

# Appendix A

## Juvenile Justice and Medicaid\*

### I. Introduction

Medicaid is the publicly-funded insurance program that covers health care services for millions of low-income Americans, including 29 million children and teenagers. The majority of children who are involved in the juvenile justice system have incomes low enough to qualify them for Medicaid. In addition, many have significant unmet physical and mental health needs. Medicaid-covered services can greatly benefit this population when their health problems and alleged offenses are interrelated. But, while many children meet Medicaid eligibility requirements, they may not be enrolled in Medicaid or may have difficulty accessing the services to which they are entitled. Unfortunately, their families may be unaware of their potential eligibility for Medicaid and the services to which they could have access. Moreover, many juvenile defenders and others who work with justice-involved children may not be aware of the full range of services available under the program. An understanding of the Medicaid program can therefore help juvenile defenders better assist the clients they serve.

Medicaid covers basic and specialized physical health services, as well as a wide array of mental, behavioral, and substance abuse treatment. It does not pay for services for most individuals who are incarcerated, including children who are placed in Youth Development Centers. Yet, it can play a central role in keeping children out of custody by, for example, funding community-based treatment alternatives and providing support for children transitioning back into the community.

Unfortunately, the complexity of Medicaid laws, policies, and administrative procedures can prevent potential beneficiaries from obtaining the services they need and confound advocates trying to assist them. This appendix to the North Carolina Juvenile Defender Manual is intended to help defenders understand the program and its potential benefits for children by providing an overview of North Carolina's Medicaid Program. It describes the structure of the Medicaid program, basic eligibility requirements, services covered, and rights to notice and opportunity to appeal denials of, and eligibility for, services. It concludes with a guide to sources of Medicaid rules and legal precedent, and a glossary of terms and acronyms.

### II. Medicaid Program Administration

Medicaid is a cooperative federal-state program designed to assist certain categories of low-income individuals—pregnant women, children under age 19 and their caretakers, people over age 65, and those with disabilities—with the cost of medical care. The program is cooperative in several important ways. Each state's Medicaid program is overseen by both federal and state agencies. Both federal and state statutes, regulations, and policies govern each Medicaid program. Moreover, as long as states comply with federal requirements, a portion of

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their Medicaid expenses will be covered by federal funds. The federal share of Medicaid costs is known as federal financial participation (FFP). In North Carolina in 2017 and 2018, federal funds cover approximately 67 percent of Medicaid services. 80 Fed. Reg. 73779 (Nov. 25, 2015); 81 Fed. Reg. 80078 (Nov. 15, 2016).

At the national level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (USDHHS). CMS provides interpretations of, and guidance on, the requirements of federal Medicaid law. Every state must make a Medicaid plan, which sets forth the specific characteristics of its Medicaid program, including who is eligible and what services are covered. CMS approves the state's Medicaid plan if it meets federal requirements.

Federal law requires each state to administer its Medicaid program through a single state agency. In North Carolina, it is the Department of Health and Human Services (DHHS). N.C. GEN. STAT. § 143-516. DHHS includes multiple separate divisions, including the Divisions of Medical Assistance (DMA), Social Services (DSS), and Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), each of which plays an important role in the Medicaid program.

DHHS has delegated primary responsibility for overseeing and managing the Medicaid program to DMA. DMA also provides training and technical assistance to county DSS offices, which determine Medicaid eligibility and administer the program at the local level. DMH/DD/SAS is responsible for managing behavioral health care for Medicaid enrollees. The division contracts with local management entities (LMEs), which are public, community-based care management entities that provide oversight for mental health, developmental disabilities and substance abuse services. Each is responsible for Medicaid beneficiaries in a designated geographic region or "catchment area." N.C. GEN. STAT. § 122C-115.4. LMEs conduct initial assessments, then contract with and refer consumers to private providers. Information for the LMEs can be found on the DMH/DD/SAS website (*see infra* Attachment A).

All LMEs are licensed and operate as Managed Care Organizations (MCOs). These MCOs can restrict the providers from whom Medicaid enrollees obtain services. In addition, they receive payments from the Medicaid agency based on the number of people enrolled. If the services they provide cost more than the payment they received from the state, the MCOs incur a loss. If services provided cost less, they may use the funds for other purposes.

North Carolina is scheduled to transition to a statewide managed care program for Medicaid in 2019. *See* 2015 N.C. Sess. Laws 245. Under this system, Prepaid Health Plans (PHPs) will manage all Medicaid services and receive monthly payments based on enrollment. For more information, see the state's website for resources on Medicaid transitions. In order to make this legislatively mandated change, in 2016 DHHS applied for permission to operate a demonstration project to implement its proposed managed care program. This type of waiver is authorized under Section 1115 of the Medicaid Act. 42 U.S.C. § 1315. In addition, the Department amended this request in 2017 to request permission to expand coverage to many low-income adults. DHHS, [NC Medicaid Transformations](#).

### **III. Eligibility**

#### **A. Background**

Low income alone does not qualify an individual for Medicaid. Under current law, applicants must also be a resident of the state in which they are applying, be a citizen or a qualified alien, and fit into a specific category—generally, certain groups of children, caretaker relatives, pregnant women, people over age 65, and people with disabilities.

The federal health reform law, the Affordable Care Act (ACA), known colloquially as Obamacare, required states to expand Medicaid coverage to include nearly all individuals who have incomes below 133 percent of the Federal Poverty Level (FPL). 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). In 2012, the U.S. Supreme Court held that the USDHHS could not penalize states that refused to participate in the Medicaid expansion by withholding their federal Medicaid funds, effectively meaning that the ACA expansion was optional. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012). As of December 2017, North Carolina was one of the 18 states that chose not to expand Medicaid to this population, although DHHS has requested permission from CMS to do so, as discussed above. The eligibility expansion would need to be approved by the state legislature to be officially submitted to CMS. After legislative approval, it would still need to be approved by CMS in order to go into effect.

Generally, individuals who are inmates of public institutions are not eligible for North Carolina Medicaid. This includes most incarcerated or detained children, with some important exceptions discussed below.

#### **B. Residency**

To qualify for North Carolina Medicaid, a child must live in North Carolina. Her residence is generally that of her parent or legal guardian. 42 C.F.R. § 435.403(i)(2)(ii); 10A N.C. ADMIN. CODE 23E.0103(a). She cannot be denied Medicaid because she has not resided in the state for a specific period of time, nor can she be denied eligibility because she does not have a permanent or fixed address. Family and Children's Medicaid Manual MA-3205.IV.A.6; 42 U.S.C. § 1396a(b)(2). If the Medicaid agency places a child in an out-of-state setting, such as a residential treatment facility, the child will, under most circumstances, still be a North Carolina Medicaid enrollee.

#### **C. Citizenship**

In order to qualify for Medicaid, a child must be a U.S. citizen or a "qualified alien." 8 U.S.C. §§ 1611, 1641; 10A N.C. ADMIN. CODE 23E.0102(b). A child is a U.S. citizen if he was born in the U.S., even if his parents are undocumented immigrants. "Qualified aliens" include refugees, asylees, children of veterans or active military personnel, American Indians born in Canada, Cuban or Haitian entrants, and Amerasian immigrants. DHHS, Integrated Eligibility Manual 15140. A child does not have to disclose the immigration status of his parents in order to apply for Medicaid. U.S. Dep't of Health & Human Servs., *Dear State Health & Welfare Officials*, (Jan. 21, 2003).

There is an exception for emergency services. Emergency services and treatment are covered for labor and delivery, and for conditions that have a sudden onset and manifest by acute symptoms of sufficient severity that the lack of immediate medical attention could seriously jeopardize health, seriously impair bodily functions, or cause serious dysfunction of organs or body parts. If an individual meets all eligibility requirements for Medicaid other than citizenship, services to treat such emergency conditions are covered. 10A N.C. ADMIN. CODE 23E.0102(c); Integrated Eligibility Manual 15190, 15190.20.

#### **D. Financial Eligibility**

To qualify for Medicaid, applicants' income—and sometimes resources—must be below certain thresholds that vary depending on the specific eligibility category. Income is money received, including earnings, investment income, and some cash benefits from government programs or pensions. It may also be “in-kind” income, such as food and shelter. Resources may be cash or property that can be liquidated or converted to cash. Income and resources are considered automatically available, or “deemed” from a parent to a child. Therefore, custodial parents' income and resources are usually counted when determining a child's eligibility for Medicaid. Family & Children's Medicaid Manual MA 3305.IV.E.1. Grandparents and stepparents are generally not financially responsible for children living with them, so their income and resources are generally not counted. 10A N.C. ADMIN. CODE 23E.0203(b)(4); Family & Children's Medicaid Manual MA 3305.IV.E.2.b-d.

#### **E. Specific Categories of Eligibility**

There are a number of eligibility categories through which children may qualify for Medicaid. Generally, children who have incomes below 210 percent of the Federal Poverty Level—about \$52,000 for a family of four—will qualify for either Medicaid or for insurance through NC Health Choice. See Division of Medical Assistance, [Basic Medicaid Eligibility](#) (Mar. 10, 2017).

##### **1. Low-Income Children**

The ACA extended mandatory Medicaid coverage to children younger than age 19 in families at or below 133 percent of the FPL. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Most non-citizen children are still excluded. The Medicaid expansion for children was not affected by the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*.

As of 2014, states now use Modified Adjusted Gross Income (MAGI) to determine Medicaid eligibility for most of these children. For income, MAGI is based largely on adjusted gross income as reported for federal income tax purposes. Under these rules, there is no resource limit; in other words, regardless of the value of houses, cars, or other property that a family owns, if their income is below the necessary level, their child still may qualify for Medicaid. 42 U.S.C. § 1396a(e)(14).

North Carolina has opted to provide Medicaid coverage to all children under age 6 if their income is below 210 percent of the FPL, or about \$52,000 per year for a family of four. As required by the ACA, children ages 6 and older, but under age 19, are eligible for Medicaid if

their household income is below 133 percent of the FPL, or about \$33,000 per year for a family of four. Division of Medical Assistance, [Basic Medicaid Eligibility](#).

## **2. Families with Dependent Children**

Traditionally, Medicaid eligibility was linked to eligibility for the federal Aid to Families with Dependent Children (AFDC). When Congress repealed that program in 1996 and replaced it with Temporary Assistance for Needy Families (TANF), it required states to cover families who would have been eligible as AFDC existed in 1996. 42 U.S.C. § 1396u-1(a).

Today, TANF is what most people refer to as “welfare,” i.e., cash payments. In North Carolina, individuals who receive benefits through North Carolina’s version of TANF, called Work First Family Assistance (WFFA), automatically qualify for Medicaid. WFFA applies only to families with children, and the income eligibility level for WFFA is extremely low—no more than about \$7,100 per year for a family of four. Families also must have resources worth less than \$3,000 to qualify. MA-3320.I.

## **3. Adopted and Foster Children**

Any child with a federal Title IV-E adoption or foster care agreement is automatically eligible for Medicaid. Family and Children’s Medicaid Manual MA-3230.VI.A. An adopted child who does not have a Title IV-E adoption agreement but has special medical or rehabilitative needs is also eligible for Medicaid. *Id.*, 3230.V.B. The eligibility of these children is determined based on their own income and resources, not the income and resources of the adoptive parents. *Id.*, 3230.V.B.3(f)(2).

Adolescents who were in foster care on their 18th birthday are eligible for Medicaid, regardless of their resources or income, until they turn 21. *Id.*, 3230.X.

## **4. Pregnant Adolescents**

If an adolescent is pregnant, she is eligible for Medicaid if she has an income up to 196 percent of the FPL. *See* Division of Medical Assistance, [Basic Medicaid Eligibility](#). In 2017, this is a monthly income of around \$2,650 for the pregnant adolescent and her unborn child. 82 Fed. Reg. 8831 (Jan. 26, 2017); Family and Children’s Medicaid Manual MA-3310.I.A. The income of her parents or others she is living with is not counted, even if they are supporting her. Family and Children’s Medicaid Manual MA-3310.III.B-C. If they give her actual cash money it will, however, count toward her income. Regardless of changes in her income, she remains eligible for 60 days postpartum. 10A N.C. ADMIN. CODE 23D.0101(7).

## **5. SSI Recipients**

Supplemental Security Income (SSI) is the federal cash assistance program for low-income people with disabilities whose disabilities or age prevent them from engaging in substantial gainful activity. 42 U.S.C. § 1382c(a)(3)(B). All recipients of SSI qualify for Medicaid, including individuals who receive SSI pending a final determination of blindness or

disability or who receive SSI conditionally pending disposal of excess resources. 10A N.C. ADMIN. CODE 23D.0101(9); *see also* 42 C.F.R. § 435.120.

## **6. Medically Needy**

Individuals who otherwise qualify for Medicaid but have income that exceeds the eligibility limits may still be eligible as “medically needy.” Such individuals may apply medical expenses to their income and “spend down” to a certain set level, called the medically needy income level (MNIL). 42 U.S.C. § 1396a(a)(10)(C). In North Carolina, this is known as meeting a “deductible.” To meet it, an individual must show that he has incurred, but not necessarily paid, medical expenses equal to the deductible within the previous six months. The MNIL is very low in North Carolina, so a significant amount of expenses must be incurred before an individual can qualify in this category. *See generally* 10A N.C. ADMIN. CODE 23E.0209; Adult Medicaid Manual MA-2360.I-III; Family and Children’s Medicaid Manual MA-3315.II-III.

## **7. Health Choice (Children’s Health Insurance Program)**

Some children with low incomes may not qualify for Medicaid, but may instead qualify for North Carolina Health Choice (NCHC), which is the state’s program under the federal Children’s Health Insurance Program (CHIP). This program serves uninsured children who do not qualify for Medicaid and have family income under 211 percent of the FPL. N.C. GEN. STAT. § 108A-70.21; Family and Children’s Medicaid Manual MA-3255.II. NCHC, like Medicaid, has used MAGI income calculations since 2014. 42 U.S.C. § 1397bb(1)(B)(v). For most children, NCHC covers a less comprehensive set of services than Medicaid and, unlike Medicaid, enrollment can be frozen and wait lists imposed if the program reaches capacity. It may still, however, provide important health care services for children who do not qualify for Medicaid.

## **F. Eligibility Rules for Inmates of Public Institutions**

Federal law does not link eligibility to incarceration status but does provide that federal funds cannot cover Medicaid services for anyone who is an “inmate of a public institution.” 42 U.S.C. § 1396d(a)(A); *see also* 42 C.F.R. §§ 435.1009(a)(1), 441.13(a)(1). Nothing in federal law prohibits inmates from being eligible for Medicaid, but states may not receive federal Medicaid reimbursement for services provided to them while they are incarcerated. The federal government does not, however, *prevent* states from terminating Medicaid eligibility for inmates. Predictably, therefore, many states—including North Carolina—do terminate Medicaid eligibility for most individuals when they enter prison, jail, or detention. Thus, in North Carolina, inmates, including children, are not eligible for Medicaid. Adult Medicaid Manual MA-2510.II.A; Family and Children’s Medicaid Manual MA-3360.II.A.

Federal guidance explains that 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.” U.S. Dep’t of Health & Human Servs., HCFA Program Issuance Transmittal Notice Region IV (Mar. 6, 1998). A public institution is one that “is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.” 42 C.F.R. § 435.1010. It does not include, however, intermediate care facility services for people with intellectual disabilities, such as the Murdoch Developmental Center, which are

covered by Medicaid. Nor does it include Psychiatric Residential Treatment Facilities or Level I-III group homes, which are also coverable under Medicaid. *See generally* 42 U.S.C. § 1396d(a); Family and Children’s Medicaid Manual MA-3360.II.D-E.

North Carolina policy provides that a child is not eligible for Medicaid if she is committed to a federal prison, state juvenile justice facility, county or local jail, forestry camp, or other facility “operated primarily for the detention of children who are determined by the court to be delinquent.” Adult Medicaid Admin. Letters, [DMA Administrative Letter No: 09-08](#) (Aug. 27, 2008); Family and Children’s Medicaid Manual MA-3360 II.A.3. This includes when she is transferred from such a setting to another facility, such as a hospital, to receive care.

Significantly, a child is not considered an inmate for Medicaid purposes if she is on house arrest, probation, or parole. Family and Children’s Medicaid Manual MA-3360.II.A.1.

### **1. Temporary Detention**

The federal prohibition on using federal Medicaid funds to cover services for inmates does not apply when an individual is in an institution for “a temporary period pending other arrangements appropriate to his needs.” 42 C.F.R. § 435.1010(b). In North Carolina, if a child is placed in a detention setting prior to adjudication, he may be eligible for Medicaid depending on his final placement. If his final placement is the Youth Development Center (YDC) or other public institution, the child is considered to have been an inmate since he was initially detained and therefore not eligible for Medicaid during that time. If the child’s final placement is any place other than a penal institution (placed with a relative or in a residential treatment center, for example) the child is considered to have never been an inmate of a penal institution, even during the period he was in the YDC. Family and Children’s Medicaid Manual MA-3360.II.A.4.a. This means that services a child may have received during such temporary detention can be covered by Medicaid.

Notably, inmates who are in the custody of Department of Corrections (unlike most children who are inmates and are in the custody of Division of Juvenile Justice) have Medicaid suspended rather than terminated. Adult Medicaid Admin. Letters, DMA Administrative Letter No: 09-08, [Medicaid Suspension Addendum 1](#) (Sept. 9, 2010), *superseded in part by* [Medicaid Suspension Addendum 2](#) (Apr. 7, 2011).

### **2. Eligibility Determinations While in a Public Institution**

For children who are not eligible for Medicaid when they are detained in public institutions, Medicaid applications may be accepted during detention. But if the child remains detained at the end of the application processing period—either because she has been committed to a YDC or because she has not yet been given a final placement—the application will be denied. If the final placement is not in a detention setting, the application will be re-opened and processed. Family and Children’s Medicaid Manual MA-3360.II.A.4.b(1).

It is important to note, however, that in practice, there is likely to be considerable variation throughout the state in procedures and policies for terminating Medicaid for children

who are inmates, depending on the county in which the child lives. It is possible that a child who is an inmate will not have her Medicaid terminated, especially if she is confined for a relatively short period of time and her eligibility re-determination does not occur until she has been released.

#### **IV. Services**

##### **A. Background**

Federal law requires states to cover certain “mandatory” services in their Medicaid plans, including physician, hospital, clinic, nursing home, and family planning services. States also may cover certain “optional” services, including rehabilitative, dental, and personal care services; and physical, occupational or speech therapy. 42 U.S.C. §§ 1396a(a)(10), 1396d(a). If a state chooses to cover optional services, they must indicate this in their state Medicaid plan. As explained below, because of Medicaid’s Early Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, there is no such thing as an optional service for children.

##### **B. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)**

###### **1. EPSDT Basics**

States must cover EPSDT for children up to age 21 who are enrolled in Medicaid. Family and Children’s Medicaid Manual MA-3540.XXXVIII; N.C. Dept. of Health & Human Servs., Division of Medical Assistance, [\*EPSDT Policy Instructions Update\*](#) (January 11, 2010), (*DMA EPSDT Policy Instructions*); *see also* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). Unlike adults, for whom Medicaid coverage is subject to more limits, children under age 21 who qualify for Medicaid are entitled to a consistent and expansive set of covered services. Family and Children’s Medicaid Manual MA-3540.XXXVIII B; *DMA EPSDT Policy Instructions*; 42 U.S.C. §1396a(a)(10)(A).

EPSDT, known as Health Check in North Carolina, is a set of services consisting of screening, immunizations, laboratory tests, and health education. Significantly, EPSDT includes all services that fit within the mandatory and optional service categories in the Medicaid Act that are “necessary to correct or ameliorate” physical and mental conditions. 42 U.S.C. §§ 1396a(a)(43)(C), 1396d(r)(5); 42 C.F.R. §§ 441.50-441.62. This means that North Carolina must cover all medically necessary Medicaid services that can be covered under federal Medicaid law *even if the state chooses not to cover the service for adults*. For example, a Medicaid agency can choose not to provide dental services to adults, but under EPSDT it must provide them to children. *DMA EPSDT Policy Instructions*, p. 3, 12 (listing required services for EPSDT).

EPSDT requires states to do more than merely offer to cover services. States are obligated to actively arrange for treatment, either by providing the service itself or through referral to appropriate agencies, organizations, or individuals, and by assisting with scheduling and transportation. The Medicaid agency must make available a variety of individual and group providers qualified and willing to provide EPSDT services. 42 U.S.C. § 1396a(a)(43)(A); 42 C.F.R. §§ 441.50-441.62



Thus, the Medicaid program must ensure that all Medicaid enrollees under age 21, including those involved in the juvenile justice system, have access to the services needed to correct a health problem, improve the problem, prevent it from getting worse, or help the child function with the problem.

## 2. Periodic and Interperiodic Screens

Medicaid must cover periodic examinations, or “screens,” that measure a child’s medical, vision, hearing, and dental status. They must be performed at regular intervals, as determined by “periodicity schedules” that meet the standards of pediatric and adolescent medical and dental practice. Medical screens must provide a health and developmental history, a physical examination, immunizations, laboratory tests, and health education.

In addition, EPSDT covers visits to health care providers outside of the periodicity schedule if needed to determine whether a child has a condition that needs further care. 42 U.S.C. §§ 1396d(r)(1)-(4). These are called “interperiodic screens.” Persons outside the health care system (for instance, a parent, court counselor, or juvenile defender) can make this determination and refer a child for an interperiodic screen. Centers for Medicare and Medicaid Services, *EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), at 5 (citing example of interperiodic screening requirement when school nurse and teacher suspect a child may have a vision problem and recommend to child’s parent that child see an optometrist). Following referral, “[a]ny qualified provider operating within the scope of his or her practice, as defined by state law, can provide a screening service,” including providers not otherwise participating in Medicaid. *Id.* at 6.

## 3. EPSDT’s Broad Treatment Mandate

Medicaid must cover any service that fits within the broad categories described in the federal Medicaid statute, if necessary to “correct or ameliorate” an illness or condition detected during a periodic or interperiodic screen. 42 U.S.C. § 1396d(r)(5). Even if the service will not cure a condition, it must be covered if the service is necessary to improve or maintain a child’s functioning or symptoms. The service requested must also be safe, effective, generally recognized as an accepted method of medical practice or treatment, and must not be experimental. 42 C.F.R. §§ 440.1-440.170.

North Carolina has adopted a detailed policy implementing the federal EPSDT requirements. The policy instruction is posted on the DMA and DMH/DD/SAS websites, and is included in the state’s training materials for Medicaid providers. *DMA EPSDT Policy Instructions Update* (Jan. 11, 2010), <https://www2.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf>. These instructions reiterate and expand on the federal Medicaid statutory EPSDT requirements, and provide that there can be:

- *No waiting list for services.* Although hospitals or clinics may have waiting lists to schedule appointments or medical procedures, the Medicaid program itself cannot impose any waiting list for eligibility or service coverage.
- *No cap on the total cost of medically necessary services.*

- *No upper limit on the number of hours or units of medically necessary services covered.*
- *No limit on the number of visits to a physician, therapist, dentist, or other licensed clinician (other than medical necessity).*
- *No set list that specifies when or what EPSDT services or equipment may be covered. Services need only fit within the general categories in the Medicaid statute at 42 U.S.C. § 1396d(a). For example, a service that fits within the category of “rehabilitative services” can be covered even if the specific service itself is not listed in DMA clinical policies or service definitions.*
- *No co-payment or other out-of-pocket cost may be charged to the recipient.*

*Id.* at 2-3.

The policy reiterates the statutory requirement that services may be covered for Medicaid enrollees under EPSDT even if such services are never covered for adults over 21 or not listed in the state Medicaid plan. It also includes a list of categories of services that are covered under Medicaid, directly from the federal statute. This list is attached *infra* as Attachment C.

#### **4. Behavioral Health Services**

Mental health and substance abuse services available under EPSDT are of particular importance for justice involved children. Although the federal law lists a number of specific mandatory services, such as inpatient psychiatric treatment, the general list of covered categories of services is not exhaustive. Under EPSDT, children have the right to virtually any home or community-based mental health service that a practitioner determines is medically necessary, as long as it fits within one of the categories of covered services. Some of the services covered through EPSDT that may be most useful to juvenile justice involved children are briefly described below. A detailed list of these service definitions can be found in the Division of Medical Assistance, [Clinical Coverage, Policy No. 8-A](#), Attachment D (rev'd Apr. 1, 2017), at 26.

- *Mobile Crisis Management.* A crisis response that is available 24 hours a day, 365 days a year, when a child is actively experiencing a crisis. Mobile Crisis Management provides immediate evaluation, triage, and access to acute mental health, developmental disability and substance abuse services.
- *Intensive in-home services.* A short-term clinical care and counseling program for children and their families within the home or community setting.
- *Multisystemic Therapy (MST).* A program designed for children who have antisocial, aggressive/violent behaviors and are at risk of out-of-home placement. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence.

- *Assertive Community Treatment Team.* A multidisciplinary team treatment that provides psychiatric treatment in a community setting to persons with serious and persistent mental illness.
- *Child and Adolescent Day Treatment.* Services provided in a licensed facility for children or adolescents.
- *Substance Abuse Comprehensive Outpatient Program.* An intensive, structured, short-term substance abuse treatment program.
- *Ambulatory Detoxification.* A program designed to safely detoxify individuals from drugs and alcohol without a hospital admission.
- *Medically Supervised Detoxification/Crisis Stabilization.* A medically supervised evaluation and withdrawal management service that occurs in a permanent facility with inpatient beds.
- *Opioid Treatment.* A service that uses methadone or other drugs approved for the treatment of opiate addiction in conjunction with the provision of rehabilitation and medical services.

Notably, some of these service definitions contain limits on services that are not consistent with EPSDT requirements or North Carolina's EPSDT policy. In order to be consistent with EPSDT's prohibition on automatic hourly limits that are unrelated to medical necessity, this policy contains a special provision related to EPSDT, providing that:

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

DMA, Clinical Coverage Policy 8-A, at 3.

North Carolina authorizes a type of provider, Critical Access Behavioral Health Agencies (CABHAs), which are responsible for providing some mental health and substance abuse services. CABHAs have specific staffing requirements, and are the only approved provider for certain types of behavioral health services (Day Treatment, Intensive In-Home, or Community Support Team).

## V. Community Alternative Programs (CAPs)

### A. Home and Community-Based Services for People with Disabilities

Federal law allows states to cover home and community-based services for people with disabilities through programs known as waivers. These programs provide services for individuals who require the level of care provided in an institution (hospital, intermediate care facility, or skilled nursing facility) and who, but for waiver services, would be institutionalized. 42 U.S.C. § 1396n(c). They are called waivers because they allow states to waive certain otherwise mandatory federal Medicaid requirements in order to target certain populations for these services. Waivers must be “cost neutral,” meaning that it must cost less for a state to provide community based waiver services to individuals in the waiver than it would to cover institutional care for those individuals.

Waivers can serve individuals who would not otherwise be eligible due to income because waivers apply the same income eligibility rules that apply to institutionalized individuals. Typically, when determining eligibility, the Medicaid agency must consider the income and resources of an applicant’s parent. If, however, an individual is in an institution or meets the criteria for a waiver, only the income and resources of the child, not the parent, are considered. This means that children generally are able to meet the income eligibility requirements and qualify for the waiver if they meet other eligibility criteria such as severity of disability. It is important to emphasize that children may receive both waiver and EPSDT services as waiver services are supposed to complement EPSDT services.

North Carolina’s waiver program for people with intellectual and developmental disabilities is the NC Innovations Waiver. The waivers cover services for people with developmental disabilities that could not otherwise be covered by Medicaid, such as respite, home modifications, and habilitation. Habilitation services are “designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully” in community settings. 42 U.S.C. § 1396n(c)(5)(A); *see also* Disability Rights North Carolina, [Innovation Waivers](#).

Some behavioral health services, notably, applied behavioral analysis (ABA) and other therapies for children with autism, have traditionally been considered habilitative and, therefore, only covered under the Innovations Waiver. In 2014, however, the federal government clarified that ABA can be covered under EPSDT. If a service fits into a Medicaid service category, such as rehabilitative or preventative services and meets other Medicaid requirements like medical necessity, it should be covered under EPSDT. For more information on this topic, *see* Disability Rights North Carolina, [Autism Related Services in North Carolina](#).

## VI. Due Process

All Medicaid enrollees, including children, have rights to written notice and the opportunity for an administrative hearing when the Medicaid agency takes an adverse action against them. These rights are based on the Medicaid statute and regulations, North Carolina statutes and regulations, and guaranteed by the North Carolina and U.S. Constitutions. 10A N.C.

ADMIN. CODE 22H .0101; N.C. GEN. STAT. §§ 108A-70.9A, B, 108A-79; 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250. Medicaid due process rights are also clarified and memorialized in a settlement of a North Carolina Medicaid case, *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694 (E.D.N.C. 2009), *aff'd sub nom., D.T.M. ex rel. McCartney v. Cansler*, 382 F. App'x 334 (4th Cir. 2010). These rights are discussed in detail in this section.

### **A. Actions Triggering Due Process Rights**

Individuals are entitled to notice and opportunity for hearing when the Medicaid agency or its contractor denies eligibility; denies requests for, terminates, or reduces services; or fails to determine eligibility or approve service requests within a reasonable time. N.C. GEN. STAT. § 108A-70.9A(d)(a); 10A N.C. ADMIN. CODE 22H.0101(a); Adult Medicaid Manual MA-2420.II.B; Family and Children's Medicaid MA-3430.II. Notice of adverse decisions must be made in writing and mailed to the appropriate person. Generally, the notice must be mailed to the custodial parent of the child. If, however, the child has a legal guardian or is in the custody of DSS, the notice must be mailed to them. Family and Children's Medicaid MA-3430.III.A.

Notices must provide the specific reason for the adverse action, cite the specific legal authority for the action, and, where applicable, provide an explanation of the right to continued benefits. The notices of action must also contain a Medicaid Services Hearing Request Form. N.C. GEN. STAT. § 108A-70.9A(e), 108A-79(c); 10A N.C. ADMIN. CODE 22H.0101, 71P.0102(3). Medicaid regulations provide that there is no right to a hearing if the sole reason is a change in law or policy, but Medicaid beneficiaries are still entitled to a hearing if such a change gives rise to a legitimate factual dispute, such as whether the change applies to that individual. 42 C.F.R. § 431.220(b).

### **B. Hearings**

There are two different types of hearing systems available for Medicaid issues—one for issues related to determinations of eligibility for the Medicaid program and a second for those related to denial, suspension, or reduction of services.

DSS handles appeals related to eligibility. Adult Medicaid Manual MA-2420; Family and Children's Medicaid MA-3430. A claimant must first have a local hearing before the county DSS director. A state-level hearing is then available if the individual is dissatisfied with the result. N.C. GEN. STAT. § 108A-79(g). State level hearings may also be requested in the first instance by individuals disputing a determination that they are not disabled. Adult Medicaid Manual MA-2420.V.B.4.; Family and Children's Medicaid MA-3430.V.B.4. Hearings may be requested orally or in writing and must be requested within 60 days of the adverse action. N.C. GEN. STAT. § 108A-79(c).

DSS hears appeals of eligibility determinations at the state level. An appeal of a local hearing to a DSS state-level hearing must be made within 15 days of the local hearing decision. N.C. GEN. STAT. § 108A-79(g).

The Office of Administrative Hearings (OAH) hears appeals of reductions, suspensions, terminations, or denials of requests for services. N.C. GEN. STAT. §§ 108A-70.9A, B. All

claimants also have to the right to participate in no-cost, optional mediation services before a hearing.

The procedure varies depending on where the individual lives and which services are involved. In some counties, Medicaid recipients must enroll in MCOs to receive behavioral health services. Individuals who are enrolled in MCOs must first exhaust an internal MCO grievance system. The timelines and other aspects of the grievance systems will be determined by the MCO's contract. This information must be provided to MCO enrollees at the time of enrollment and when a notice of action is provided.

A request for a formal OAH hearing must be made within 30 days of the notice of action, or the decision from an MCO internal grievance. N.C. GEN. STAT. § 108A-70.9A(d). Additional information about OAH hearings can be found at [Hearings Division – Medicaid](#).

Requests for hearings to contest transfer or discharge from a facility must be made within eleven days of the action. 10A N.C. ADMIN. CODE 22H.0203.

Issue	Eligibility	Services
Local Hearing	DSS (mandatory, except for disability determination)	None
Time to request	60 days after notice mailed/given	11 days after notice mailed/given
State-level hearing	DSS	Office of Administrative Hearings
Time to request	15 days after mailing local decision	30 days after action
Right to petition for judicial review	Yes	Yes

If a hearing request is made before the effective date of the adverse action, generally within ten days of the date of the notice, the claimant must continue to receive benefits pending the result of the hearing. N.C. GEN. STAT. §§ 108A-70.9A(c)(7), 108A-79(c)(6).

### C. Rights at Hearings

The hearing must be conducted at a reasonable time, date, and place by an impartial hearing official who did not take part in the initial decision. N.C. GEN. STAT. § 108A-79(d). All administrative hearings must be *de novo* and the hearing officer must be permitted to consider evidence that was not available to the agency at the time of the agency's original decision. *Robinson ex rel. Robinson v. N.C. Dep't of Health and Human Servs.*, 715 S.E.2d 569 (N.C. App. 2011). At the hearing, the claimant must be able to present witnesses, establish facts, present argument without undue interference, and cross-examine witnesses. N.C. GEN. STAT. § 108A-79(e).

#### **D. Post-hearing action**

If the decision is favorable to the child, corrective payments must be made retroactive to the date that the incorrect action was taken, if the payments were not made during the pendency of the appeal. 10A N.C. ADMIN. CODE 23G.0203. If the decision is not favorable to the child, the state may institute an action to recover any costs of the continued services during the appeals process. 10A N.C. ADMIN. CODE 22H.0104(d).

The final agency decision may be appealed by filing a petition in Superior Court within 30 days of receiving notice of the decision. N.C. GEN. STAT. §§ 150B-43 – 150B-45.

#### **VII. Conclusion**

Medicaid is a crucial resource for justice-involved and at risk children. Working knowledge of the program can help juvenile defenders better represent these children and, perhaps, avoid commitment. The program is, however, complex, dense, and ever-evolving. Additional resources are available to help navigate Medicaid, including advocates who represent children in Medicaid appeals. Some of these sources and agencies are described in the attachments that follow.

## **Attachment A: Sources of Medicaid Law, Policy, and Information**

### *Federal Law:*

42 U.S.C §§ 1396-1396w-5.

42 C.F.R. §§ 430-456.725.

### *Federal Policy:*

Centers for Medicare and Medicaid Services (CMS)

- State Medicaid Manual (sub-regulatory policy statements)
  - [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html)
- Dear State Medicaid Director Letters
  - [www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html](http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html)

### *North Carolina Law:*

N.C. General Statutes 108a-54 et seq.

10 N.C. Administrative Code. Chapters 26 and 50

### *North Carolina Medicaid Policy:*

- Adult Medicaid Manual
  - <https://www2.ncdhhs.gov/info/olm/manuals/dma/abd/man>
- Family and Children's Medicaid Manual
  - <https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man>

### *Federal Agencies:*

- **Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS)**
  - [www.cms.gov](http://www.cms.gov)
  - [www.medicaid.gov](http://www.medicaid.gov) (information about Medicaid)
  - [www.healthcare.gov](http://www.healthcare.gov) (information about enrolling in public insurance coverage)

### *North Carolina State Governmental Entities:*

- **Division of Medical Assistance**
  - [www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)
  - EPSDT information - [www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm](http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm)
- **Division of Mental Health/Developmental Disabilities/Substance Abuse Services**
  - [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas)
  - Listing of LMEs - [www.ncdhhs.gov/mhddsas/lmeonblue.htm](http://www.ncdhhs.gov/mhddsas/lmeonblue.htm)
- Mental health and substance abuse service definitions - [https://files.nc.gov/ncdma/documents/files/8A\\_1.pdf](https://files.nc.gov/ncdma/documents/files/8A_1.pdf)



- **Department of Social Services**
  - [www.ncdhhs.gov/dss](http://www.ncdhhs.gov/dss)
- **Office of Administrative Hearings**
  - [www.ncoah.com](http://www.ncoah.com)

*Medicaid Advocacy Organizations:*

These organizations may be able to assist children who have been denied Medicaid services.

- Disability Rights North Carolina – [www.disabilityrightsn.org](http://www.disabilityrightsn.org)
- Legal Aid of North Carolina – [www.legalaidnc.org](http://www.legalaidnc.org)
- Advocates for Children’s Services – [www.legalaidnc.org/Pages/about-us/projects/Advocates-for-Childrens-Services.aspx](http://www.legalaidnc.org/Pages/about-us/projects/Advocates-for-Childrens-Services.aspx)
- Charlotte Center for Legal Advocacy (formerly Legal Services of the Southern Piedmont) – [www.lssp.org](http://www.lssp.org) (Charlotte area)
- Council for Children’s Rights – [www.cfcrights.org](http://www.cfcrights.org) (Charlotte area)

## Attachment B: Glossary of Acronyms

### AFDC

Aid to Families with Dependent Children

*Former federal cash assistance program for children deprived of parental support.*

### CABHA

Critical Access Behavioral Health Agency

*Behavioral health entity that supplies Community Support Teams, Intensive In-Home Services, and Day Treatment.*

### CAP

Community Alternatives Programs

*Medicaid program for individuals with disabilities that provides services in the community to prevent institutionalization.*

### CAP/IDD

Community Alternatives Program for Intellectual or Developmental Disabilities

*CAP program for people who need the level of care provided in an intermediate care facility for people with intellectual or developmental disabilities (including state developmental centers).*

### CHIP

Children's Health Insurance Program

*Federal-state program for uninsured children with incomes too high to qualify for Medicaid.*

### CMS

Centers for Medicare & Medicaid Services

*Federal agency responsible for administering Medicaid and Medicare.*

### DMA

Division of Medical Assistance

*North Carolina's state Medicaid agency.*

### DMHDDSAS

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

*North Carolina's agency serving people with one of these disabilities.*

### EPSDT

Early and Periodic Screening, Diagnosis and Treatment

### FFP

Federal financial participation

*Federal funding provided to the state to match its state Medicaid expenditures.*

FPL

Federal poverty level

*Federally established income level denoting the official poverty level, linked to eligibility for many programs.*

HCFA

Health Care Financing Agency

*Former name of CMS, name changed in 2001.*

LME

Local management entity

*Local agency (private or public) that oversees and administers mental health, developmental disability, and substance abuse services.*

MCO

Managed Care Organization

OAH

North Carolina's Office of Administrative Hearings

PBH

Piedmont Behavioral Health

TANF

Temporary Assistance to Needy Families

*Federal program of cash assistance to low income families.*

WFFA

Work First Family Assistance

*North Carolina's TANF program.*

### **Attachment C: Covered EPSDT Services**

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law

- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Source: 42 U.S.C. § 1396d(a); *DMA EPSDT Policy Instructions Update* (Jan. 11, 2010), <https://www2.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf>