as Medicaid dollars: exclusion of federal financial participation ("FFP") for "inmates of public institutions." 42 CFR §435.1009.

1801 CALIFORNIA STREET • SUITE 4900 • DENVER, CO 80202
MAIN NUMBER (303) 894-6366 • FAX (303) 894-9239
www.ColoradoLawyersCommittee.org

We would like to share with you our research and conclusions which, consistent with Medicaid law and regulations, CMS policy, and the findings of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing ("HCPF"), establish that most of the residents in the 35 Colorado residential community corrections facilities are residents of private, not public, institutions, and are eligible to receive medical care with FFP dollars.

Attached is a letter written by Joan Hennenberry, the Executive Director of HCPF, on November 6, 2009 which supports our position and conclusion (attached as Ex. A). We believe you will reach the same result and we ask that you promptly share your conclusion with our regional CMS office so that the residents of Colorado Community Corrections facilities will once again become eligible for health care mandated by law. I will summarize these results in the remainder of this letter. I am also providing the fifteen page policy paper (attached as Ex. B) and a few key exhibits that comprehensively explain the issue.

Perhaps the most succinct statement of the law regarding FFP for inmates of public institutions is contained in two letters from your agency. Although the letters are a little over 10 years old, the law and regulations have not substantially changed. The April 10, 1998 letter from Denver Regional [HCFA] CMS (attached as Ex. C) tracks the December 12, 1997 letter from CMS Headquarters in Baltimore (attached as Ex. D) and both address what appears to have caused the confusion at HCPF: the distinction between the state control inherent in the definition of "inmate," and the state control involved in determining whether a facility is a "public institution."

Both documents clarify that inmate status requires involuntary confinement and excludes individuals on parole. Part of the test for excluding FFP, of equal importance, also requires that the individual be an inmate of a "public institution." Both the April 1998 and December 1997 letters track the federal regulations by defining a public institution as a facility under the responsibility of a governmental unit, or over which a governmental unit exercises administrative control. Exs. C & D at 2. The letters further clarify that this governmental control can exist when a facility is:

1. Actually an organizational part of a governmental unit, or
2. When a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates, or
3. When a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

As outlined in the attached policy paper, of the 35 residential community corrections facilities in Colorado, approximately three are non-medical institutions that are an organizational part of a governmental unit (most often a county), and therefore meet the definition of public institution. However, most community corrections facilities are operated by private, usually nonprofit, organizations that contract with local community corrections boards, which receive funds from the Department of Public Safety (not the Department of Corrections). No governmental unit exercises final administrative control, including either ownership or control of the physical facilities and grounds used to house inmates. These private organizations are responsible for the day-to-day operations of each facility, including the hiring and firing of employees. They, therefore, do not meet the definition of public institution and FFP should be available for residents of these facilities, whether voluntary or involuntary.

Ms. Kathleen Sebelius
January 14, 2010
Page 3

We have met with our state officials, including those with HCPF, regarding this issue since January 2009. From our research and meetings with HCPF staff it appears that HCPF amended the CACP rules to exclude residents of private community corrections facilities because of confusion regarding the federal rules and policies regarding the definition of "inmates of public institutions." In an abundance of caution, in 2005 HCPF changed its regulation to deny eligibility for participants in community corrections programs. It apparently feared that CMS might cease providing federal matching dollars (and recoup prior payments) because it would determine that community corrections participants are inmates of public institutions, instead of what they are by definition: private institutions.

In August 2009, HCPF reconsidered its position on this issue and has since written the attached letter (Ex. A), supporting that most of Colorado's Community Corrections programs are private facilities, and most residents of community corrections program should be eligible for health care services funded with FFP dollars. However, HCPF has been waiting for Denver CMS to provide guidance. Apparently Denver CMS will not provide definitive guidance to HCPF until it receives guidance from your Center for Medicare and Medicaid Services. This process may well continue for another year, a year which can detrimentally affect many lives. The Mental Health Task Force also has tried to meet with Denver CMS and has sent Denver CMS copies of the existing guidance on this issue. However, the Denver CMS has not responded to our requests for a meeting or addressed the continuing validity of existing CMS guidance.

We are considering litigating this issue with the State of Colorado, which (we presume) might want to implead your agency. However, we do not want more time and unnecessary litigation to come between these needy individuals and their critical health care. We have been in touch with individuals who have gone back to prison to receive health care, and we are aware of individuals who have died from lack of care in community corrections. We also believe that individuals who receive no health care in community corrections may be eligible for health care funded with FFP after they leave the program, but they drain our general and Medicaid funds when they do not receive care until their health condition is so exacerbated the cost of care is extremely expensive.

We believe that the Denver Regional Office of CMS needs swift guidance from you that FFP should be available for residents of Colorado's private community corrections facilities. Please feel free to contact me at your convenience for further discussion or if you need additional information. We eagerly await your response.

Sincerely,



Iris Eytan, Attorney at Law
Chair, Mental Health Task Force
Colorado Lawyers Committee

cc: The Honorable Diana DeGette, United States Congresswoman – Colorado
Joan Hennenberry, Executive Director, Colorado Dept. Health Care Policy and Financing
Richard Allen, Associate Regional Administrator, Division of Medicaid & Children's Health Operations
Kris Lorez, Senior Policy Analyst for Health, Office of Governor Bill Ritter, Jr.
Ed Kahn, Colorado Center on Law and Policy

EXHIBIT A



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

November 6, 2009

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services
1600 Broadway, Suite 700
Denver, Colorado 80202

Re: Individuals Residing in Colorado Community Corrections Facilities are Eligible for Health Care Services Funded with Federal Financial Participation

Dear Mr. Allen:

This letter is a continuation of the correspondence related to the May 26, 2009 letter from the Department of Health Care Policy and Financing (Department) regarding "Suspension of Medicaid Eligibility for Incarcerated Persons." This letter focuses on providing an explanation as to why most participants in the State's community corrections programs should not be considered inmates of a public institution, and thus potentially should be eligible for services (specifically including Medicaid) funded with Federal Financial Participation ("FFP").

Background

In Colorado, community corrections programs are a unique collaboration between state agencies, local officials and (predominately private) community corrections providers, with an emphasis on local control. The community corrections program was established in 1974 as a viable alternative to incarceration in prison and to provide a variety of services to offenders. These services generally include case management, life skills training, drug and alcohol education, money management assistance, and educational and vocational guidance. The term "community corrections" is one that is often confusing. In the broadest sense, it is the supervision or treatment of criminal offenders in non-secure settings. They manage offender populations that would otherwise be placed in secure facilities, such as county jails or state prisons.

As will be elaborated further, community corrections residential facilities are not private prisons, nor do they operate as private prisons: (1) individuals residing in community corrections are not physically locked-up or confined; (2) generally speaking, law enforcement officers or peace officers are not employed as staff at community corrections, and are not contracted to work at the residential facilities; and (3) the facilities are not funded by the Department of Corrections.

The Colorado Department of Public Safety (specifically the Department of Criminal Justice/DCJ) has the responsibility to audit and monitor community corrections programs to ensure compliance with state standards and contracts, federal grant requirement and established operating standards. These operating standards establish minimum objective criteria that describe how programs should deal with issues related to public safety, offender management and best practices in offender rehabilitation. Services are designed to promote productive reintegration of offenders back into the community, which include:

- Services for offenders sentenced to community corrections in lieu of prison (diversion clients);
- Services for offenders who are transitioning from prison prior to parole (transition clients);
- Services for parolees released by the Colorado Board of Parole (condition of parole clients);
- Short-term stabilization services for offenders on probation (condition of probation clients);
- Services for adults adjudicated as juveniles and paroling from the juvenile system as adults (condition of juvenile parole clients); and
- Specialized treatment for offenders with a history of substance abuse and mental illness.

Local community corrections boards are responsible for establishing programs within their judicial district. Local community corrections boards vary by size, membership, philosophy and degree of program control. Citizen board members are typically appointed by locally elected officials. The primary responsibility of the local community corrections boards is to screen and accept or reject any offenders referred to programs in their communities. Diversion offenders who are not approved for placement in the local community corrections program return to the sentencing judge for an alternative sentencing, which is most likely the Department of Corrections. In addition, local community corrections boards may institute guidelines for the operation of the programs that go above and beyond the DCJ's requirements, enforce their local guidelines, and monitor program compliance with state and local standards. Many boards provide an array of critical services designed to assist programs to better serve the needs of the offenders. None of the community corrections programs are exactly the same and the diverse nature of the programs are part of the system's strength.

Currently there are 22 local community corrections boards throughout Colorado and 35 separate residential facilities offering community corrections programs. In five communities, units of local government operate the programs. The remaining programs are directly operated by private agencies, either as for-profit or not-for-profit facilities. The not-for-profit facilities operate under a 501(c)(3) tax exempt status. Two of the not-for-profit facilities that specialize in the treatment of substance abuse receive financial and facility support from the University of Colorado Hospital, but they are not owned or operated directly by the hospital or the State.

Local community corrections boards authorize community corrections programs to manage two main types of offenders.

- “Diversion clients” are directly sentenced to community corrections programs by the courts or, in rare instances, have been sentenced as a condition of a probation placement for up to 30 days. In such cases, community corrections programs serves as the step right before, or alternative to, prison. One measure of success in the management of diversion clients is whether they can permanently demonstrate that they do not require time in prison to become safe and productive members of society.
- “Transition clients” have been in a Colorado prison facility, are still under the supervision of the Colorado Department of Corrections, and are preparing for a gradual return to society by participating in a community corrections program. These offenders include parolees and offenders that must participate in an intensive supervision program. In such cases, the community corrections program serves as the step down from prison, and the offenders’ transition back to the community. One measure of success in the management of these clients is whether they remain crime-free, both during and after their transition from institutional life to freedom.

An offender must receive a referral from either the State judicial branch (diversion) or the Department of Corrections (transition) to participate in one of the community corrections program. Referrals for direct sentence (diversion) offenders are made from local judicial districts to local community corrections boards. Referrals for transition, parole or offenders that need an intensive supervision program upon release from prison are made by the Division of Criminal Justice in the Department of Corrections. Condition of Parole offenders are referred from the parole board as a condition of the offender’s period of parole. Please see an attachment to this letter which depicts the funding and referral process for community corrections programs.

Placement of Individuals in Community Corrections

The placement of individuals in community corrections is fairly complex. Community correction programs consist of residential and nonresidential phases. During the residential phase, offenders are expected to find employment, but are required to reside at the facility. The purpose of the residential phase of community corrections programs is to provide offenders with the knowledge and skills necessary to be emotionally, cognitively, behaviorally and financially prepared for their reintegration back into the community. Residential programs strive to accomplish this rehabilitative task by a variety of means. Through assessment-driven individual treatment plans, programs attempt to match offender risks and needs with the most appropriate treatment modality. Offenders are assisted in obtaining regular employment and encouraged to participate in educational and vocational services. Community corrections program staff monitor the payment of restitution, court fines, court ordered child support and useful community service requirements. Further, program staff carefully monitors offenders in the community to enhance offender accountability and to address public safety concerns.

Once a diversion offender is successfully discharged from the residential phase of community corrections, the remainder of the sentence is typically completed under different types and levels of non-residential supervision. Most community corrections offenders progress through the system to become "nonresidential clients" or "day reporting clients." Typically, these offenders have "graduated" from the more structured part of their programs and are permitted to live with some independence. They check in as often as every day, provide urine samples to detect any substance abuse, and are subject to monitoring at their jobs and elsewhere. Many diversion nonresidential offenders continue classes begun while they were in residence at the community corrections program.

The nonresidential phase of community corrections is designed to assist in the transition and stabilization of residential Diversion offenders back into the community with a gradual decrease in supervision. These offenders have conducted themselves well in a highly-structured residential setting. They have obtained a suitable independent living arrangement, managed their finances appropriately and have progressed in treatment. Offenders in nonresidential placement are required to meet with case management staff, retain employment, participate in mandatory treatment, honor their financial responsibilities and remain drug and alcohol free.

Transition clients from the Department of Corrections generally progress to nonresidential status by way of the Intensive Supervision Program (ISP inmate) until they are paroled by the parole board. These offenders still receive services from the community corrections facilities, but they are also supervised by ISP parole officers.

The two facilities that specialize in the treatment of substance abuse provide an intensive residential treatment program for individuals with serious substance abuse problems. The treatment programs are structured to accommodate persons with disorders related to prolonged substance abuse. Additionally, intensive residential treatment programs treat individuals who lack a positive support system, experience substantial denial and exhibit an inability to sustain independent functioning outside of a controlled environment. The purpose of residential treatment program is to provide a brief and intensive treatment intervention is aimed at increasing positive coping and relapse prevention skills and identifying negative thinking errors that have resulted in prior substance abuse and criminal behavior. Intensive residential programs last 45 days and offenders do not leave the facility for the duration of the program. It is important to note that these programs are being phased out, and will revert back to a longer program.

You may find more information on the State's community corrections programs at <http://dcj.state.co.us/occ/>. Further, we have attached a listing of the programs by location and ownership.

Legal Analysis

We understand that a person who is an “inmate of a public institution” is not eligible for Medicaid Federal Financial Participation (“FFP”) under 42 CFR § 435.1010. When determining whether a person incarcerated at a Colorado community corrections facility falls into this category, this presents a two-prong test: (1) whether the person is an “inmate,” and (2) whether the facility is a “public institution.”

Based on the foregoing description of the community corrections program, we believe that a participating offender residing in either a for-profit or a not-for-profit facility should not be considered an “inmate of a public institution” for the purpose of determining whether the State will be entitled to FFP for any Medicaid expenditures. This is for two separate reasons.

First, we urge you to consider our view that such an offender should not be considered an “inmate,” regardless of whether he or she is residing in a public or private community corrections program. Such a ruling would ease the administration burden of the Department and allow these offenders to access to Medicaid benefits assuming they meet the relevant eligibility criteria.

As an initial matter, it is clear under Colorado law these individuals are classified as “offenders,” and not “inmates.” *See, e.g.,* C.R.S. § 17-27-102. They are not locked up or in prison, and the personnel operating community corrections programs do not have law enforcement duties, nor the legal authority to physically keep program participants from leaving the facilities. The Colorado Supreme Court has expressly distinguished between incarceration and confinement in a community corrections facility, calling the latter “not as harsh.” *People ex rel. VanMeveren v. Dist. Ct.*, 575 P.2d 4 (1978); *see also People v. Wilhite*, 817 P.2d 1017, 1019 (Colo. 1991).

This “offender” (not “inmate”) classification makes good practical sense in this context. Medicaid providers are unaware of an offenders living arrangement when he or she is participating in a community corrections program. Since some programs are residential and others are non-residential programs, they cannot determine if they can bill for outpatient services (and other services not classified as inpatient hospital services) when the offender is Medicaid-eligible. Without the ability to make a Medicaid payment for all offenders participating in community correction programs, the Department will need to established specific eligibility criteria to determine if offenders are involuntarily residing in a public-owned facility. In addition, that information will need to be entered into the State’s eligibility state, Colorado Benefits Management System (“CBMS”), so the client’s Medicaid eligibility can be temporarily suspended while residing involuntarily residing in a public-owned facility, which will prevent providers from billing for services. The only way to prohibit Medicaid payments, and thus limit FFP, to providers for this population are expensive changes to CBMS to provide notification when no Medicaid payment is available even though the client may retain their Medicaid eligibly while residing in a community corrections program.

Additionally, as you are no doubt aware, Colorado does not have an eligibility category that would apply to many of these inmates, since most would be considered to be residing in a household without dependent children. We note, however, that there is a strong public policy argument in favor of allowing pregnant women residing in a community corrections program to receive Medicaid services and would like to consider including other individuals under a Medicaid expansion through an 1115 Waiver for adults without dependent children in the household planned for 2011.

Notwithstanding the foregoing, even if your office cannot concur with our view that providers may receive Medicaid payments for all qualifying medical services provided to all community corrections offenders, we nonetheless believe FFP should be available with respect to the vast majority of these individuals. This is because private community corrections facilities do *not* constitute “public institutions” for the purposes of determining if a Medicaid payment is available when medical services are rendered. We note in this regard that at least 28 (and possibly 30) of the state’s 35 community corrections institutions are not owned or operated by any governmental entity.

We have been able to locate two sources that provide some guidance on the issue of whether a private institution will nonetheless be classified as a “public institution” for Medicaid purposes. First, according to CMS regulations, a facility is a “public institution” only if it is “the responsibility of a governmental unit or over which a governmental unit exercises administrative control.” *See* 42 C.F.R. § 435.1010.

In addition to the CMS regulation, the 1997 Clarification memo from CMS (then called the Health Care Financing Administration) observes that administrative control exists where “an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates.” *See* 1997 Clarification memo. It also will be present when “a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a government unit, board or officer has final authority to hire and fire employees.” *Id.*¹

Based on these criteria, the state’s private (for-profit or not-for-profit) community corrections facilities should not be deemed to be “public institutions” for Medicaid eligibility purposes.

Furthermore, the state standards governing community corrections programs show that, according to the factors set forth above, programs contracted to private agencies are not under government control. *See* Colorado Community Corrections Standards (the “CCCS”) (available at <http://dcj.state.co.us/occ/pdf/2007%20Community%20Corrections%20Standards.pdf>). These

¹ This guidance is similar to that provided by the SSA in POMS § SI 00520.001(C)(2)(a), stating that a strong indication of governmental control exists when a government (1) appoints an institution’s board of trustees, (2) appoints the institution’s administrator, (3) assumes the obligation to appropriate funds to make up the institution’s operating deficits, (4) receives payment on behalf of the institution, or (5) holds the operating certificate or license. *Id.*

standards apply to contracts with community corrections programs and form the basis of overseeing these contracts. They also illustrate that each program is responsible for its own day-to-day operations.

For example, the facilities used by private community corrections programs are controlled by the private organizations that are under contract to provide the programs. *See, e.g.*, CCCS § 5-5010 *et seq.* (providing standards for fire alarms, health and sanitation that programs must comply with). In addition, neither a private facility's administrator nor board of trustees will be appointed by any governmental unit – to the contrary, they presumably will be selected like any other employee, trustee or director of a private entity. *See, e.g.*, CCCS § 1-1010(b)(1) (discussing legal status of public and private facilities). Also, the employees of a private-owned community corrections facility are hired and/or fired by institution itself, and there is no indication in the CCCS guidelines that government will have any direct or indirect authority in making these personnel decisions. *See, e.g.*, CCCS § 2-050 (requiring that information from personnel files be available to the local community corrections board and/or state oversight agencies ***only for the purpose of verifying compliance with standards or contractual requirements***). Furthermore, there is no indication in the CCCS that the state will assume any obligation to appropriate funds to make up any operating deficit. *Id.* at § 1-1040 (discussing fiscal affairs). Similarly, there is no governmental entity that will receive payment on behalf of a private institution. *Id.* Finally, the facility itself will hold the requisite license, and not any state agency. *Id.* at 1-010(b).

In summary, there is no final administrative control exerted by any governmental unit over a private community corrections facility – although the CCCS prescribes that the facility must formulate and implement a number of policies and procedures governing personnel, management, security, *etc.*, no government entity will participate in this process, and with a few exceptions, there is not even any requirement that the policies or procedures be formally approved. *See, e.g.*, CCCS § 3-010. Moreover, with respect to the ongoing daily activities of a private-owned community corrections facility, there is no government involvement in devising or enacting the foregoing policies and procedures governing operations (and even *ex post* approval is rarely required). This is consistent with judicial opinions addressing similar types of programs, which generally tend to view such private-owned facilities as something other than a “public institution.” *See, e.g., Dixon v. Stanton*, 466 F. Supp. 335, 339 (D.C. Ind. 1979).

Therefore, if CMS cannot concur with the Department's preferred view that an individual participating in any community correction program is not an inmate of a public institution, then based the foregoing analysis, we believe that it is clear that privately-operated community corrections program facilities should not be classified as “public institutions” for the purpose of determining the eligibility for FFP for offenders residing there.

The Department requests that CMS respond to the Department's analysis so a formal policy can be properly developed and implemented. We reiterate that there is a strong public policy argument in favor of increasing the eligibility of community corrections participants in FFP-funded programs, consistent with federal law. For example, pregnant women residing in a

community corrections program should be allowed to receive Medicaid services, and we would like to consider including other individuals under a Medicaid expansion through an 1115 Waiver for adults without dependent children in the household planned for 2011.

If you have any additional questions or concerns regarding this issue, or would like additional information about Colorado's community corrections programs, please contact Chris Underwood, Director of State Program and Federal Financing at 303-866-4766 and we will be happy to accommodate this request. Mr. Underwood has taken the lead on researching the suspension of Medicaid eligibility for incarcerated persons for the Department and is available to meet with your staff to help address our questions.

Once again, thank you for your attention to this issue.

Sincerely,

/s/

Joan Henneberry
Executive Director

Attachments

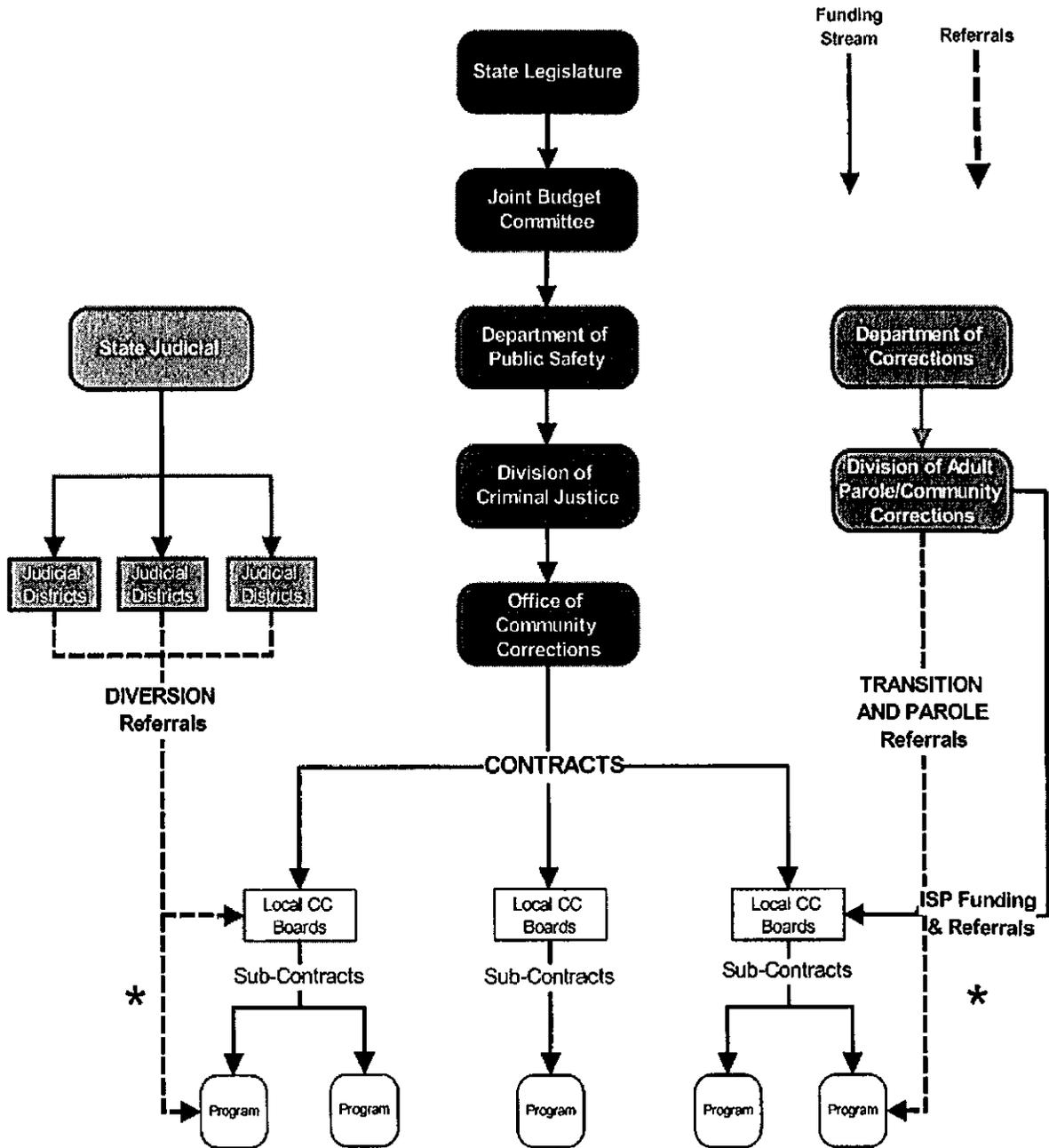
Table 1
Community Corrections Program Ownership in Colorado

<i>Program Name</i>	<i>Program Location</i>	<i>Program Ownership/Sponsorship</i>
Arapahoe County Treatment Center	Sheridan	501(c)(3)
ComCor, Inc.	Colorado Springs	501(c)(3)
Crossroads-Turning Points	Pueblo	501(c)(3)
Hilltop House	Durango	501(c)(3)
ICCS Jefferson	Lakewood	501(c)(3)
ICCS Weld	Greeley	501(c)(3)
Peer I	Denver	University-sponsored not-for profit
San Luis Valley Community Corrections	Alamosa	501(c)(3)
The Haven	Denver	University-sponsored not-for profit
Garfield County Community Corrections	Rifle	County-owned
Gateway: Through the Rockies ¹	Colorado Springs	County-owned
Larimer County Community Corrections	Ft. Collins	County-owned
Mesa County Community Corrections	Grand Junction	County-owned
Phase I ²	Denver	County-owned
Advantage Treatment Center	Sterling	For-profit ownership
Arapahoe County Residential Center	Englewood	For-profit ownership
CMI-Boulder	Boulder	For-profit ownership
CMI-Centennial	Centennial	For-profit ownership
CMI-Columbine	Denver	For-profit ownership
CMI-Dahlia	Denver	For-profit ownership
CMI-Fox	Denver	For-profit ownership
CMI-Longmont	Longmont	For-profit ownership
CMI-Ulster	Denver	For-profit ownership
Community Alternatives of El Paso	Colorado Springs	For-profit ownership
Correctional Alternative Placement	Craig	For-profit ownership
Independence House-Federal	Denver	For-profit ownership
Independence house-Fillmore	Denver	For-profit ownership
Independence House-Pecos	Denver	For-profit ownership
Minnequa Community Corrections	Pueblo	For-profit ownership
Phoenix Center	Henderson	For-profit ownership
Pueblo Community Corrections	Pueblo	For-profit ownership
Time to Change-Adams	Welby	For-profit ownership
Time to Change-Commerce City	Commerce City	For-profit ownership
Tooley Hall	Denver	For-profit ownership
Williams Street Center	Denver	For-profit ownership

¹ Small, jail-based program with no residential beds

² Jail-based program with no residential beds and special mission

Figure 2
COLORADO COMMUNITY CORRECTIONS
Funding and Referral System



* Some referrals are made directly to programs where boards have developed automatic acceptance criteria

EXHIBIT B



COLORADO LAWYERS COMMITTEE

HAND DELIVERY

December 22, 2008

Governor Bill Ritter
200 East Colfax Avenue
Denver, CO 80203

Re: Health Care for Community Corrections Participants

Dear Governor Ritter:

We are writing you on behalf of the Colorado Lawyers Committee Mental Health Task Force to bring to your attention a serious issue facing individuals in community corrections in Colorado.

The Task Force has learned that individuals in community corrections are not receiving health care (including mental health) benefits and often choose to be incarcerated (or re-incarcerated) in order to address their serious health concerns. After researching the law and facts, we discovered that in 2005 Colorado's Department of Health Care Policy and Finance (HCPF) implemented a change to the Colorado Indigent Care Program (CICP) that has had the impact of denying CICP benefits to almost all community corrections participants.

The HCPF rule change was implemented in an attempt to mirror federal law, which prohibits spending federal dollars on health care for inmates in public institutions. However, the rule change does not mirror federal law and the result is inconsistent both with federal law and regulations and with state law. Most community corrections participants who are medically indigent should be eligible for CICP benefits. We believe that changing the CICP regulation back to its original language with clarifications provides an easy solution that will come with very little cost, if any, to the taxpayers, and may save and avoid costs for the State of Colorado.

Attached is a policy paper that describes this serious problem in greater detail. We have already met briefly with Christy Murphy to discuss this issue. Ms. Murphy was receptive to having further discussions and to reviewing the policy paper outlining our analysis of this issue. We look forward to additional meetings with your staff to explore a mutually agreeable resolution.

Thank you for your consideration of this issue.

Constance C. Talmage
Executive Director

Iris Eytan (Reilly Pozner LLP)
Co-Chair, Mental Health Task Force

Enc.

cc: Christy Murphy
Trey Rogers
Cody Belzley

1801 CALIFORNIA STREET • SUITE 4900 • DENVER, CO 80202
MAIN NUMBER (303) 894-6366 • FAX (303) 894-9239
EXECUTIVE DIRECTOR (303) 894-6363
CTalmage@ColoradoLawyersCommittee.org
www.ColoradoLawyersCommittee.org

**ACCESS TO MEDICAL BENEFITS
FOR INDIVIDUALS IN COMMUNITY CORRECTIONS**

**Prepared by the
Colorado Lawyers Committee
Mental Health Task Force**

December 2008

Access to Medical Benefits for Individuals in Community Corrections

This paper was prepared by the Mental Health Task Force of the Colorado Lawyers Committee. The Lawyers Committee is a nonprofit, nonpartisan consortium of 51 Denver metro law firms whose volunteer lawyers do impact pro bono work to create and increase opportunities for children, the poor, and other disadvantaged communities. In the summer of 2008, the members of the Lawyers Committee's Mental Health Task Force were approached by community advocates who expressed concern that individuals in community corrections were not receiving health care (including mental health) benefits and were often choosing to be incarcerated (or re-incarcerated) in order to address their serious health concerns.

The Task Force spent a number of months meeting and conferring with health care advocates, community corrections officials and others. The Task Force also researched the legal and factual issues surrounding health care in Colorado, including Medicaid and the Colorado Indigent Care Program (CICP). This paper summarizes our conclusions and recommendations. We hope it will provide a starting point for conversations with the Governor's office and others regarding health care for the serious medical problems of individuals in community corrections.

I. Introduction

The State of Colorado provides a safety net to indigent individuals who need urgent medical treatment, but excludes all those participating in Community Corrections programs. This exclusion was created in 2005 as a result of a State rule change which was designed to mirror federal requirements. However, the modification of this rule was based on a misinterpretation of federal law and now prevents indigent community corrections participants from accessing the most basic medical care. Restoring the ability of these individuals to access indigent medical care, will benefit the State financially and will put Colorado in compliance with state and federal law.

There are approximately 4,500 individuals in community corrections programs in Colorado. Many are indigent and would ordinarily qualify for publicly funded health care services through the Colorado Indigent Care Program ("CICP"). In 2005, the Colorado Department of Health Care Policy and Financing ("HCPF") revised Colorado's CICP regulation to bar residents of community corrections facilities from obtaining CICP eligibility. This change was based on the mistaken belief that the federal prohibition against funding inmates of public institutions applied to these facilities. In addition, this new regulation has been broadly misinterpreted by eligibility workers and community corrections employees to exclude from eligibility virtually everyone in community corrections. By denying CICP benefits to all community corrections participants, Colorado has left a number of individuals, who are trying to stabilize their lives and become productive, non-offending members of their community, without the means to care for their basic medical needs.

As detailed below, the solution to this problem is straightforward —the State should reinstate its former regulation, with additional clarification, to again allow individuals in community corrections to obtain CICP benefits. Such a change would return the State to compliance with state and federal law and might also result in cost savings and cost avoidance for the State. Of the 4,500 community corrections participants, only 18% would likely apply for and utilize CICP each year. The CICP program is not an expensive medical program and is much less expensive than the cost of providing medical care in the Department of Corrections ("DOC") (because the State receives federal funding for CICP, whereas the State is solely responsible for medical costs for offenders incarcerated in DOC) or the cost of treating more severe medical conditions resulting from lack of medical care. In addition, the availability of CICP medical care would likely keep many individuals from re-incarceration, thereby avoiding costs to the State of approximately \$4,000-\$19,000 per person, per year and would ensure that low-income members of our community obtain needed medical care.

II. Background

When the Colorado Lawyers Committee's Mental Health Task Force began its investigation of medical benefits for individuals in community corrections, members of the Task Force quickly discovered that, while the solution may be simple, the statement of the problem is complicated. There are at least seven types of community corrections participants, in 59 different facilities (which fall into at least three different categories) who might be eligible for at least three benefits programs, each of which is funded by a different percentage of state and federal funds. Moreover, Colorado's community corrections system is unique around the country and the benefits of community corrections—for the State, the participants and society—are significant, both financially and in terms of the quality of Colorado's system of criminal justice. This section of the paper provides a description of these issues, with a view towards assuring that our conversations with the Governor and others begin with a common understanding.

A. Overview of the Problem

The State's 2005 regulatory change has adversely impacted many community corrections participants who are unable to take care of their basic or urgent medical needs. The seriousness of this problem is demonstrated by the individuals whose challenges are described below.

- While serving a three-year sentence at Kit Carson Correctional Center (a DOC facility), David Isberg, noticed blood in his urine and submitted to testing to determine the nature of the problem. Before the results of Isberg's tests came back, however, he was transferred to a community corrections facility. Isberg subsequently began working full-time but did not qualify for health care through his employer until he completed three months of employment. Ineligible for medical benefits through the State because of his community corrections status, Isberg waited to follow-up on his condition until he could obtain insurance through his employer. When Isberg finally saw a doctor about his condition, the physician was shocked he had waited so long to see someone—Isberg had bladder cancer. After his surgery was scheduled, but before the procedure, Isberg was sentenced back to prison; thus, DOC ultimately had to cover all costs associated with Isberg's cancer treatment.¹
- Similarly, Jocelyn Wilson, while incarcerated in the Denver Women's Correctional Facility (a DOC facility), discovered a mass in her breast, had a biopsy and scheduled an operation with Denver Health to remove the lump. When Wilson transferred to a community corrections facility prior to her scheduled surgery, however, the operation was canceled. Wilson was told that because she was in a community corrections program she was not eligible for medical benefits, and without benefits the surgery was too expensive.²
- Roxanne Holguin was also denied State medical benefits due to her community corrections status. Holguin went to a Denver Health clinic seeking indigent care to cover pre-natal visits during her pregnancy and was told that because she was in a community corrections facility they could not treat her. She also learned it would cost \$650 up front to be seen. Ironically, Holguin had received treatment for appendicitis from the very same facility just weeks earlier while she was still incarcerated in a DOC facility.³

¹ Naomi Zeveloff, Death Sentence, Westword, Dec. 6, 2007 (Ex. A)

² Jim Spencer, Out of Jail, They Can't Get Health Care, Denver Post, July 27, 2006 (Ex. B). Wilson later found a cancer clinic that agreed to remove the lump for free.

³ Id.

B. Overview of Community Corrections

Community corrections is an alternative to traditional incarceration in prison. Community corrections facilities generally provide services for: (1) individuals convicted of less severe offenses who are diverted from prison (“diversion participants”); (2) individuals transitioning out of prison (“transitional participants”); (3) parolees released by the Colorado Parole Board placed there as a condition of parole; and (4) individuals on Pre-Parole Inmates on Intensive Supervision (“ISP inmate”). Community corrections programs provide services for both individuals who live on-site (residential) and individuals who do not live on site (non-residential).⁴ There are 35 residential community corrections facilities in Colorado and 24 non-residential facilities.⁵ In sharp contrast to prison, community corrections are not locked facilities. Further, unlike prisons, community corrections staff do not have the authority to physically restrain participants, there are no barred cells in the facilities, and the grounds are not secured by fences or wires.

The Fiscal Year 2007 to 2008 budget allocated funding for 2,998 residential participants, and 1,405 non-residential participants and day reporting participants, for a total of approximately 4,500 community corrections participants throughout the State.⁶ The Office of Community Corrections, which is part of the Department of Public Safety, Division of Criminal Justice (“DCJ”), allocates the State funds allotted for community corrections to local community corrections Boards in each of Colorado’s 22 judicial districts. Each Board subsequently subcontracts with one or more local program to provide for the supervision and treatment of offenders.⁷ The vast majority of these subcontractors are non-profit or for-profit (i.e. non-governmental, private) organizations that are charged with the day-to-day operations of each facility. While community corrections facilities must comply with State program standards, and while the DCJ and local Boards periodically conduct audits and monitoring to ensure such compliance, neither the local Boards nor the DCJ is involved in the day-to-day activities of the private facilities. In addition, the DCJ and local Boards do not exercise administrative control over the private community corrections facilities and cannot hire and fire the facility employees.

Furthermore, community corrections participants are expected to be self-supporting and are required to pay for their room and board, court costs, treatment programs, fines, restitution and court-ordered child support. They are also required to maintain employment and to pay federal, state and local taxes. Most offenders are employed in low-wage jobs earning an average of \$927 per month (and in most instances are not provided with health insurance as part of their employment).⁸

Residential participants are charged, on average, approximately \$17 per day or \$400 per month by community corrections. Non-residential participants are charged approximately \$3 per day or \$93 per month. Both residential and non-residential community corrections participants pay an average of \$70 per month for court costs and restitution. Any remaining funds are generally allocated to child support, treatment costs and other necessities. Thus, most community corrections participants are medically indigent. Without CICIP benefits, they are unable to afford urgent or basic medical care.⁹

⁴ Thus, there are seven types of offenders in Community Corrections programs including: (1) residential diversion; (2) residential transition; (3) nonresidential diversion; (4) residential parole; (5) nonresidential parole; (6) nonresidential ISP; and (7) residential ISP.

⁵ All but four of the 35 residential facilities are privately run by profit or non-profit organizations.

⁶ Colorado Association of Community Corrections Boards, Fact Sheet, July 2007 to June 30, 2008, (Ex. C, p. 1).

⁷ Colorado Division of Criminal Justice Funding Flow Chart (Ex. D).

⁸ Colorado Association of Community Corrections Boards, (Ex. C, p. 3).

⁹ 2006 Community Corrections Annual Report, (Ex. E, pgs. 27-30).

C. Benefits of Community Corrections to Offenders & State

Community corrections provides numerous benefits to offenders as well as the State. First, these programs aid offenders in becoming pro-social individuals thereby promoting public safety and reducing recidivism rates. Community corrections promotes productive reintegration of offenders back into society by aiding offenders in preparing emotionally, cognitively, behaviorally and financially for their reintegration into society. Less than 1.6% of community corrections participants are terminated for a new crime and 55.3% complete the program.¹⁰ In a two-year follow-up of individuals who successfully completed their community corrections program, 75% had no misdemeanor or felony filings.¹¹

The success of community corrections programs has not gone unnoticed. Governor Bill Ritter endorsed the mission and work of community corrections in his FY 2008-2009 Crime Prevention and Recidivism Package.¹² The package provides additional funding for community corrections programs in an effort to divert offenders away from expensive prison beds and reduce criminal recidivism.

As identified by Governor Ritter's package, community corrections costs far less than prison incarceration. The average cost per person for residential placement in community corrections is \$8,477 per year. The average cost per person for non-residential community corrections placement is \$1,839 per year. In contrast, the average cost per person of incarceration at a DOC facility is \$27,500 per year.¹³

	Department of Corrections	Residential Community Corrections	Non-Residential Community Corrections
Average Cost/Person Per Day	\$75.58	\$37.18	\$5.04
Average Cost/Person Per Year	\$27,586	\$13,570 ¹⁴	\$1,839

Given these baseline numbers, the State avoids costs of approximately \$14,000 to \$17,000 per year for each individual placed in a residential community corrections facility rather than in jail or prison¹⁵. Likewise, the State avoids costs of approximately \$25,000 per year for each individual who participates in a non-residential community corrections program instead of going to a DOC prison.

¹⁰ Colorado Association of Community Corrections Boards, (Ex.C, p. 3).

¹¹ *Id.*

¹² Governor's Office of State Planning and Budgeting, Fact Sheet, Governor Ritter's FY 2008-09 Crime Prevention and Recidivism Package, (Ex. F).

¹³ Colorado Association of Community Corrections Boards, Ex. C, p. 1).

¹⁴ The actual costs are \$8,477 a year as the average length of stay is 228 days. See Community Corrections Annual Report, (Ex. E, p. 21).

¹⁵ The State of Colorado Office of State Budget and Planning utilizes the private prison cost and non-specialty community corrections cost to come to a \$4,000 cost differential. However, the baseline budgetary difference between the DOC and Community Corrections placement is approximately \$19,000 as indicated in both the 2006 Department of Corrections Annual Report (Ex. G) and the Community Corrections Annual Report, (Ex. E).

The lack of medical benefits for community corrections participants may lead to increased costs to the State in more direct ways as well. Because in many instances community corrections participants are currently precluded from obtaining medical benefits, those individuals presented with the option of community corrections or prison may opt for a prison sentence recognizing that the State is required to fund their medical needs while in prison. Similarly, individuals with serious medical concerns and no means to pay for needed care have an incentive to re-offend to gain treatment in prison.¹⁶ Furthermore, local Boards, recognizing that potential transitional clients have costly health care needs may refrain from recommending otherwise eligible offenders to community corrections knowing that they may not be able to pay for outside medical care.

Costs to the State to provide medical coverage for community corrections participants under CICIP are lower than costs for incarcerated offenders because the State receives federal funding for CICIP whereas the State, through the DOC, is solely responsible for medical costs for incarcerated offenders. Only 18% of the Colorado indigent population utilizes CICIP,¹⁷ and we estimate the percentage should not be much higher for community corrections participants. And, even if the penetration is higher, it is less expensive for the State to provide access to even 20-25% of community corrections participants, since CICIP costs only \$179 per person, less than a three night stay in the Department of Corrections.¹⁸

Finally, because individuals in community corrections cannot get health coverage, many go untreated until they are out of community corrections. Health care problems often become more acute when left untreated. Once an individual with an untreated ailment is out of community corrections and qualifies for public health care programs, the State is likely stuck paying for his/her treatment when it is most expensive (i.e., when the problem is exacerbated and requires more treatment at a higher cost). By making health care benefits available to community corrections participants, the State could again reduce its costs because these individuals would likely obtain needed care earlier and avoid needlessly increasing the severity of their problem.

D. Colorado Indigent Care Program

Through HCPF, Colorado offers a variety of programs to aid indigent individuals with health care needs. The two main programs available to adults are Medicaid and CICIP.

Colorado Medicaid is a State-administered health insurance program for certain disabled adults, low-income children 18 years of age and under, families with dependent children 18 years of age and

¹⁶ A few community corrections directors, who asked to remain anonymous, reported that community corrections participants frequently elect to return to prison to obtain necessary medical care. For example, a transition client who had complications due to an eye socket injury in the Department of Corrections returned to the Department of Corrections due to lack of resources in his community and denial of CICIP and Medicaid. There is institutional knowledge that community corrections participants commit technical violations and sometimes walk away, which is a Felony Escape, just to obtain medical care.

¹⁷ To be eligible for CICIP, an individual's income must be below 250% of the federal poverty level. By using the U.S. Census Bureau, we approximate that the number of adults in Colorado below 250% of the federal poverty level ranges between 867,190 and 938,667. Of those individuals, only 172,510 people, or approximately 18% of all qualified indigent persons in Colorado accessed CICIP in 2007. We assume the penetration rate may be about the same for community corrections participants. See United States Census Bureau Fact Sheets, (Ex. H), Colorado Medically Indigent and Colorado Indigent Care Program 2006-2007 Annual Report by the Department of Health Care Policy and Financing (Ex. I), and Colorado Indigent Care Program Fact Sheet, (Ex. J).

¹⁸ CICIP costs the state \$30,952,165 a year, and only 172,510 Colorado residents accessed CICIP in 2007. The average cost to the State per individual a year is \$179. (Ex. I, p. 5).

under, and pregnant women. Medicaid operates as an insurance program for those individuals meeting its qualifications. The State receives federal matching funds for the qualifying dollars spent in its Medicaid program.

CICP is a State-run program that provides discounted health care services to low income individuals at participating providers. CICP is not an insurance program. Instead, individuals request financial assistance at participating hospitals and clinics. Each participating health care provider is required by State law to determine CICP eligibility by assessing how acute the medical needs of the applicant are and whether the individual's income level qualifies for CICP. Individuals generally must be at or below 250% of the federal poverty level to qualify.¹⁹ The providers are then reimbursed by the CICP program, which uses both state dollars and federal Disproportionate Share Hospital ("DSH") dollars.²⁰

¹⁹ See Ex. I and J.

²⁰ Federal DHS dollars are authorized by Section 1902(a)(13) of the Social Security Act.

III. The State Law Creating CICIP Does Not Authorize The Categorical Exclusion of Community Corrections Participants

The CICIP Program has both federal and state law components. (Federal law and the state regulation are discussed in the next section of this paper.) In authorizing CICIP in Colorado, the General Assembly²¹ recognized that health care for indigent people was a significant priority, but also that program resources would always be limited. As a result, the Colorado statute provides that “medically indigent persons accepting medical services from such program shall be subject to the limitations and requirements imposed by the CICIP statute.”²² The statute specifically sets out the only eligibility criteria:

A client’s eligibility to receive discounted services under the program for the medically indigent shall be determined by rule of the state board based on a specified percentage of the federal poverty level, adjusted for family size, which percentage shall not be less than two hundred fifty percent.²³

The statute also places restrictions on eligibility of immigrants, and on funding for abortions.²⁴

These are the only statutory provisions that categorically limit program eligibility and the medical services that can be provided under the program. Thus, the CICIP statute defines the pool of eligible individuals broadly. It does not provide for any exclusion of individuals based on their status as community corrections participants. Although HCPF is authorized to issue program regulations, that authority is limited to rules “as are necessary for the implementation” of the CICIP statute.²⁵ HCPF has no authority to issue rules for the CICIP program that would categorically exclude community corrections participants, because such a rule would not be “necessary” to implement the CICIP statute.

Because CICIP is not an entitlement program, a person eligible for CICIP may not actually receive program benefits for particular medical services. Instead, participating health care providers are required to prioritize their CICIP funding in the following order of three criteria:²⁶

- Emergency care for the full year;
- Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons;
- Any other additional medical care.

In other words, providers are required to allocate limited CICIP funding in order of priority of medical needs. Providers have no authority to exclude individuals from CICIP based on factors not related to income, medical need, or the other statutory categories of immigration and abortion.

The CICIP statute makes it clear that neither the state nor participating providers may arbitrarily create new eligibility rules not based on the statutory factors described above. As an obvious example, HCPF cannot mandate a minimum educational requirement to be eligible for CICIP, or prohibit divorced individuals from receiving benefits. Community corrections, as a class, is no different. HCPF has no authority to bar individuals in community corrections from receiving CICIP benefits.

²¹ C.R.S. § 25.5-3-101, *et seq.*

²² C.R.S. § 25.5-3-102(b)(2).

²³ C.R.S. § 25.5-3-104(2).

²⁴ C.R.S. §§ 25.5-3-105 and 25.5-3-106.

²⁵ C.R.S. § 25.5-3-104(1).

²⁶ C.R.S. § 25.5-3-108(8)(b).

IV. The State's 2005 Change to Its CICIP Regulation Was Not Required by Federal Law and Has Been Misinterpreted to Exclude Qualified Individuals

In 2005, Colorado implemented a rule change which, on its face, excludes individuals in residential community corrections facilities from CICIP eligibility. This rule not only misinterprets federal law, but has itself been misinterpreted to apply to all individuals in community corrections. As a result, individuals in private facilities, in medical institutions, in non-residential community corrections, as well as those on parole and ISP inmates have been denied eligibility. This section of the paper begins with an analysis of federal law and the Colorado rule change and then discusses why CICIP or some other medical coverage should be provided pursuant to state and federal law for all community corrections participants.

A. Federal Requirements and Colorado's 2005 Regulatory Change

Section 1905(a)(A) of the Social Security Act, which applies to both federal Medicaid matching funds and to DSH reimbursement funds used for CICIP, excludes Federal Financial Participation ("FFP") for medical care "*for any individual who is an inmate of a public institution (except as a patient in a medical institution).*"²⁷ Federal regulations likewise provide that FFP is not available for services provided to "individuals who are inmates of public institutions."²⁸ FFP is therefore unavailable to fund health care benefits where two requirements are met: (1) the individual seeking medical care is an inmate; *and* (2) the facility in which the individual is residing is a *public institution*.²⁹

Because CICIP care is available only to those who are not excluded from FFP rules, the State must follow the federal guidelines. Prior to December 2005, Colorado's CICIP regulations provided as follows:

The following individuals are not eligible to receive discounted services under available CICIP funds: . . .

2. Persons in institutions or penitentiaries, or persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.³⁰

In December 2005, Colorado revised its regulation concerning CICIP eligibility. As revised Colorado's CICIP requirements now state:

1. The following individuals are not eligible to receive discounted services under available CICIP funds: . . .

- b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in halfway houses that have not been released on parole, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.³¹

²⁷ 42 U.S.C. § 1396d(a)(28)(A) (emphasis added).

²⁸ 42 C.F.R. § 435.1009(a)(1) & 42 C.F.R. § 435.1010.

²⁹ Memorandum from the Dep't of Health & Human Servs., Clarification of Medicaid Coverage Policy for Inmates of a Public Institution, (Dec. 12, 1997) (Ex. K, p. 2).

³⁰ 10 COLO. CODE REGS. § 2505-10 8.904(E) (2004).

³¹ 10 COLO. CODE REGS. § 2505-10 (F)(1)(b) (2008) (emphasis added).

HCPF's stated rationale for revising the CICIP regulation in 2005 was to ensure that HCPF complied with FFP requirements so it would receive federal funds when available. The letter from HCPF³² which signaled the proposed rule change was the first sign that the State had misinterpreted the FFP requirements. Meeting minutes from HCPF's discussion of the revision explicitly state that the change was made to "follow[] federal regulations that no federal financial participation is available for this incarcerated population" and to "*mirror Federal language*."³³ However, HCPF's change did not "mirror Federal language," as it *did not* clearly incorporate the fact that the FFP is available to inmates living in private institutions and to inmates who are patients in medical institutions. Moreover, as discussed in detail below, by denying benefits to all individuals "residing in halfway houses who have not been released on parole," HCPF's rule change went far beyond FFP requirements and improperly precludes numerous community corrections individuals from obtaining medical benefits.³⁴

Furthermore, the 2005 regulation has been misapplied to non-residential community corrections participants. Many *non-residential* community corrections participants are often denied CICIP eligibility under this regulation, despite the fact that they do not *reside* in a halfway house and by the terms of the regulation are not precluded from receiving CICIP benefits.³⁵ In fact, as a result of the new rule that is being too broadly applied, all individuals accepted into community corrections programs are mandated to sign a waiver³⁶ drafted by HCPF stating that individuals in halfway houses are not eligible for CICIP, unless they are on parole.

B. Federal Requirements Do Not Render Community Corrections Participants Residing In "Private" Facilities Ineligible for Medicaid or CICIP Benefits

Federal statutory and regulatory mandates make clear that *only* inmates residing in "public institutions" are excluded from federally funded medical benefits.³⁷ The Centers for Medicare and Medicaid Services ("CMS") have likewise interpreted the FFP requirements and recognized that FFP exclusions are limited to inmates residing in "public institutions" specifically finding that:

- *Inmates of private institutions . . . are seemingly eligible under the state to receive FFP for services provided to them.*³⁸

³² Letter from Chris Underwood, Manager of Safety Net Financing Section with HCPF, to Carol Lovseth, Finance Manger of Denver Health, Sept 15, 2005 (Ex. L). This letter was written three months before the rule change was official, and it misapplies and misinterprets the federal regulations. This letter was distributed to numerous community corrections facilities and participants, and was the primary cause of the legal misinterpretation which precludes community corrections participants from CICIP eligibility.

³³ Medical Services Board Meeting Minutes, Colo. Dep't of Health Care Policy & Financing (October 14, 2005 and December 9, 2005) (Exs. M and N) (emphasis added).

³⁴ Although HCPF's 2005 rule change was based upon Federal Medicaid law, it was drafted and approved to apply specifically to community corrections participants seeking CICIP, not Medicaid, eligibility. However, community corrections directors, who have asked to maintain their anonymity, have confirmed that this unfortunately misinterpreted rule has often been improperly extended to community corrections participants seeking Medicaid coverage.

³⁵ Several community corrections directors have reported that the CICIP exclusion has been applied to both non-residential and residential community corrections participants.

³⁶ Clarification of Incarceration and Eligibility for CICIP (Ex. O). The DOC requires offenders transitioning out of DOC and into community corrections to sign this "clarification" as a waiver of benefits.

³⁷ See 42 U.S.C § 1396d(a)(28)(A) (excluding FFP "for any individual who is an inmate of a public institution (except as a patient in a medical institution)"); 42 C.F.R. § 435.1009(a) (stating FFP is not available for services provided to "individuals who are inmates of public institutions," which "means a person who is living in a public institution").

³⁸ Memorandum from the Dep't of Health & Human Servs., Availability of Federal Financial Participation for Individuals Who Are Inmates in a Public Institution, (Feb. 13, 1991) Ex. P, p. 2.

- [T]he “Federal Government participates in the cost of assistance payments to persons residing in *private*, but not in public institutions.”³⁹
- “Previous General Counsel opinions have concluded that there is no statutory or legal authority to support: [1] expanding the regulatory definition of inmate of a public institution to include inmates in *private institutions*.”⁴⁰

A “public institution” is defined as an institution which is “the responsibility of a governmental unit” or over which a “governmental unit exercises administrative control.”⁴¹ CMS has provided additional guidance as to what constitutes a “public institution” explaining that:

This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.⁴²

Of the 35 residential community corrections facilities in Colorado, at least 30 are undoubtedly “private” entities, not “public institutions.” FFP restrictions thus do not apply to most of the 3,000 residential community corrections participants in Colorado because they are not “inmates of a public institution” as required for FFP exclusion. Specifically, each of the 30 private facilities is operated by non-profit or for-profit entities under contracts with the local community corrections Boards. While these private facilities contract with the local Board, they are not an organizational part of the local Board, local government, the DCJ, or any other governmental entity.

Furthermore, the DCJ and local Boards do not exercise administrative control over these private community corrections facilities. While each facility must comply with State program standards which are overseen by the local Boards and the DCJ, neither the Boards nor the DCJ are involved in the day-to-day activities of the facilities or the facilities’ administrative functions—hiring and firing, staffing, program design and implementation, facility decisions, and all other administrative decisions are left up to each separate facility. In addition, the State does not own or control the physical infrastructure of these 30 facilities. Rather, each entity leases its own space under its own contracts or owns the facility property outright.

Denver’s Regional Social Security Administration (“SSA”) office also has concluded that Colorado’s private community corrections facilities are not public institutions, finding that individuals in private facilities are not categorically excluded from Supplemental Security Income (SSI) as disabled individuals, and therefore also may be eligible for Medicaid benefits:

For SSI eligibility purposes, it must be determined if any or all of the halfway houses are agents of the Colorado Division of Criminal Justice. A private facility is considered public via an agency relationship to a public penal authority, only if the private facility has the authority to confine individuals for punitive/correctional purposes. . . . *The[] private [community corrections]*

³⁹ Dep’t of Health & Human Servs, Ex. P, p. 3 (citing H.R.Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949).

⁴⁰ Dep’t of Health & Human Servs, Ex. P, p. 2.

⁴¹ 42 C.F.R. § 435.1009.

⁴² Dep’t of Health & Human Servs, Ex. P, p. 2.

*centers are not agents for the Colorado Division of Criminal Justice because they are not performing the correction function of confinement. All residents in the centers are treated the same and are not confined. They are potentially eligible for SSI benefits*⁴³

By denying benefits to all individuals “residing in halfway houses who have not been released on parole,” HCPF’s rule change plainly went far beyond “mirroring” FFP requirements as the vast majority of community corrections participants in Colorado do not reside in “public institutions” and FFP funds are therefore available for their medical care. The State should thus reinstate its prior CICP regulation, with clarification, to rectify the overbroad nature of its current regulation.

C. FFP Is Available for Medical Care for Community Corrections Participants Residing in the Three Community Corrections Facilities Which Are Medical Institutions

Of the 35 residential community corrections facilities, five may not fall within the “private” entity category discussed above. Those facilities include: (1) the Haven (including the Haven Harmon House, Baby Haven and Mom’s House); (2) Peer I; (3) Larimer County Community Corrections; (4) Garfield County Community Corrections; and (5) Mesa County Community Corrections.⁴⁴ However, residents of the Haven and Peer I, and many residents of the Larimer County Community Corrections facility, are inpatients of a medical institution and thus FFP is available for their medical care.

A “patient in a medical institution” is excepted from the federal statutory prohibition of FFP for inmates of a public institution.⁴⁵ Federal regulations also provide that “[t]he term ‘public institution’ does not include . . . [a] medical institution” and define “medical institution” as an institution that:

- (a) Is organized to provide medical care, including nursing and convalescent care;
- (b) 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;
- (c) Is authorized under State law to provide medical care; and
- (d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses’ aid services, sufficient to meet nursing care needs; and a physician’s guidance on the professional aspects of operating the institution.⁴⁶

⁴³ Memorandum from the Denver Regional Social Security Administration, Prisoners in Colorado Community Correction Centers (Halfway Houses), (June 20, 2007) (Ex. Q, p. 2) (emphasis added). This regional policy is also supported by the national SSA, which stated in a recent iteration of its Program Operations Manual System (“POMS”), that “[a] privately operated halfway house is treated as a public institution only when it is acting as an agent of the correctional authorities. A facility that has the authority to confine the residents all or part of the times is acting as an agent of Federal, State, or local penal authorities.” POMS § SI 00520.009.

⁴⁴ This policy paper takes no position on whether these five facilities are, in fact, “public institutions” according to the definitions set out in federal law and regulations. However, recognizing that these five may be perceived as public institutions, this paper addresses the possibility that they in fact fall in that category.

⁴⁵ 42 U.S.C. § 1396d(a)(28)(A).

⁴⁶ 42 C.F.R. § 435.1010.

The Haven, Peer I, and the Larimer County Community Corrections facility meet this “medical institution” exception. These three facilities are organized to provide “medical care, including nursing and convalescent care” as they provide comprehensive substance abuse and mental health treatment for their patients. Each facility has the necessary professional personnel (including physicians, registered nurses or licensed practical nurses), equipment and facilities to meet the needs of their patients. These institutions are also authorized under State law to provide medical care and function in accordance with generally accepted standards to provide adequate, continued care and supervision for their patients. Each facility also obtains a physician’s guidance on the operation of the institution. In fact, the Haven and Peer I are part of the University of Colorado’s School of Medicine.

CMS has clarified that because the “medical institution” exception applies to inpatient care only, FFP still is unavailable on “an outpatient basis.”⁴⁷ This means that community corrections participants who are *inpatients* in a medical institution qualify for FFP, and thus should not be categorically excluded from CFCP. “Inpatient” is defined as:

[A] patient who has been admitted to a medical institution as an inpatient on recommendation of a physician . . . and who—

- (1) Receives room, board and professional services in the institution for a 24 hour period or longer, or
- (2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

The Haven, Peer I and Larimer County Community Corrections facility are residential facilities. Community corrections patients reside in these facilities on a full-time basis for the purpose of receiving substance abuse and/or mental health treatment as recommended by a physician. The patients of these facilities rarely exit the facility and are bound to these residential programs strictly for the purpose of receiving treatment.⁴⁸ In other words, they are “inpatients” under the federal definition recited above.

FFP is available for those community corrections participants who are “patients in a medical institution.” Exclusion of these individuals from medical benefit eligibility is therefore unnecessary.

D. Fundamental Fairness, Equity, and the Eighth Amendment Require that Residential Participants of the Two Public Community Corrections Facilities Should Not Be Excluded from Medical Care

Two residential community corrections facilities are government run, public institutions. These institutions include: (1) Garfield County Community Corrections; and (2) Mesa County Community Corrections. Combined these residential programs make up 4%, or 211 persons a year, of all persons in residential community corrections beds in Colorado.⁴⁹ To preclude the participants who reside in

⁴⁷ Dep’t of Health & Human Servs., Ex. P, p 3.

⁴⁸ Not all residents of the Larimer County Corrections facility are “inpatients” of a “medical institution.” Only those individuals participating in the facility’s substance abuse and mental health treatment programs meet the “patient in a medical institution” exception.

⁴⁹ Community Corrections Annual Report, Ex. E, p. 6. This statistic includes both transition and diversion residential community corrections participants.

these two facilities from obtaining medical benefits simply because they were sentenced in Garfield or Mesa County is fundamentally unfair and may be violation of equal protection and/or due process.

Furthermore, of the 211 persons a year in the Garfield and Mesa County community corrections residential beds, approximately 90 of these participants are transitioning from the DOC. The denial of basic medical care to inmates coming from the Department of Corrections, in what may be public institutions, may rise to the level of an Eighth Amendment violation as the failure to provide inmates with adequate medical care is considered “cruel and unusual punishment” in violation of the Eighth Amendment.⁵⁰

The 211 individuals residing in the Garfield and Mesa community corrections programs need access to medical care. We are committed to working with the State to find a way to provide access to medical benefits for these community corrections participants. Such a solution would ensure the constitutionality of Colorado’s community corrections system, and save thousands of dollars a year which accrue when an offender is sentenced to community corrections rather than prison where the State would have to pay both the full care of the medical treatment and housing.

E. The State’s Regulation Should Not Be Applied to Non-Residential Community Corrections Participants as well as Individuals on Parole and Probation

The State’s CICIP regulation excludes eligibility only for applicants “involuntarily . . . residing in halfway houses who have *not been released on parole.*”⁵¹ Thus, by its express terms, the regulation does not apply to non-residential participants (those not “residing” in a community corrections facility) or individuals released on parole.

HCPF has issued a “clarification” of the State’s regulation that recognizes that “[a]n applicant *on parole or probation is eligible for CICIP*” and that “[a]n applicant who is living in a halfway house *is eligible for CICIP only if they are on parole.*”⁵² This clarification not only reiterates that parolees are eligible for CICIP, it also delineates that individuals on probation are also eligible. This position is supported by CMS which listed “paroled individuals” and “individuals on probation” as “[e]xamples of when FFP is available.”⁵³

Non-residential participants and individuals on parole or probation are eligible for CICIP under the terms of the State’s 2005 regulation. However many providers making CICIP eligibility determinations continue to be confused by the 2005 regulatory change, and deny eligibility simply because of their connection to Colorado’s community corrections program. The State can easily alleviate the confusion associated with non-residential participants, parolees and probationers by reinstating the terms of its prior regulation and clarifying the meaning of inmate and public institution.

⁵⁰ The Eighth Amendment to the United States Constitution prohibits the states from inflicting “cruel and unusual punishments” on those convicted of crimes. *Rhodes v. Chapman*, 452 U.S. 337, 344-46 (1981), and requires that prison officials provide inmates with adequate medical care. *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976).

⁵¹ 10 COLO. CODE REGS. § 2505-10 (F)(1)(b) (2008) (emphasis added).

⁵² Clarification of Incarceration and Eligibility for CICIP (Ex. O). In fact, the DOC requires offenders transitioning out of DOC and into community corrections to sign this “clarification” as a waiver of benefits.

⁵³ Dep’t of Health & Human Servs., Ex. P, p. 3 ; see also Dep’t of Health & Human Servs., Ex. K, p. 8 (“Individuals paroled, released from custody following completion of sentence, released from custody whole on bail, or released from a public institution permanently (i.e, terminating a stay at a public institution) are no longer ‘inmates’ and are no longer living in a public institution. Therefore, section 1905(a) does not apply and FFP is available for their care.”).

V. Conclusion

The problem of the availability of health care services for indigent individuals in Colorado is a serious one. The federal assistance available for these individuals is limited, but denial of access to urgent medical care can have devastating consequences, for both the individuals who do not receive medical care and for the State, which often must absorb the monetary costs of this crisis.

It is widely accepted that providing CICIP coverage will not resolve all the State's serious health care issues. However, making sure that all indigent individuals in community corrections have access to health care would not only help these individuals but also have positive financial consequences for the State, not to mention returning Colorado to proper utilization of federal health care law.

The State should reinstate its prior CICIP regulation, which complies with state and federal law, and allow eligible individuals in community corrections to participate in Medicaid and CICIP programs. Upon reinstatement, the State should also clarify the meanings of inmate and public institutions to reduce misapplication of the regulation and improve the consistency of eligibility determinations. These two steps would go a long way to solving a serious problem in Colorado.

EXHIBIT C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

**MEDICAID
REGIONAL INFORMATION LETTER****Region VIII
Federal Building
1961 Stout Street
Denver, CO 80294-3538**

RIL NO. 98-22

DATE: April 10, 1998

CODE: EA-9;tp

TO: State Medicaid Directors

SUBJECT: Medicaid Coverage for Inmates of Public Institutions -- INFORMATION

Based upon various inquiries from States, it is apparent that policy regarding Medicaid coverage for inmates of public institutions can be ambiguous. This letter is to help clarify, and in some instances modify existing policy interpretations. Section 1905(a)(A) of the Social Security Act is the defining statute on this issue. Specifically, it excludes Federal Financial Participation (FFP) for medical care or services for any person who is an inmate of a public institution, unless that person is a patient in a medical institution.

From this definition, two points are apparent. First, the statute precludes FFP but not Medicaid eligibility. If a person is an inmate of a public institution, the person may still be eligible for Medicaid. However, no FFP will be available for medical care or services provided to the individual. Second, the terms "inmate" and "public institution" are both significant in determining whether FFP is available. Unless a person is an inmate **and** in a public institution, the prohibition against FFP in section 1905(a)(A) is not applicable. The following provides additional information about inmates of public institutions.

Inmate

The term "inmate" carries a strong connotation of a person being involuntarily confined to a facility. Following this connotation, the term "inmate" would not include individuals who are voluntarily residing at such facilities. By using this guideline, we have determined that FFP is not available when a person is involuntarily residing in a public institution. (See below for information on medical institutions.) If a person is voluntarily residing in a public institution, however, the statutory prohibition on FFP does not apply because the person is not an inmate.

By focusing on a person's voluntary status, it becomes evident that a person is not considered to be an inmate of a public institution when the individual is voluntarily residing in a public educational or vocational training institution for purposes of securing an education or training. Likewise, if a person is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made, the individual is not considered to be an inmate.

At times, a person is confined involuntarily to a public institution while awaiting criminal proceedings, penal dispositions, or other involuntary detention determinations. During this

period of time, the person is not considered to be voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made. Instead, the person is considered to be an inmate, and FFP is not available under such circumstances. The focal point in determining if FFP is available should not be on the length of stay. Rather, the focal point should be on whether or not the person is voluntarily or involuntarily residing in the public institution. If a person is voluntarily residing in the public institution, pending other arrangements, FFP is available. Otherwise, FFP is generally not available.

Finally, it should be noted that the statute does not specify the term "inmate" should only be applied to adults. Due to the absence of such language, this policy applies to juveniles and adults in the same manner. For example, a juvenile awaiting trial in a detention center is no different than an adult awaiting trial in a maximum security prison for purposes of FFP availability. Both are considered to be inmates and FFP is not available.

Public Institution

When determining if FFP is available, the definition of a public institution is as important as the definition of an inmate. According to 42 CFR 435.1009, a facility is a public institution when it is under the responsibility of a government unit, or over which a governmental unit exercises administrative control. This control can exist when a facility is:

1. Actually an organizational part of a governmental unit, or
2. When a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates, or
3. When a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

Generally, when a person is an inmate of a public institution, FFP is not available. However, if an inmate is in a medical institution, the FFP exclusion may not apply.

Medical Institutions

Section 1905(a)(A) provides an exception to the prohibition of FFP for inmates of public institutions. If an inmate is a patient in a medical institution, FFP may be available for the individual's medical care and services. In order for a person to be a patient in a medical institution for purposes of this policy, the person must be admitted as an inpatient in a hospital, nursing facility, institution for mental disease, or intermediate care facility; and must be expected to remain in the facility for a period of 24 hours or longer. When an inmate is an inpatient in such a facility, FFP is available for Medicaid covered services provided to the individual, even though the person is still considered to be an inmate. (The statement of FFP availability presumes that the individual meets all other factors pertinent to Medicaid eligibility and coverage.)

FFP is not available for services provided at any of the above noted facilities when the services are provided on an outpatient basis to an inmate of a public institution. FFP is also not available

when medical care is provided to an inmate at a clinic, physician office, prison hospital, or dispensary. In these situations, the person is not considered to be a patient in a medical institution.

When determining the availability of FFP, it is important to note that when FFP is prohibited it is based upon an individual's involuntary confinement in a public institution and not merely upon an individual being detained or taken into custody. This distinction is important when a person is arrested, taken into custody, and then transported directly to a medical facility. Because the person has not obtained "inmate" status in a public institution, FFP is not precluded for medical services provided to the individual even if the medical services are not provided on an inpatient basis.

Private Health Care Entities

Some States have contracted with private health care entities to provide medical care in public institutions to the institutions' inmates. FFP is not available for medical care and services provided in such situations because inmates are not receiving services as patients in a medical institution. Rather, they are continuing to receive medical care in a public institution.

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

Policy Application

The following examples are given to help in the determination of FFP availability. Please keep in mind that these are broad, general examples and that extenuating circumstances may affect the determination.

FFP is available for the following individuals:

1. Infants living with an inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals living voluntarily in a detention center, jail, or county penal facility while other living arrangements are being made for them (e.g., transfer to a community residence)
5. Individuals on home release, unless they must report to a prison for overnight stay
6. Inmates who become inpatients of a hospital, nursing facility, institution for mental disease, or an intermediate care facility for the mentally retarded (subject to meeting other requirements of the Medicaid program.)

FFP is unavailable for the following individuals:

1. Individuals (including juveniles) being held involuntarily in a detention center awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in a half-way house under governmental control
4. Inmates receiving care as an outpatient
5. Inmates receiving medical care on the premises of a prison, jail, detention center, or other penal setting.

If you have any questions regarding this information, please contact me at (303) 844-2121, extension 419.

/s/

Tobi Potestio
Health Insurance Specialist

EXHIBIT D



Dove

DEC 12 1997

97 DEC 16 AM 11 10

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

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

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

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

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

Statute and Parameters

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

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

Criteria for Prohibition of FFP

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



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

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

Privatization of Prisons

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

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

Exception to Prohibition of FFP

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

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

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

Policy Application

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

Examples when FFP is available:

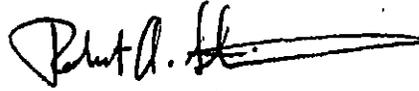
1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility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

Examples when FFP is unavailable:

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

4. Inmates receiving care as an outpatient
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

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

A handwritten signature in black ink, appearing to read "Robert A. Streimer", with a long horizontal flourish extending to the right.

Robert A. Streimer



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

AUG 19 1996

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

FROM: Acting Director
Medicaid Bureau

SUBJECT: Medicaid Coverage of Infants of Prison Inmates (Your Memo Dated February 6, 1996)

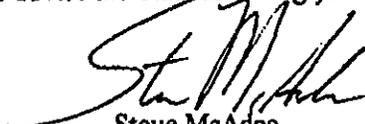
TO: Acting Associate Regional Administrator
Division of Medicaid
New York

This is in reply to your memorandum regarding Medicaid coverage of infants of prison inmates. Apparently, the prior memorandum was misplaced during our relocation to single site. We apologize for the oversight.

You asked, in light of a directive issued by New York's Department of Social Services which stated that such children may be Medicaid-eligible as a result of AFDC eligibility, whether FFP is available for medical care provided to infants in a prison nursery. Apparently, as you noted in your correspondence, the Administration for Children and Families under HHS has verified the State's policy by acknowledging that cash assistance for these children is available. The State is now suggesting that since these children are AFDC-eligible, FFP should also be available for them for the medical care they receive.

Based on our review and after consultation with our Office of General Counsel, FFP would be available for medical care provided to infants of inmates in accordance with section 1905(a) of the Act. This is based on the fact that infants are not inmates because they are not incarcerated, detained, confined, or otherwise involuntarily living in a public institution.

Thank you for your inquiry. Please advise the State accordingly.


Steve McAdoo

cc: All Associate Regional Administrators
for Medicaid

96 AUG 23 AM 10 29



DEPARTMENT OF HEALTH & HUMAN SERVICES

Inmates
Lyn Crozier
Office of the General Counsel
Health Care Financing Division

FEB 13 1991

MEMORANDUM

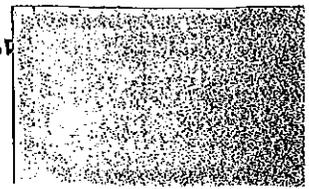
TO : Christine Nye
Director
Medicaid Bureau

FROM : Robert P. Jaya
Deputy Associate General Counsel

SUBJECT: Availability of Federal Financial Participation for
Individuals Who Are Inmates in a Public Institution

In an effort to resolve various recurring issues raised regarding the above-captioned subject, we have reconsidered our October 16, 1989, memorandum entitled "Medicaid for individuals detained by the criminal justice system" and several other General Counsel opinions issued over the past twelve years.¹ In our October 16, 1989, memorandum we concluded that persons arrested, taken into custody and sent directly to a medical institution before being sentenced or incarcerated are constructively "inmates of a public institution." Consequently, FFP would not be available for services provided to them. Our revised conclusion differs greatly from the advice we previously issued. Following our reconsideration of this opinion as well as many other General Counsel opinions, we now conclude that individuals detained or arrested and sent directly to a medical institution are not "inmates of a public institution" as that term is used in the regulations, and FFP is available for the services provided to them. We have tried, in this memorandum, to consider the entire structure of the "inmate of a public institution" issue, in order to arrive at a coherent analysis

¹ November 9, 1978 memorandum to Alwyn Carty Jr., Re: 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; June 28, 1984 memorandum to Marty Svoles, Re: Medicaid Eligibility Status of Individuals Under 21 in Prison Diversion Programs; August 3, 1981 memorandum to Larry Oday, Re: Medicaid Eligibility Status of Individuals Under 21 Who Are in Prison Diversion Programs; and the March 21, 1986 memorandum to Michelle French, Re: ERRC-292-P, Definition of "Public Institution" and "Inmate of a Public Institution"



⊕

Christine Nya - page 2

which can be used to answer a variety of questions. It should be apparent to you after reading this, that new regulations would be highly desirable.

Introduction

Section 1905(a) of the Social Security Act provides that FFP is not available for services provided to individuals who are inmates of public institutions, except insofar as they are patients in a medical institution. Accordingly, inmates of private institutions, patients in medical institutions, and individuals living in public institution but not "inmates," are seemingly eligible under the statute to receive FFP for services provided to them.

Our interpretation of § 1905(a) is supported by the legislative history. In discussing whether federal monies would be available to aged individuals, the committee report notes that

Under present law, the Federal Government participates in the cost of assistance payments to persons residing in private, but not in public institutions. Under the bill, the Federal Government would share in the cost of payments to old-age assistance recipients living in public medical institutions other than those for mental disease and tuberculosis.

.

Your committee is of the opinion that aged persons should be able to receive State-Federal assistance payments while voluntarily

² In apparent conflict with the statute and legislative history, HCFA's regulation at 42 C.F.R. § 435.1009 defines an inmate of a public institution as a "person who is living in a public institution." This definition, which would define individuals "voluntarily" residing in public institutions as "inmates," and accordingly deny FFP, seems to be overly broad and to contravene Congress' view that the Federal government should share in the cost of care to those individuals "voluntarily" residing in public institutions. In this regard, "inmates" carries with it a strong connotation of involuntariness. In particular, inmate is defined as "a person confined or kept in an institution." Webster's Third New International Dictionary 1165 (3rd ed. 1955). See also pp. 4-6, *infra*.

residing in public medical institutions,
including nursing and convalescent homes.

H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949). (Emphasis added).

Thus, it is apparent that Congress' intent was to provide money for individuals only if they were voluntarily living in a public medical institution. This concern was translated into the clause exempting patients in medical institutions (presumably whether or not there voluntarily) from the statutory prohibition denying FFP for all other "inmates of public institutions." See, § 1905(a). Obviously, persons "involuntarily" living in a public institution (e.g. persons incarcerated under State or Federal sentence) are not entitled to receive State-Federal assistance payments while living in a public institution (e.g., prison, jail, etc.)

After reconsidering our previous opinions, we have arrived at the following understanding, which requires a two-fold analysis which may be summarized as follows: first, is the institution a "public institution" and second, is the person living in the institution an "inmate."

Public Institution

The statute and legislative history make clear that States are not entitled to receive FFP for inmates of "public institutions." While the statute does not specifically define "public institution," the statute does specifically limit the denial of FFP to "inmates of public institutions" only. See, § 1905(a). Moreover, the legislative history provides that the "Federal Government participates in the cost of assistance payments to persons residing in private, but not in public institutions." H.R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949). In addition, longstanding HOPA rules have interpreted the term "public institution" to mean an institution which is "the responsibility of a governmental unit" or over which a "governmental unit exercises administrative control." 42 C.F.R. § 435.1009. This definition, while quite general and in some

³ Although if the "patient" is there voluntarily, s/he would not seem to be an "inmate" under the statute. This is merely one example of the difficulties we face in trying to make pure sense of this area.



Christina Nya - page 4

respects ambiguous, conports with the ordinary meaning of the term.

The Social Security Administration ("SSA") has attempted to address the issue of "governmental control" in its Program Operations Manual System (POMS) at SI 00520.0902. While it is true that the POMS are neither precedential nor binding, they provide insight on how SSA has interpreted and applied section 1611(e) of the Act. Under this POMS reference, "public control exists when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control." Administrative control can exist "when a governmental unit is responsible for the ongoing daily activities of a facility; i.e., when facility staff members are government employees or when a governmental unit, board, or officer has the final authority . . . to hire and fire employees." We remain available to assist HCPA should it decide to further define "public institution" as outlined above.

While we recognize HCPA's desired goal to prevent states from avoiding their traditional responsibility of taking care of the incarcerated or wards of the State by sending such individuals to private facilities, we are also mindful of the very narrow limits established by section 1903(a) of the Act. We suggest that the best way for HCPA to redefine "inmate of a public institution" to include private institutions is by seeking

⁴ Conceivably HCPA could redefine the term to include any "institution that performs a governmental function." This redefinition would allow HCPA to deny FFP to individuals living in private jails or facilities. However, it would be difficult, in light of the legislative history, to amend the regulation without a corresponding legislative amendment to sustain a definition which encompasses facilities not under governmental control. While we are somewhat dubious that the statute could be stretched to encompass any private institutions we would clear an NPRM that redefined the term "public institution" to include "private institutions under contract with the State." This expanded definition would further clarify the current vague regulatory definition which defines "public institution" in terms of "governmental responsibility and administrative control" by substituting references that specifically relate to the contractual relationship between the private enterprise and the State.

⁵ Section 1611(3) provides, with certain exceptions not relevant here, that "no person shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if throughout such month he is an inmate of a public institution."



Christine Nye - page 5

a congressional amendment of the Act and then, with SSA, simultaneously redrafting both the Medicaid and SSI regulations. Alternatively, HCFA could attempt to further define "public institution" to include specific types of facilities associated with a governmental unit. We caution HCFA that a redefinition can not make public those facilities that are truly private. However, certain "private" facilities may, by regulation, be deemed public when they are under the control of a governmental unit or are a contractual agent of a governmental unit.

Once HCFA determines that the institution is public (or deemed to be public under 42 U.S.C. § 435.1009 because the institution is the responsibility of a governmental unit or a governmental unit exercises administrative control over it) the next question to consider is whether the person living in the public institution is an "inmate."

Inmate

Once again, the statute does not define the term "inmate." However, the legislative history makes clear that FFP is available for persons voluntarily living in a public institution. H.R. Rep. No. 1300, 81st. Cong., 1st. Sess., 42 (1969). Accordingly, it logically follows, as stated in the statute, that FFP is not available to persons "involuntarily" living in public institutions. Since "inmate" connotes "involuntary" commitment, we conclude that the statutory reference to "inmate" means persons serving time or confined in State or Federal prisons, jails, or other penal facilities. Accordingly, persons incarcerated or involuntarily detained and living in a public institution while serving time or awaiting trial (or other penal disposition) are "inmates" of a public institution and FFP is not available. Conversely, individuals voluntarily living in public institutions are not "inmates." Hence, the statutory prohibition does not apply.

While HCFA's regulation at 42 C.F.R. § 435.1009 does not specifically define the terms "inmate," it states that an individual is not an inmate if

- (a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or
- (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

We agree that individuals in public institutions for educational or vocational training purposes (or for other reasons appropriate

to their needs, i.e., public emergency shelters) are not "inmates." However, our conclusion that such individuals are not "inmates" comes from the typical definition of "inmate" which connotes "involuntariness." Since individuals seeking educational or vocational training are typically in an educational institution voluntarily, the statute, amplified by the regulation, authorizes the payment of FFP for their care. Given that the statute provides that individuals in public educational or vocational training institutions voluntarily are entitled to receive FFP for their care, the regulatory characterization of "inmate" which specifically states that such persons are not inmates adds little to the current statutory structure and is dubious and misleading.

First, the existence of these exceptions suggests that individuals in non-educational or vocational training institutions are "inmates" and not entitled to FFP. However, this is not the case. As stated above, if the individual is voluntarily in a public institution -- regardless of the reason, FFP is available. Accordingly, the regulatory exception is confusing. It would be preferable to change the regulation to limit inmate status to involuntary residents and avoid the need for these exceptions. Second, subsection (b) states that an individual is not an "inmate" if "he is in a public institution for a temporary period pending other arrangements appropriate to his needs." Again, the issue here should be whether the individual is voluntarily in the public institution not whether his stay is "temporary." Following this regulatory provision, an individual living in a public institution on a non-temporary basis is an "inmate." Since the statute does not qualify the duration of an individual's time in an institution, HCFA's regulatory limitation may be contrary to the statute. Therefore, we suggest that the regulation be amended to conform to the statute.

Once HCFA has determined that the person is an "inmate" living in a public institution, FFP is not available. However, the inquiry does not stop here. Over the past years, we have considered many questions regarding the possibility that subsequent circumstances (i.e., furloughs, work release, medical leave, parole, etc.) can remove an individual's "inmate" status and allow States to receive FFP for the medical services provided. The remaining discussion addresses many of the specific issues raised by HCFA and the States over the past years.

1. Individuals, after having established "inmate" status by serving a sentence or being held (i.e., living in a public institution -- jail, prison, etc.) pending sentencing or other penal disposition are considered "inmates of a public institution" and FFP is not available even if the individual is

on furlough or work release.⁶ The rationale is that these individuals, while not currently "living in" the institution continue to have a physical nexus with the institution. Even though they have been removed from the institution, the removal is temporary and they will return to the institution following their furlough or at the conclusion of the work day.

2. Inmates transferred to medical institutions create an ambiguous situation. While we normally find that brief separations from the public institution will not destroy an individual's "inmate" status, "inmates" transferred to medical institutions who become patients are entitled to receive FFP for their care. As stated above, the statute specifically provides that FFP is available to individuals who are "patients in a medical institution." Section 1905(a). Since FFP is available to individuals who are patients in a medical institution, an individual must be an inpatient. An individual does not become a "patient in a medical institution" while receiving care on an

⁶ We note that HCFA has two options regarding an individual's "inmate" status while he is on furlough. First, HCFA could find that since the individual is not released from his sentence and will ultimately return to the public institution, he retains his "inmate" status and FFP is not available. After having established his "inmate" status the brief separation does not destroy the individual's physical nexus with the public institution. Accordingly, since his living arrangements have not permanently changed, his "inmate" status remains the same. We believe that this is the better position and have incorporated it in our discussion above. On the other hand, HCFA could find that if the person leaves the public institution and is no longer "living in" the institution, the individual is no longer an "inmate" living in a public institution and FFP would be available until he returned to the public institution. Under this position, HCFA should be aware that States may submit Medicaid claims for these people.

⁷ Individuals on work release, while working in the community during the day and away from the institution, typically return during the night. Such individuals are still "living in" the public institution and are not eligible to receive FFP for services received by them.

⁸ A unique situation occurs with individuals serving a weekend sentence. Since the individual is sentenced to be incarcerated on the weekend, s/he is an "inmate of a public institution" on Saturday and Sunday only. Accordingly, FFP is not then available. However, when the individual is released on Monday morning, s/he is no longer an "inmate of a public institution" and FFP would be available.



Christine Nye - page 8

outpatient basis. Accordingly, the availability of FFP is limited to individuals who become inpatients of a medical institution.

Moreover, it is important to note that a prison hospital may not be a "medical institution" as defined in HCFA's regulations at 42 C.F.R. § 435.1009. The regulations define "medical institution," in part, as an institution that "is organized to provide medical care, including nursing and convalescent care." A prison is organized to house convicts under criminal sentence; it is not "organized" to provide medical care -- even if it has a hospital or dispensary. Therefore, we believe that an "inmate" taken to the prison hospital for treatment does not become a "patient in a medical institution." This individual remains an "inmate of a public institution" and FFP is not available.

3. Individuals paroled, released from custody following completion of sentence, released from custody while on bail, or released or removed from a public institution permanently (i.e., terminating a stay at a public institution) are no longer "inmates" and are no longer living in a public institution. Therefore, section 1905(a) does not apply and FFP is available for their care. Moreover, if a person is released from custody and is staying in the public institution pending other arrangements appropriate to his needs (i.e., transportation, job, etc.) the individual is not an "inmate" because he is remaining voluntarily -- not under force of State or Federal action. Accordingly, FFP would be available.

4. Individuals who are arrested, taken into custody and taken immediately to a hospital before being sentenced to serve time in a public institution (i.e., county jail, state penitentiary, etc.) or held pending other penal disposition, would have FFP available to them because they have not obtained "inmate" status. Moreover, to the extent these individuals become "patients in a medical institution," the statute specifically provides that FFP is available.

The statutory exclusion of inmates in public institutions is based on their confinement in public institutions, not on their status as detained persons or arrestees. To deny FFP for detained persons would attribute institutional status to persons not yet (and perhaps never to be) institutionalized. Individuals would then be excluded on the basis of their status as "detained persons" rather than on their presence in a public institution, as Congress intended. We can find nothing in the statutory

⁹ Thus, if a jailed inmate is taken to the local hospital-- even to its prison ward--on an inpatient basis, FFP would be available.

language or its legislative history that would indicate that Congress intended to exclude detained persons from coverage.

Conversely, individuals held in jail or other public institution awaiting trial or sentence are "living in" a public institution. Such individuals are "inmates of a public institution" and FFP is not available.

5. In response to HRC-202-P, HCFA's proposed regulation that would make several changes to the definitions of "public institution" and "inmate of a public institution," we commented that the proposed rule unjustly differentiates between juvenile "wrongdoers" and other juveniles removed from home by court order and placed in a public institution. For philosophical reasons, HCFA proposed to include juvenile "wrongdoers" and exclude other juveniles removed from the home and placed in a public institution from the definition of "inmate of a public institution." HCFA found it reasonable to deny FFP to individuals who have become prisoners of the State through their own actions. Conversely, HCFA deemed it unjust, particularly since the Medicaid program is designed to help the disadvantaged, to deny Medicaid to individuals who have become involuntary wards of the State through no fault of their own. As stated previously in our comments on the proposed regulation, we believe this distinction is not supported by the statute. There is no statutory basis for treating "wrongdoers" differently from the rest of the population when all such individuals are involuntarily living in "public institutions." "Wrongdoing" has no correlation with an individual's status as an "inmate of a public institution." Accordingly, the only questions which HCFA must address under the statute are (1) whether the facility is a "public institution" and (2) whether the individual is an "inmate" living in that institution.

Previous General Counsel opinions have concluded that there is no statutory or legal authority to support 1) expanding the regulatory definition of inmate of a public institution to include inmates in private institutions; 2) differentiating between juvenile "wrongdoers" and juveniles removed from their home by court order when both are placed in "public institutions"; and 3) excluding individuals in public emergency shelters from the definition of "inmate of a public institution." After careful consideration of these specific, and many other general, issues we now conclude that we are correct as to 1 and 2. As to number 3, there is support in the statute and current regulations to exclude individuals in public emergency shelters or vocational training institutions from the definition of "inmate of a public institution" only if they are there voluntarily and are free to leave at will.



Christina Nya - page 10

We have attempted to resolve many of the recurring issues resulting from the statutory prohibition of VFP availability for services provided to "inmates of a public institution." We hope that this memorandum puts to rest any questions or concerns HCFA may have had regarding the General Counsel's interpretation of section 1905(a) of the Act. Undoubtedly new questions will arise in the future, however, if this memorandum has not provided sufficient guidance or if HCFA wishes to discuss this matter further, please do not hesitate to call David Cade at FTS 269-3377 or Lyn Crosier at FTS 615-9655.

cc: Roy Trudel