SERVING YOUTH PLACED INTO RESIDENTIAL TREATMENT FACILITIES FOR NON-EDUCATIONAL REASONS AND OUTSIDE OF THE CSA PROCESS

Workgroup Report to the State Executive Council
March 19, 2015

The workgroup was convened at the direction of the State Executive Council to review and advise on specific recommendations presented to the SEC on December 18, 2014 by an SEC Taskforce. The workgroup met on February 12, February 25, and March 4, 2015. The final workgroup membership is included as Addendum B. The policy statement considered by the SEC on December 18, 2015, showing revisions to reflect the process recommendations of this workgroup, is included as Addendum C. Documents provided to and utilized by the workgroup are included as Addendum D.

1. The workgroup elected not to recommend a policy implementation date, but recommends that the SEC consider the additional actions required before implementation can occur. Such actions include amendments to DMAS regulations, amendments to performance contracts between the Department of Behavioral Health and Developmental Services and Community Services Boards, and, possibly, amendments to the Code of Virginia.

2. In addition to necessary regulatory and contract changes, the workgroup identified a number of actions and matters for the SEC to consider prior to implementation of policy. These include the following:

    a. Reconciliation between Medicaid mandates regarding a parent/client right of choice of service provider with local contracting and quality assurance procedures under the CSA.

    b. Development of stronger relationships between in-patient psychiatric facilities and local community service boards and CSA teams.

    c. Development of general expectations for CSB performance related to referring a child to FAPT, e.g., preparation of documents, assessment, case management.

    d. Identification and sharing of best practices for reducing unnecessary burdens in FAPT processes, e.g., reducing paper-work, clarifying expectations for assessments, reviews, etc.

    e. Development of a "universal notice" that acute facilities and residential treatment facilities will provide to families to outline service options, CSA process, parent rights and responsibilities, etc.

    f. Identification/creation of fiscal resources to support CSB activities, e.g., billing via Medicaid and/or CSA for assessments related to Certificates of Need and case management/case support.

    g. Identifying and addressing barriers to timely access to FAPT whether referrals are from parents, providers, or public agencies.

h. Clarification of "Child in Need of Services" statutory language in the context of eligibility for CSA funding.

i. Increasing awareness and understanding of CSA by parents and private mental health professionals; ensuring education within public agencies of staff responsibilities regarding referral of children in need of services to CSA.

j. Building of connections between emergency rooms, regional crisis stabilization units, and local CSA teams.

k. Clarification of legal authority for the SEC to consider RTF placements through a certificate of need signed by the CSB as emergency placements in accordance with § 2.2-5209.

3. The workgroup recommends change to the process recommended by the SEC Taskforce on December 18, 2014. The process recommended by the workgroup is outlined in the table below. Addendum A represents the workgroup recommendations as "tracked changes" to the Taskforce recommended process. Primarily, the changes:

   a. require referral of a child to the local community for assessment and planning as early as possible and prior to the child's admission to a residential treatment facility, and

   b. require that the independent team certifying the need for placement into a residential treatment facility will include the Community Service Board.

RECOMMENDED PROCESS	ACTION NEEDED
ACUTE CARE FACILITY RESPONSIBILITIES At time of admission to an acute care facility, the acute care facility shall: 1. provide a "universal notice" to the parent and inform the parent of the potential for development of a plan for community-based services; 2. obtain consent from the parent to release confidential information regarding the youth to the CSB serving the area in which the child resides and to the FAPT serving the area in which the child resides; and, 3. refer the youth to the local CSB serving the area in which the child resides for discharge planning consistent with §16.1-346.1 and for referral to the FAPT.	DMAS: Amend regulations to add provider requirement for acute facilities to refer admitted youth to the local CSB for discharge planning. Recommended actions: Amend §16.1-338 C, 16.1-339 C: require referral to CSB following voluntary admission to psychiatric facility of consenting and objecting minors. Amend § §16.1-338 C and §16.1-339 C 2: Require CSB to engage in discharge planning for minors admitted to acute psychiatric facility: Amend paragraph 2 or add a new section that applies to both voluntary and involuntary commitments and sets out more

	fully what is expected from the CSB and why this coordination is established in relation to funding through CSA. Amend § 16.1-346.1 regarding discharge planning.
RESIDENTIAL TREATMENT FACILITY RESPONSIBILITIES 1. In conjunction with the process of assessment for admission, the RTF shall: a. provide "Universal Notice" to the parent and shall: i. inform the parent of the need for local Family Assessment and Planning Team review of services; ii. inform the parent of the potential for development of a plan for alternative services, i.e., community-based services; iii. inform the parent that, if admission to the RTF is warranted, the CSB serving the area in which the child resides will need to provide a Certificate of Need for the placement; and iv. inform the parent, if admission to the RTF is warranted, of potential fiscal responsibility for educational services if the FAPT develops a plan for alternative services but the parent wishes to pursue the RTF placement; b. obtain consent from the parent to release confidential information about the youth to the CSB serving the area in which the child resides and to the FAPT serving the area in which the child resides; and c. refer the youth to the CSB serving the area in which the child resides. 2. If, during the process of assessment for admission, the RTF determines that the youth meets admission criteria, the RTF shall again refer the youth to the CSB serving the area in which the child resides, i.e., shall inform the CSB of such determination.	DMAS: Amend regulations to add provider requirement for Level C RTF to obtain consent for release of information and refer youth to the CSB serving the area in which the child resides and to require that the independent team certifying psychiatric residential treatment will include the CSB serving the area in which the child resides.
COMMUNITY SERVICE BOARD RESPONSIBILITIES Upon referral from Level C RTF, the CSB shall: 1. immediately refer the youth to the local FAPT, and 2. assess appropriateness of the request for admission. a. If the CSB deems admission to the RTF is appropriate, the CSB will complete the Certificate of Need as soon as practicable but no later than 10 business days from the date of referral from the RTF. b. If the CSB deems admission to the RTF is not appropriate, the CSB	DBHDS: Amend performance contracts to require execution of responsibilities as outlined in DMAS regulations regarding independent team certification of admission to psychiatric residential treatment facility.

will inform the parent and RTF as soon as practicable but no later than 10 business days from the date of referral from the RTF.	
FAPT RESPONSIBILITIES The FAPT shall review the case and develop an Individual Family Services Plan (IFSP) for the youth. 1. If the CSB certifies that admission to the RTF is appropriate, completes the Certificate of Need, and the youth is admitted to the RTF prior to the FAPT review, there are multiple options available to the FAPT when reviewing the youth's needs. These options are as follows: a. FAPT may determine the RTF placement is necessary to meet the youth's needs. If the FAPT so determines: i. The FAPT shall develop an IFSP for RTF. ii. The CPMT shall assume responsibility for the RTF placement beginning on the date of admission. Fiscal responsibility includes payment of the daily cost of educational services and the local match on treatment services. b. FAPT may determine the youth's needs can be met through community based services. If the FAPT so determines: i. The parent/provider shall assume responsibility for the cost of educational services in the RTF beginning with the first day of placement. ii. The locality shall assume responsibility for community-based services per the IFSP. iii. If discharge from the RTF is delayed pending implementation of the IFSP, the locality shall assume responsibility for the RTF placement beginning day 15 post admission through the date of discharge when the IFSP is implemented (i.e., daily cost of educational services, local match on treatment services). iv. If the parent rejects the services outlined in the IFSP, the parent and/or provider shall assume responsibility for the child's placement at the RTF. The local CPMT appeal process will be available to the parent. c. If the FAPT fails to meet and/or fails to develop an IFSP within 14 days of the admission to the RTF, the CPMT shall assume responsibility for the RTF placement beginning on the first day of admission, i.e., payment of the daily cost of	SEC: Adopt policy that FAPT shall meet within 14 days of a child's admission to the RTF. (See Attachment A) SEC: Adopt policy regarding locality fiscal responsibilities as outlined (See Attachment A)

educational services and the local match for treatment services. 2. If the FAPT meets prior to the CSB making a determination regarding admission to the RTF (i.e., within 10 business days of the referral from the RTF), the FAPT shall assess the strengths and needs of the child and family. The FAPT and family shall develop an IFSP for appropriate services. If the FAPT determines admission to a RTF is appropriate, the FAPT shall complete the certificate of need with 10 business days of the referral from the RTF to the CSB. 3. If the FAPT meets after the CSB has provided notice to the parent and RTF that admission is not deemed appropriate, the FAPT shall assess the strengths and need of the child and family and develop an IFSP for appropriate services.	

ADDENDUM A

ADDENDUM A

SERVING YOUTH PLACED INTO RESIDENTIAL TREATMENT FACILITIES FOR NON-EDUCATIONAL REASONS AND OUTSIDE OF THE CSA PROCESS

Workgroup Recommendations to the State Executive Council
March 19, 2015
RECOMMENDED CHANGES TO SEC TASKFORCE PROCESS

RECOMMENDED PROCESS	ACTION NEEDED
ACUTE CARE FACILITY RESPONSIBILITIES At time of admission to an acute care facility, the acute care facility shall: 1. provide "Universal Notice" to parent and inform parent of the potential for development of a plan for community-based services; •2. obtain consent from the parent to release confidential information regarding the youth to the ~~local~~ CSB serving the area in which the child resides and the ~~local~~ FAPT serving the area in which the child resides; and, •3. refer the youth to the local CSB serving the area in which the child resides for discharge planning consistent with § 16.1-346.1 and for referral to the FAPT.	DMAS: Amend regulations to add provider requirement for acute facilities to refer admitted youth to the local CSB for discharge planning. Recommended actions: Amend §16.1-338 C, 16.1-339 C: require referral to CSB following voluntary admission to psychiatric facility of consenting and objecting minors. Amend § §16.1-338 C and §16.1-339 C 2: Require CSB to engage in discharge planning for minors admitted to acute psychiatric facility: Amend paragraph 2 or add a new section that applies to both voluntary and involuntary commitments and sets out more fully what is expected from the CSB and why this coordination is established in relation to funding through CSA. Amend § 16.1-346.1 regarding discharge planning.

RESIDENTIAL TREATMENT FACILITY RESPONSIBILITIES ~~At the time of admission to a Level C RTF~~1. In conjunction with the process of assessment for admission, the RTF shall: •a. provide "Universal Notice" to the parent and shall: ~~obtain consent from parent to release confidential information about the youth to the local CSB and the local FAPT;~~ •i. inform the parent of the need for local ~~community~~ Family Assessment and Planning Team review of services; ii. inform the parent of the potential for development of a plan for alternative services, i.e., community-based services; iii. inform the parent that, if admission to the RTF is warranted, the CSB serving the area in which the child resides will need to provide a Certificate of Need for the placement; and • iv. inform the parent~~-~~, if admission to the RTF is warranted, of potential fiscal responsibility for educational services if ~~local community~~ the FAPT develops a plan for alternative services but the parent wishes to ~~maintain the~~ pursue the RTF placement; •b. obtain consent from the parent to release confidential information about the youth to the CSB serving the area in which the child resides and to the FAPT serving the area in which the child resides; and c. refer the youth to the ~~local~~ CSB serving the area in which the child resides. 2. If, during the process of assessment for admission, the RTF determines that the youth meets admission criteria, the RTF shall again refer the youth to the CSB serving the area in which the child resides, i.e., shall inform the CSB of such determination. •	DMAS: Amend regulations to add provider requirement for Level C RTF to obtain consent for release of information and refer youth to the ~~appropriate~~ CSB serving the area in which the child resides and to require that the independent team certifying psychiatric residential treatment will include the CSB serving the area in which the child resides.

COMMUNITY SERVICE BOARD RESPONSIBILITIES Upon ~~notice~~ referral from Level C RTF ~~that a youth has been admitted~~, the CSB shall: 1. immediately refer the youth to the local FAPT, and 2. assess appropriateness of the request for admission. a. If the CSB deems admission to the RTF is appropriate, the CSB will complete the Certificate of Need as soon as practicable but no later than 10 business days from the date of referral from the RTF. b. If the CSB deems admission to the RTF is not appropriate, the CSB will inform the parent and RTF as soon as practicable but no later than 10 business days from the date of referral from the RTF.	~~SEC: Adopt policy that CSB shall refer youth to FAPT upon receipt of notice that child has been admitted to RTF (See Attachment A)~~ DBHDS: Amend performance contracts to require execution of responsibilities as outlined in DMAS regulations regarding independent team certification of admission to psychiatric residential treatment facility.
FAPT RESPONSIBILITIES The FAPT shall review the case and develop an Individual Family Services Plan (IFSP) for the youth. ~~within 14 days of the CSB receipt of referral from the RTF.~~ 1. If the CSB certifies that admission to the RTF is appropriate, completes the Certificate of Need, and the youth is admitted to the RTF prior to the FAPT review, ~~T~~there are multiple options available to the FAPT when reviewing ~~a~~the youth's needs. ~~admitted to a Level C RTF~~These options are as follows: ~~1~~a. FAPT may determine the RTF placement~~, including its educational services,~~ is necessary to meet the youth's needs. If the FAPT so determines: • i. The FAPT shall develop an IFSP for RTF. • ii. The ~~locality~~ CPMT shall assume responsibility for the RTF placement beginning on the date of admission. ~~Local~~ Fiscal responsibility includes payment of the daily cost of educational services and the local match on treatment services. ~~2~~b. FAPT may determine the youth's needs can be met through community based services. If the FAPT so determines: • i. The parent/provider shall assume responsibility for the cost of educational services in the RTF beginning with the first day of placement. • ii. The locality shall assume responsibility for community-based services per the IFSP. • iii. If discharge from the RTF is delayed pending implementation of the IFSP, the locality shall assume responsibility for the RTF placement	SEC: Adopt policy that FAPT shall meet within 14 days of ~~CSB's receipt of notice that child has been admitted to RTF~~a child's admission to the RTF. (See Attachment A) SEC: Adopt policy regarding locality fiscal responsibilities as outlined (See Attachment A)

beginning day 15 post admission through the date of discharge when the IFSP is implemented (i.e., daily cost of educational services, local match on treatment services).

iv. If the parent rejects the services outlined in the IFSP, the parent and/or provider shall assume responsibility for the child's placement at the RTF. The local CPMT appeal process will be available to the parent.

c. If the FAPT fails to meet and/or fails to develop an IFSP within 14 days of the ~~receipt of notice by the CSB that the youth has been admitted~~ admission to the RTF, the ~~locality~~ CPMT shall assume responsibility for the RTF placement beginning on the first day of admission, i.e., payment of the daily cost of educational services and the local match for treatment services.

2. If the FAPT meets prior to the CSB making a determination regarding admission to the RTF (i.e., within 10 business days of the referral from the RTF), the FAPT shall assess the strengths and needs of the child and family. The FAPT and family shall develop an IFSP for appropriate services. If the FAPT determines admission to a RTF is appropriate, the FAPT shall complete the certificate of need with 10 business days of the referral from the RTF to the CSB.

3. If the FAPT meets after the CSB has provided notice to the parent and RTF that admission is not deemed appropriate, the FAPT shall assess the strengths and need of the child and family and develop an IFSP for appropriate services.

ADDENDUM B

RTF-Education Workgroup
February 12, 2015

Nominee	Role/Stakeholder Group
Lesley Abashian	CSA Coordinator
Wanda Barnard-Bailey	Deputy City Manager/VML
Phyllis Savides	Assistant DSS Director/VLSSE
Cristy Gallagher	Parent
Cristy Corbin	Parent
Jamie Molbert	Private Provider
Gail Giese	Private Provider
Michael Farley*	Private Provider
Sandy Bryant	CSB Director/VACSB
Ivy Sager	CSB Director/VACSB
Amy Walters	Family Advocate/Families
Ron Belay	SLAT Member/CPMT/CSU directors
Angie Neely	SLAT Member/CPMT/Schools
Joe Paxton*	County Manager/VACo
Lelia Hopper*	Supreme Court/Judiciary
Karen Kimsey*	DMAS
Paul McWhinney*	VDSS
Paul Gilding	DBHDS
Pat Haymes	DOE
Scott Reiner	Assistant Director, OCS
Susie Clare	Executive Director, OCS

**member of orignial SEC taskforce*

ADDENDUM C

SERVING YOUTH PLACED INTO RESIDENTIAL TREATMENT FACILITIES FOR NON-EDUCATIONAL REASONS AND OUTSIDE OF THE CSA PROCESS

Amendments Based on Workgroup Recommendations
March 19, 2015

Proposed Policy

FAPT Review of Child/Youth Placed into a Residential Treatment Facility

When the parent of a child/youth ~~has been placed by his/her parent~~ seeks admission into a residential treatment facility (RTF) through a process other than through the Family Assessment and Planning Team (FAPT) the child/youth shall, with parental consent, be reviewed by the FAPT.

Upon receipt of referral from an RTF, i.e., notice by an RTF that a parent seeks admission of a child/youth ~~has been admitted~~ to the RTF outside of the FAPT process, the local CSB shall refer the child/youth for assessment by the FAPT. If the child is admitted to a residential treatment facility prior to FAPT review, t~~T~~he FAPT shall, in accordance with §2.2-5209, assess the youth within 14 days of the ~~CSB's receipt of notice of the~~ child/youth's admission to the RTF and shall develop an Individualized Family Services Plan (IFSP) for services appropriate to meet the needs of the child/youth.

If the FAPT determines that residential treatment is the most appropriate service to meet the needs of the child/youth, the CPMT shall authorize necessary funding for the RTF beginning on the date ~~the CSB received notice from the RTF~~ of admission.

If the FAPT determines that the needs of the child/youth can be appropriately met through services other than residential treatment services, the CPMT shall authorize necessary funding for the RTF beginning on day fifteen (15) of the RTF placement until the date services in the IFSP are initiated.

ADDENDUM D

Non-CSA Residential Placements Workgroup
LIST OF REFERENCE DOCUMENTS

A. 2011 CSA Biennial Plan *(Excerpt: Goals and Strategies)*

B. SLAT Report to SEC (June 20, 2014)

C. SEC Retreat, June 20, 2014, Group 1 Notes

D. Online Survey Results: Service Access Under the CSA

E. Projected Fiscal Impact of Funding Non-CSA Residential Placements Through CSA (October 30, 2014)

F. Projected Local Fiscal Impact v2; Non-CSA Medicaid Funded Parental Placements into Residential Treatment Programs (Dec 15, 2014)

G. Projected Fiscal Impact of Funding Non-CSA Residential Placements Through CSA, Revised 12/15/2014

H. Taskforce Recommendations to SEC, December 18, 2014 *(with SEC amendments)*

I. Memorandum Soliciting Workgroup Members

J. Workgroup Members

K. Cross-systems Eligibility Criteria

L. RTC Admission Flow: Current and Proposed

M. Workgroup Minutes: February 12, February 25, March 4, 2015

REFERENCE DOCUMENT A

Goals and Strategies

1. Support implementation of a singular, unified system of care that ensures equal access to services for at risk youth across the Commonwealth.

Strategy	Responsible Body	Dates
1. Review and revise the policies of child serving agencies that govern the use of funds (e.g., CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative) to align: • service criteria • assessment • authorization • utilization review	SEC (via SLAT)	1/1/2013-6/30/2014
2. Ensure protected, i.e., "non-mandated," allocations are utilized for youth who are included in the target population but who are not otherwise eligible for mandated services.	SEC	7/01/2013-6/30/2014
3. Support local development of services through state facilitated collaborative meetings between regional representatives and private providers.	SEC Finance Committee	10/1/2012-6/30/2014
4. Review, revise, recommend policy and/or statute to enable development of new services which will address identified service gaps.	SEC Finance Committee	
5. Examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process, e.g., • Medicaid match • Family-of-one eligibility • Education costs	SEC (via SLAT)	1/1/2013-6/30/2014
6. Support cross-secretariat leadership (i.e., HHR, Education, and Public Safety) on practice issues for the delivery and assessment of children's services at the state level.	SEC	1/1/2013-6/30/2014

2. Support informed decision making through utilization of data to improve child and family outcomes and public and private performance in the provision of services to children and families.

Strategy	Responsible Body	Dates
1. Enhance collection, analysis, and utilization of appropriate client level data to enable comprehensive analysis of needs, services, providers, and outcomes.	OCS	11/1/2012-6/30/2014
2. Improve availability of meaningful data via CSA statistics web page.	OCS	1/1/2013-6/30/2014
3. Develop and implement training for users to sustain data systems.	OCS	1/1/2013-6/30/2014

3. Improve the operational effectiveness of CSA administration.

Strategy	Responsible Body	Dates
1. Support a comprehensive internal audit program designed to evaluate financial and programmatic processes and provide consultation and recommendations for improvement.	OCS	7/1/2012-6/30/2014
2. Enhance the engagement of CPMT representatives (including parents and private providers), juvenile judges, school superintendents, government administrators, and elected leaders in local administration of the CSA through increased opportunities for education regarding the CSA.	SEC	10/1/2012-6/30/2014
3. Update CSA Manual for increased usability.	OCS	7/1/2012-4/30/2013
4. Enhance fiscal and data reporting requirements to reduce local administrative burden and improve utilization of data for program evaluation and improvement.	OCS	1/1/2013-6/30/2014
5. Implement robust training plan	OCS	7/1/2012-6/30/2014
6. Build/enhance a systemic culture of collaboration across state and local CSA stakeholders through technical assistance in team building, communication, consensus building, etc.	OCS	7/1/2012-6/30/2014

7.	Enhance collaboration between SLAT and SEC through annual joint meeting for review of strategic planning initiatives.	SEC	9/20/2012-6/30/2014

Estimated Costs

The goals and related strategies identified in this plan will be implemented through the budget of the Office of Comprehensive Services. The Office will utilize approximately $1 million in general fund for data integration, analysis, and reporting activities in FY2013.

REFERENCE DOCUMENT B

Presented to SEC
6/20/2014

SLAT Review of SEC Strategic Plan Goal:

"Examine and Address Inadvertent Fiscal Incentives for Residential Placement, Parental Placement, Avoidance of FAPT/MDT Process"

I. BACKGROUND:

A. This was the second of two goals in the SEC strategic plan that the SLAT was tasked as the "responsible body" to address by June 30, 2014.

B. SLAT began examining the issues in December, 2013, and sought input from agencies and staffs represented on the SLAT to provide examples for examination. We would accept any examples, and specifically asked for data related to –

- Medicaid match
- Family-of-one eligibility
- Education costs
- Adoption subsidy

C. The only issue that was presented for examination was related to educational costs, as follows:

1. A presentation to the March 24, 2104, SEC meeting by VCOPPA and VAISEF as a "statement of inadequate comparable education services for children admitted to residential facilities for non-educational reasons."
2. The presentation ended with, "As we explored this issue during the 2014 Session with the many numerous stakeholders, it appeared the most desirable outcome was to find a way for these children to become eligible for CSA funding as soon as possible for their educational services."
3. The essence of the problem was the amount of educational services provided to residential clients not placed through a locality's CSA program for which providers were not being compensated. The extent of the problem is having a negative impact on sustaining quality services.
4. SLAT was directed to examine this issue as it related to the strategic plan.

II. SLAT REVIEW:

A. Data was provided by DMAS on the number of children in Level C residential facilities each year from 2008 thru 2013 as placed through a locality's CSA or not. For the last three years, 30% to 33% of these placements (roughly 500 children) were made without CSA involvement. The DMAS presentation included that when these families initially contacted residential providers, the providers commonly redirected these families to their local CSA program for service planning and approval.

1. We do not know how many of these children are being served without payment for their educational services.
2. The charge for monthly residential educational services is around $3,000.

B. There is a lack of clarity on the circumstances for placements made without CSA involvement; therefore, the following comments are highlights of the discussion by SLAT members and those in attendance:

1. How is addressing this issue relevant to the SEC strategic goal to, "Support implementation of a singular, unified system of care that ensures equitable access to quality services for at-risk youth across the Commonwealth"? The responses are:
   a. Education is essential and required in the care of at-risk youth.
   b. There is uncertainty as to the specific responsibility of local CSA programs to fund all children placed.
   c. Need to examine if access to care should be designed as a singular (i.e., only one way to do it) process or as a flexible process to accommodate a variety of circumstances.

2. Why are children placed without local CSA involvement?
   a. Knowing why would help shape ideas on what needs to be done.
   b. The assumptions ranged from the possibility that families are not aware of support options or families that chose to take full responsibility for treatment services independent of government intervention/assistance to the possibility that localities' CSA programs do not qualify these families as eligible for CSA support.
   c. If local CSA programs are concluding that these children do not meet CSA criteria, is it due to appropriate use of the code or to a misapplication of CSA guidance?

3. Ethical and practical concerns:
   a. Providers shared their dilemma –
      - To feel compelled to admit a child who meets medical necessity despite the absence of a locality's CSA approval.
      - To continue serving a child without a locality's approval despite challenges by licensing/accreditation to be cited for "unacceptable placements".
   b. Local CSA programs feel they are –
      - Complying with state requirements in how they serve their at-risk youth population through an appropriate use of multi-disciplinary teams. The value of a local CSA program is to maximize both the effectiveness and efficiency of a collaborative service planning and management process. However, this problem is presented with an emphasis "to find a way for these children to become eligible for CSA funding" and not enough emphasis on the principles of CSA, i.e., assessment and service planning to maximize use of nonresidential services.
      - Being forced to accommodate funding for services in which they were not involved in the decision-making process.

   c. Families with these children represent the entire socio-economic spectrum and start with far too little knowledge of what services are needed, available, and how to access them. A solution needs to include ways for families to be fully and easily informed so they can make good decisions and get services in a timely manner for all levels of treatment.

4. Local capacity and capability: Local resources to case manage, conduct FAPT meetings, and maintain standards of utilization reviews and utilization management is already fully used. If CSA is expected to absorb an additional 500 clients, extra consideration will need to be given to determine how to increase local resources.

5. This issue was a good use of SLAT resources. It provided a means for expression of a variety of opinions. Unfortunately, more time is needed for a discussion to be able to determine the practical value of suggested actions and comments. For example, here are a variety of comments made:
   - CSA Coordinators value the utilization review requirements of CSA.
   - CSA Coordinators believe local systems do not have the capacity to manage additional referrals to FAPT. This would represent a request to "do more with the same resources."
   - CSA coordinators believe private providers should not admit youth into residential treatment programs without funding for educational services.
   - Private providers and DMAS expressed that families report failed attempts to access services through the CSA process and call seeking assistance.
   - Private providers expressed that refusing to admit youth who meet medical necessity for residential treatment due to financial reasons (e.g., lack of funding for education) conflicts with ethical and licensing/accrediting requirements.
   - Parent representatives expressed a lack of knowledge by many families that CSA exists or how to obtain assistance through CSA within their locality.
   - Require certificate of need to be completed only by FAPT

- Establish new fund stream for educational services
- Seek additional administrative funding for local operation of CSA
- Provide education to families regarding CSA
- State provide clarification of intent, values, ethical responsibilities for serving youth
- Local school divisions assume responsibility for teachers/educational services in residential facilities
- Use CSA teams as the Independent Certification team since the CSB's aren't consistently able to meet that demand or offer the educational funding.
- Establish one location for obtaining the certificate of need to be consistent with the system transformation initiatives and allows the locality to manage the service array for the person and possibly avoid a placement, it would also allow one source of coordination contacts for Magellan to assist in care coordination.
- Pursue flexibilities with educational funding through legislative initiatives.

6. Given the complexity of this issue, the SLAT would like to continue its examination to ensure both local and state level stakeholders have an effective mechanism to share concerns and to work together to solve problems.

REFERENCE DOCUMENT C

SEC RETREAT
JUNE 20, 2014
GROUP 1 NOTES

Background Information

1. *See "Background-Creation of the Comprehensive Services Act"*

2. Virginia amended its Medicaid state plan in 2000 to enable the use of federal dollars to support residential and treatment foster care placements. The intent of this change was to reduce state and local expenditures under the CSA for services that are eligible for Medicaid funding.

3. The potential for a "cost shift" to DMAS was recognized. *"There must be a verifiable way to ensure that CPMTs don't cost shift to the DMAS by encouraging private referrals in order to avoid the local match."*[1] There is not a mechanism in place to identify when private referrals are encouraged.

4. There is fiscal incentive to a locality when parents make direct placements to residential programs without FAPT involvement, i.e., the locality does not pay education and does not pay the "local Medicaid match" on the treatment services.

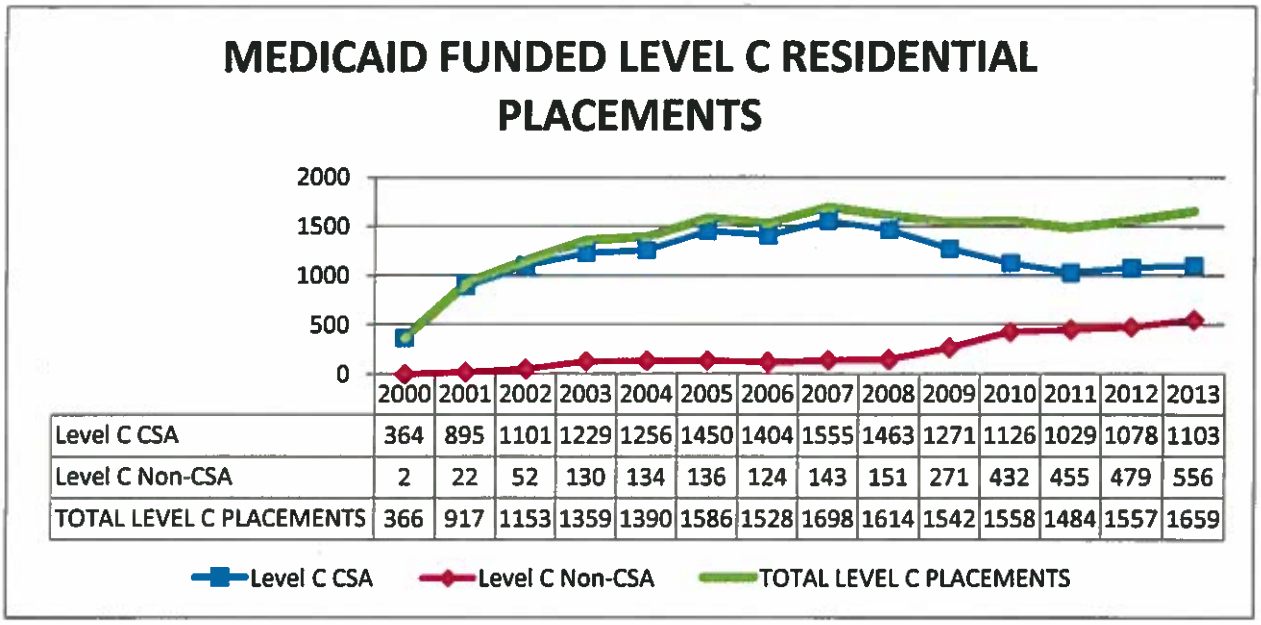
Notes:

1. The availability of Medicaid funds for services (especially those services previously funded under the CSA) has resulted in the functional operation of two separate "systems of care" by which Virginia's children may access behavioral health services. This is contradictory to the SEC strategic goal to "support implementation of a comprehensive system of care that provides equitable access to quality services for all youth" and is counter to the overall mission of the CSA ("to create a collaborative system of services and funding ..."). See table below for comparison:

PUBLICLY FUNDED BEHAVIORAL/MENTAL HEALTH SERVICES FOR CHILDREN IN VIRGINIA		
Services available	**Medicaid funded**	**CSA funded**
Multi-disciplinary community planning		X
Family supports & prevention services		X
Outpatient services	X	X
Intensive In-Home	X	X
Therapeutic Day Treatment	X	X
Mental Health Skill Building	X	X
Case management/Targeted case management	X	X
Intensive Care Coordination		X
Residential treatment clinical services	X	X
Residential treatment – educational services		X

[1] *CSA/Medicaid Community Bulletin, Vol. 2, September 1998*

2. Level C residential placements funded by Medicaid are displayed below:



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Level C CSA	364	895	1101	1229	1256	1450	1404	1555	1463	1271	1126	1029	1078	1103
Level C Non-CSA	2	22	52	130	134	136	124	143	151	271	432	455	479	556
TOTAL LEVEL C PLACEMENTS	366	917	1153	1359	1390	1586	1528	1698	1614	1542	1558	1484	1557	1659

3. Funding streams should not drive the system of care and access to services. Fund streams should be viewed as the resources available to enable implementation of effective service plans.

4. A child may receive progressively more intensive services through Medicaid funding and never become involved with the CSA system. The child can rise to the level of residential treatment without ever having the benefit of community planning and access to "non-medical" services, i.e., the family support services that are available through CSA.

5. As reflected in roundtable discussions and comments at SLAT, local CSA representatives have expressed the following:
    a. There is belief that children funded through Medicaid without the benefit of CSA involvement may rise to higher levels of care (as compared to those in the CSA system) due to the lack of community-based planning and supports and a lack of access to a broad array of prevention/family-based services (including Intensive Care Coordination).
    b. CSA Coordinators value the utilization review requirements of CSA and believe such activities are important to appropriate delivery of services.
    c. Local systems do not have the capacity to manage additional referrals to FAPT. This would represent a request to "do more with the same resources."
    d. CSB and CSU case managers do not refer children to FAPT for multidisciplinary planning when community-based services might be needed and appropriate to serve the child and family. Comments include:
    - Referrals are made by CSB and CSU staff only when residential services are needed.
    - CSB and CSU staff do not want and/or are not able to assume case management for the child/family

  - CSB and CSU staff do not want to deal with the hassle of CSA requirements (e.g., completing CANS, conducting utilization review, attending FAPT).
- There is belief that private provider referrals to FAPT are not appropriate because private providers are in a position to make a profit by referring clients to CSA.
- There is belief private providers should not admit youth into residential treatment programs without funding for educational services; however, the referral to FAPT at the point a child is determined to meet medical necessity for residential treatment is not felt to be appropriate for the following reasons:
  - It is too late for referral at this point as FAPT isn't familiar with child and has not had the opportunity to provide less restrictive services,
  - Families are already committed to their child receiving residential services and may not be amenable to considering less restrictive services.

6. Per roundtable discussions and comments at SLAT, many local CPMTs do not allow referrals to FAPT by any entity other than one of the public child-serving agencies. Thus, children and families may not have easy entry into the CSA system.

7. As reflected by survey results, some local CSA teams acknowledge the appropriateness of residential treatment but instruct families to make direct parental placements through the private provider. (See on-line survey results - Q5, Item 6)

8. Per roundtable discussions and comments at SLAT, private providers express lack of understanding of local CSA practices and how to assist families access help through CSA. There is significant variation across localities with regard to CSA processes.

9. Per roundtable discussions and comments at SLAT, parent representatives expressed a lack of knowledge by many families that CSA exists or how to obtain assistance through CSA within their locality.

<u>Potential strategies</u>

1. DMAS require that the certificate of need for Level C residential treatment must be completed by the FAPT.

   Pros:

   a. ensures community involvement in the service plan...opportunity for provision of less restrictive services, implementation of Intensive Care Coordination, discharge planning, and community supports upon discharge.

   b. creates "single door" access (returns system to the CSA design that existed prior to the Medicaid state plan amendment which enabled use of federal dollars for residential treatment)

   c. eliminates the circumstance that child is placed without funding for education.

Cons:

a. Additional referrals to local CSA teams.

b. Potential fiscal impact to local governments for provision of community-based services not currently being provided and/or the educational costs and Medicaid match associated with residential placement. *This fiscal impact this is consistent with original intent for shared funding when Medicaid plan was revised to allow use of federal funding. The fiscal impact may be reduced in the longer-term based on evidence that earlier intervention is likely to reduce need for future more costly services.*

c. The structure does not exist to ensure access to the CSA team for youth who are/may be "on the path" the residential treatment. Statute provides local CPMTs the authority to establish policies regarding referrals to and review by FAPT.

2. DMAS require that Magellan authorization of Level C residential treatment to be contingent upon review and approval by FAPT. (Pros and cons mirror those listed #1 above)

3. DMAS require the CSB to refer a child to FAPT if the VICAP supports intensive community-based services (e.g., intensive in-home, therapeutic day treatment, mental health skill building).

Pros:

a. provides early access to community-planning and family based/prevention oriented services and interventions.

b. particularly if implemented with strategy #1 or #2, creates "single door" entry to services and supports a singular, unified system of care not defined by the funding stream used for services.

c. works within local policies that restrict referring sources to public child serving agencies.

d. is consistent with evidence that the provision of prevention services will reduce reliance upon more restrictive and costly residential services.

4. Conduct public information campaign to increase awareness of CSA and how to seek assistance for children and youth with behavioral health needs. There are opportunities to partner with non-profit organizations (Voices, NAMI, etc.).

5. Establish 100% state funding source for educational services for youth placed into Level C residential treatment through non-CSA processes.

Pros:

a. Eliminates burden on local government human and fiscal resources.

Cons:

a. Institutionalizes a bifurcated systems of care whereby the process by which a family is served and the services available to that family are dependent upon the child's eligibility for funding.

REFERENCE DOCUMENT D

Q1 Which of the following best describes the size of the locality/region for which you are responding?

Answered: 305 Skipped: 0

Answer Choices	Responses	
Very small	6.56%	20
Small	21.31%	65
Medium	34.75%	106
Large	27.21%	83
Very large	10.16%	31
Total		305

Q2 Which of the following best describes the area for which you are responding?

Answered: 305 Skipped: 0

Answer Choices	Responses	
Rural	43.61%	133
Suburban	34.75%	106
Metropolitan	21.64%	66
Total		305

Q3 Name the "CSA Role" in which you serve.

Answered: 305 Skipped: 0

Answer Choices	Responses	
CPMT Member	26.56%	81
FAPT Member	26.89%	82
CSA Administrator/Coordinator/Manager	15.74%	48
UR Specialist	0.98%	3
Case Manager	21.97%	67
Consumer/Consumer Advocate	2.62%	8
Provider (non FAPT/CPMT member)	13.44%	41

Total Respondents: 305

Q4 Name the organization in which you work (i.e., your primary work assignment).

Answered: 305 Skipped: 0

Answer Choices	Responses	
Court Services Unit	9.84%	30
Community Services Board	13.77%	42
Schools	12.79%	39
Social Services	27.87%	85
Parent	2.30%	7
Advocacy Organization	2.62%	8
Private Provider	13.11%	40
Health Department	2.62%	8
County/City Government	4.59%	14
CSA	10.49%	32
Total		**305**

Service Access Under the CSA

Q5 For a youth with significant behavioral/mental health issues, but who is not otherwise involved with CSA (e.g., via foster care or special education) what are your thoughts about each of the following?

Answered: 255 Skipped: 50

	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	Average Rating
1. The parent of this youth would readily know how to seek potential assistance through CSA in our community.	36.47% 93	48.63% 124	11.76% 30	3.14% 8	255	1.82
2. The schools in our community would likely refer this youth to FAPT if the parent was seeking help and made them aware of issues interfering with the youth's functioning outside the school setting.	11.81% 30	31.89% 81	45.28% 115	11.02% 28	254	2.56
* 3. This youth would have a high likelihood of being assessed by FAPT upon referral by a private physician, a private provider, a parent, or a source outside of one of our child serving agencies.	19.92% 50	36.25% 91	33.07% 83	10.76% 27	251	2.35
4. Our FAPT is well equipped to assess this youth's clinical needs and to develop a plan for appropriate care/services (e.g., our team has at least one member with clinical training and/or experience).	0.79% 2	11.11% 28	47.22% 119	40.87% 103	252	3.28
5. This youth is likely to have easy access to a timely FAPT for assessment and service planning if he/she were being discharged from an acute care hospitalization with the professional recommendation for residential treatment services or intensive community-based services.	2.79% 7	19.12% 48	58.57% 147	19.52% 49	251	2.95
* 6. If this youth is eligible for Medicaid and the parent is seeking residential treatment, it is likely the parent would be advised to work directly with a private residential provider to make a direct parental placement.	10.57% 26	37.80% 93	42.68% 105	8.94% 22	246	2.50
7. As a routine matter of course, our FAPT would assess to determine if this youth meets criteria for mandated funding as a Child in Need of Services (CHINS).	3.66% 9	17.48% 43	50.81% 125	28.05% 69	246	3.03
8. This youth is likely to be determined not eligible for funding under the CSA, i.e., is not in the eligible population.	11.93% 29	48.97% 119	32.92% 80	6.17% 15	243	2.33
9. The youth is likely to be determined eligible for "non-mandated" CSA funding in our community.	6.56% 16	34.84% 85	49.18% 120	9.43% 23	244	2.61
* 10. Unless the youth is already being served by one or more of our child serving agencies (e.g., has an open case with an agency), he/she would not be assessed by the FAPT and/or would not be eligible to receive CSA funded services.	12.60% 31	39.02% 96	38.21% 94	10.16% 25	246	2.46
11. Our locality does not utilize non-mandated CSA funding so it is likely this youth would not be assessed by the FAPT and/or would not receive services through CSA in our community.	28.93% 70	47.93% 116	18.18% 44	4.96% 12	242	1.99
12. It is likely our community would require that services to this youth be funded through "Non-Mandated Mental Health Initiative" funds (available through the local Community Services Board) or some other funding stream.	10.25% 25	35.25% 86	47.54% 116	6.97% 17	244	2.51

Q7 For a youth before the court due to delinquency or truancy and who is at risk of out-of-home placement, what are your thoughts about the following?

Answered: 239 Skipped: 66

	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	Average Rating
1. The judge is likely to refer the youth to FAPT.	1.67% 4	23.43% 56	50.21% 120	24.69% 59	239	2.98
2. The judge is likely to support service recommendations made by the FAPT.	0.42% 1	5.02% 12	68.20% 163	26.36% 63	239	3.21
3. The youth is likely to be referred, or to already have been referred, to FAPT by the juvenile court services worker.	3.39% 8	19.49% 46	62.71% 148	14.41% 34	236	2.88
4. The youth is likely to receive services through CSA to prevent out-of-home placement.	1.69% 4	11.81% 28	61.18% 145	25.32% 60	237	3.10
5. It is likely our community would find this youth not eligible for CSA funding, i.e., that the youth is not included in an eligible population.	17.67% 41	57.33% 133	21.12% 49	3.88% 9	232	2.11
6. It is likely our community would find this youth eligible for "non-mandated" CSA funding.	3.04% 7	34.35% 79	55.65% 128	6.96% 16	230	2.67
7. As a routine matter of course, our FAPT would assess to determine if the youth meets criteria for CSA mandated funding as a Child in Need of Services (CHINS).	3.38% 8	13.50% 32	58.23% 138	24.89% 59	237	3.05
8. It is likely our community would utilize VJCCCA or some other funding stream, but not CSA funds, to provide needed services to this youth.	9.25% 21	49.34% 112	38.33% 87	3.08% 7	227	2.35

Provide comments on any of the above items.
Open-Ended Response

Our juvenile court service workers access community based services through means other than CSA such as medicaid and VJCCCA funds frequently. If these funds are not available and/or are not meeting the needs of the child/family, they refer to CSA for additional options for the family. We screen many children via CHINS as an option for funding.

Our Judges are much more likely to refer a case to DSS Foster Care Prevention rather than specifically to FAPT. Many of those cases end up being referred to FAPT, but not because it was ordered by the Judge. As with the previous question, we would use the CHINS checklist to determine eligibility for mandated funding, and if the youth does not meet that criteria, we may determine eligibility for use of non-mandated funding. I cannot think of a case where one of these youth have been referred to FAPT and the Team did not find the child to be included in the eligible population.
no comment

Questions #6 & #7 were judged as likely, but always depending on the specifics of the case.
Not familiar with how CSA provides their funding and who meets the criteria for services bases upon eligibility.

This youth would come into the agency care to obtain services as juvenile court services would not be willing to FAPT this case and work witht the parents. It is not likely that the courts would allow this youth to remain in the home of its parent or make any efforts to prevent out of home placement.

All VJCCCA funds go to our local detention center and programs that they run. The money is not available to any other programs or youth.

Again it is interesting to see the variation from city to city, with one city appearing to be more willing to bring a child into foster care. The judges do appear to utilize FAPT as a resource and may order individauls to follow FAPT reccomendations.

If the youth is under the supervision of the court due to truancy, the Code requires a FAPT convene. However, it is likely the CSU would fund services through VJCCCA if an out of home placement wasn't deemed necessary. In that case the child would need a mandate CHIN Services) to receive CSA funds.

Our court workers rarely bring cases to FAPT. They use medicaid & 294. If they bring a case, it is usually in very bad shape and not much preventive was done before the situation got out of control.

We actually provide FAPT meeting times slots to the Judges each month because they order families to FAPT so often on CHINS and delinquincy cases. A staff person attends court once per month in one locality just to sit in and explain FAPT to families on "CHINS" day. There are many downsides to this but overall it seems to improve access to FAPT for families and promote communication with the courts. We could use our non-mandated money a little better than we do but there are several cases where it is utilized. We have not policy stating that we can't use it, though in one locality our mandated allocation has decreased significantly over the years despite rising costs and when we are over local budget signficantly utilizing non-mandated funds is not a priority. Our Office on Youth manages VJCCCA funds for our CSU. Court involved use readiliy access those funds for services. Once the case becomes CSA and we start funding then that source is no longer available. We do use PSSF and other funding streams when we can but really these other sources, outside of Medicaid, do not have funds to provide high level intensive services.

1. May not be LIKELY but it has occurred. If the youth had other behavioral mental health issues, then this youth would be eligible for CSA covered services. If delinquency and truancy were the sole issues, then the child would not meet criteria.

Regarding #5 and #6 FAPT would assess eligiblity based on the facts of the case.

We would look at all funding sources, eligibility, and Medicaid depending on the age and other safety issues.

If another funding stream is available and appropriate, that funding stream would be explored and utilized prior to using any CSA funds.

Of course VJCCCA funds would be pursued for this child, but in our small locality it is likely that funding would not be available.

The judges in our locality refer cases to FAPT on a regular basis. The main problem we are having in our locality with our Court Service Unit is their delay in bringing cases before our FAPT because the cases have not been adjudicated. Many of these cases are youth who truly need services in a timely way but the Probation officers refuse to move beyond their regulations.

If there is another funding source available, we make every effort to use it.

All other sources of funding are utilized before CSA funds are used; however, funding is not a criteria used to determine whether services are necessary.
It all depends if the youth is on probation

The parents that I work with their youth are already in detention and have stated that they did not know how to access the services and at this point they are frustated, unwilling and lack the trust to participate in services.

VJCCCA funds in our area are not accessed for the reason above. These funds are earmarked to be used for programs through the CSU which are consider for appropriateness before accessing CSA funds.

As a private provider not familiar with FAPT procedures, I can only guess at the above questions since there was not an option for don't know.

When VJCCCA funding is used, the youth is not usually referred to FAPT unless there are additional non-funded services that are recommended.

It is very likely we would use VJCCCA funds, but not to the exclusion of CSA funds.

In our community, juvenile services workers typically use other funding streams for community based services, to include Medicaid, for such youth and avoid referrals to FAPT. I believe this is more the choice of the CSU workers than it is a function of the CSA/FAPT.

Our Judge initially refers truancy cases to the Truancy Prevention Team for staffing and recommendations.

when I stopped laughing about getting a nickle out of VJCCCA, and focused on other funding streams I would agree that the other service providers would work to find resources or donate services to help the youth.

This community does not the availablity of VJCCA funds for services other than outreach detention services.

#4 & #5 - The answers to these two are dependent on the circumstances. If the youth is a CHINSupervision, has a judge placed DSS "on notice" for a risk of out of home placement in order to make the youth "eligible" for CSA funding? Also, a youth can be a CHINServices without DSS being placed on notice based on the CSA checklist. #6 - With a little over $20,000 in non mandated funded , it does not allow our locality to offer much in the way of non mandated services. This really is a case by case question. #8 - Our locality does have access to VJCCC funds for services. These dollars fund a position.

In this locality the FAPT serves at the Interdisciplinary Team so all CHINSup cases are ordered to the Team by the Court. If this locality had two separate teams, most likely no, or few, cases would be sent to FAPT by the Court.

Currently their is debate in our area over these children, as should they go to court due to truancy individuals at FAPT are stating that is a CHINS-Child in need of supervision not CHINS-Child in need of services and therefore ineligible for mandating funding, and with a lack of non-mandated funds these children are not being served through CSA at this time.

I'm not certain I know what is being referred to by "non-mandated" CSA funds.

We are gradually increasing our use of community based services and wrap around approach to prevent out of home placement. The courts often refer cases to FAPT to assess. The courts have an MDT team which reviews cases that need to go to FAPT for residential or community-based services. We have utiized CSA placement agreements when appropriate. If a child has a mental health need we would review the case. If the child has conduct behaviors which preclude them from being integrated into the mental health population, it is most likely they will be determined to be inappropriate for any of our service providers and it limits our ability to service the youth via CSA. Providers have been driven to provide Medicaid funded services and while conduct disorder has been in the DSM-IV diagnoses, it is not considered a medicaid eligible diagnoses if it is the primary diagnosis. Our state sadly lacks adequate resources for this population. In most cases, the conduct disordered youth has suffered underlying trauma that is masked by the behavioral disorder. Thus, we completely overlook the underlying needs because they are so skilled at covering it up and pushing people away, being repeatedly rejected, etc.

I co not find local jduiges aware of their ability to access FAPT

Our system of care has the ability to complete a needs assessment fort he purpose of planning for a youth. In addition our community has a youth review team who reviews youth who are at risk of residential, have multiple treatment failures or there is no knowledge of the youth' sand families needs or desires.

I am unaware of the requirements for #6 are and I don't know what VJCCCA is.

Once again, if VJCCCA funds are available and appropriate, then Westmoreland CSA would utilize those funds, but it is not an one "instead" of another, but a collaborative effort.

I don't have much experience with 'non-mandated' CSA funding so I did not respond to those statements. Again, each county will handle differently

#3 It is more likely that our court would order foster care prevention services through D.S.S. and require a report be submitted back to the court before the next court hearing. No action by the C.S.U. would be needed.

Judge would order child to TPT (Truancy Prevention Team) to address Truancy Issues.

As a CHINS worker I often found that VJCCCA funding was not able to be used for clinical services for a child found to be a CHINS Supervision case. CSA non-mandated funding was available, however.

As I understand it, we attempt to utilize all appropriate funding streams and assess the case after a family resource meeting, when a fuller understanding of needs has been determined and a plan of intervention developed. It is unusual for a youth to come to court based only on truancy, as we work with multidisciplinary teams to determine other interventions, and/or cases are diverted at intake if truancy is the sole issue. We would not rule out eligibility on the face of the case, but would need much more information to make a determination of whether or not the youth is eligible for CSA funds.

question 3: our CSU rarely brings cases that are not FAPT court ordered. Our CSU refuses to case manage most CSA funded cases, unless FAPT has been court ordered. Our judge, thankfully, court orders cases to FAPT regularly. FAPT then staffs the case, makes recommendations, and reports the recommendations back to the court. question 6: it depends, if the child meets the CHINS checklist/ or has been found CHINS(services) by a court order then the child is mandated. If not, then non-mandated community cased services are utilized.

Number 8 is double-barrelled as well. If VJCCCA money is not available, then CSA would be used.

#8. If VJCCCA funds are not available CSA funds would be accessed.

The local CSU prefers to utilize alternate funding streams but will bring cases before the FAP team. Our judges will order cases come before the FAPT but are more likely (in a case like this) to order DSS Foster Care Prevention Services. Then coming before the FAPT is a joint effort.
juvenile court services worker may bring a delinquency child public school system would bring a truancy case

Again, questions are misleading and tend to support an answer that reflects silos or splitting. Quite the contrary, we provide a full range of services by our agencies in collaboration. FAPT is only sought when all other options are no longer available. Cases do not come to FAPT to resolve this, they only come after this (i.e., all other funding options, services) has occurred.

We only use VJCCCA for Shelter court and outreach detetnion. Many truancy and CSU youth come to FAPT for staffings, case guidacne adn support- not just funding. We view FAPT as a tool and asset in our community- not money!!!

5. If the youth is involved with one of the child serving agencies a FAPT referral can be made.

it really depends on the judge and his order to the juvenile staff and the FAPT team.

These cases are sent to our Interdisciplinary Team with recommendations to the court. Re: #8 - These funds would have been utilized before coming into CSA.

VJCCA funding could be considered, but youth is now 18 and ineligible for CSA funded services.

We simply do no get enough VJCCCA money to serve many children. We exhausted this money in about mid-year. We take our judge seriously and at least try to get Medicaid services or maybe invite the family to join in community, non-profit activities. If he really wants services, he will find the child to be a CHINServices. So far, he has approved all our recommendations and has not asked for additional services.

Our CSA would pick up the bill. Courts refer the children to us. We have explained how to use the MHI funding to the CSB. No response.

REFERENCE DOCUMENT E

PROJECTED FISCAL IMPACT OF FUNDING NON-CSA RESIDENTIAL PLACEMENTS THROUGH CSA

NON-CSA			CSA PLACEMENTS		
PER DIEM COSTS					
Residential Education	$	**160.00**			
Parent/private provider pay	$	160.00	State Match (65%)	$	104.00
State and Local share	$	-	Local Match (35%)	$	56.00
			Residential Education per diem	$	**160.00**
Combined Residential Services					
Federal Match (50%)	$	196.75	Federal Match - 50%	$	196.75
State Match (DMAS) (50%)	$	196.75	Effective Residential State Match (28%)	$	110.18
Local Match (0%)	$	-	Effective Residential Local Match (22%)	$	86.57
	$	393.50		$	393.50
Total cost of educational services for NON-CSA youth (FY13)					
Number of youth placed		556	**If placed through CSA:**		
Average length of stay per youth (# days = 5/7*200)		142	State share education costs (65%)	$	8,211,008.00
Per diem cost	$	160.00	Local share education costs (35%)	$	4,421,312.00
TOTAL COST (currently borne by parents/providers)	$	**12,632,320.00**		$	**12,632,320.00**
Total cost of combined residential services for NON-CSA youth (FY13)					
number of youth placed FY13		556			
average length of stay per youth (# days)		200			
per diem cost	$	393.50			
TOTAL COST (currently borne by fed and state)	$	**43,757,200.00**			
Federal share-Combined Res Svs (50%)	$	21,878,600.00	Federal share-Combined Res Svs (50%)	$	21,878,600.00
State share (DMAS) -Combined Res Svs (50%)	$	21,878,600.00	State share (CSA)-Combined Res Svs (28%)	$	12,252,016.00
Local share-Combined Res Svs (0%)	$	-	Local share-Combined Res Svs (22%)	$	9,626,584.00
	$	**43,757,200.00**		$	**43,757,200.00**
			FISCAL IMPACT TO STATE:		
			Educational Services	$	8,211,008.00
			Savings: State Share -Combined Res Services	$	(9,626,584.00)
				$	**(1,415,576.00)**
			FISCAL IMPACT TO LOCAL:		
			Educational Services	$	4,421,312.00
			Combined Res Svs	$	9,626,584.00
				$	**14,047,896.00**

NOTE: length of stay derived from CSA data set

NOTE: Fiscal Impacts do not reflect potential parental co-pays

Presented to Taskforce 10/30/2014

REFERENCE DOCUMENT G

PROJECTED FISCAL IMPACT OF FUNDING NON-CSA RESIDENTIAL PLACEMENTS THROUGH CSA (Revised 12/15/2014)

COST AND PAYMENT SOURCE FOR NON-CSA PLACEMENTS

PER DIEM COSTS		
Residential Education (average of rates reported by facilities)	$	*160.00*
Parent/private provider pay	$	*160.00*
State share	$	*-*
Local share	$	*-*
	$	*160.00*
Combined Residential Services (rate established by DMAS)		
Federal share (50%)	$	*196.75*
State share (DMAS) (50%)	$	*196.75*
Local share (0%)	$	*-*
	$	*393.50*
AVERAGE PER DIEM COST FOR LEVEL C RESIDENTIAL PLACEMENT	$	*553.50*

COST AND PAYMENT SOURCE FOR CSA PLACEMENTS

*Parent**/provider pay*	$	*-*
State share (65%)	$	*104.00*
Local share (35%)	$	*56.00*
	$	*160.00*
Federal share (50%)	$	*196.75*
Effective Residential CSA State share (28%)	$	*110.18*
Effective Residential Local CSA share (22%)	$	*86.57*
	$	*393.50*
	$	*553.50*

Total cost of educational services (FY13)

Number of youth placed		556
Average length of stay* per youth (# days = 5/7*160)		114
Average per diem cost	$	160.00
TOTAL COST EDUCATION SERVICES	**$**	**10,141,440.00**
Parent/provider cost	$	10,141,440.00
State share (0%)	$	-
Local share (0%)	$	-

Parent**/provider	$	-
State share education costs (65%)	$	6,591,936.00
Local share education costs (35%)	$	3,549,504.00
	$	**10,141,440.00**

Total cost of combined residential services (FY13)

Number of youth placed FY13		556
Average length of stay* per youth (# days)		160
Average per diem cost	$	393.50
TOTAL COST RESIDENTIAL TREATMENT SERVICES	**$**	**35,005,760.00**
Federal share-Combined Residential Services (50%)	$	17,502,880.00
State share (DMAS) -Combined Residential Svs (50%)	$	17,502,880.00
Local share-Combined Residential Services (0%)	$	-
	$	**35,005,760.00**

Federal share-Combined Res Svs (50%)	$	17,502,880.00
State share (CSA)-Combined Res Svs (28%)	$	9,801,612.80
Local share-Combined Res Svs (22%)	$	7,701,267.20
	$	**35,005,760.00**

NET FISCAL IMPACT TO STATE GENERAL FUND:**		
New Cost: Educational Services-State Share	$	6,591,936.00
Net Savings: State Share Combined Res. Svs.	$	(7,701,267.20)
	$	**(1,109,331.20)**

FISCAL IMPACT TO LOCAL:**		
New Cost: Educational Services-Local Share	$	3,549,504.00
New Cost: Combined Res Svs-Local Share	$	7,701,267.20
	$	**11,250,771.20**

→ *represents change per recommended policies and processess*

**length of stay per Magellan Monthly Business Review, reported October 2014*

***fiscal impacts do not reflect parental co-pays collected by locality*

REFERENCE DOCUMENT H

SERVING YOUTH PLACED INTO RESIDENTIAL TREATMENT FACILITIES FOR NON-EDUCATIONAL REASONS AND OUTSIDE OF THE CSA PROCESS

Task Force Recommendations to the State Executive Council
December 18, 2014

PROBLEM STATEMENT

Thirty percent (30%) of Medicaid-funded youth placed into Level C Residential Treatment Facilities are placed by parents outside of the CSA process. These placements lack the benefit of multi-agency planning by the Family Assessment and Planning Team (FAPT) and lack a public source of funding for required educational services.

BACKGROUND

Prior to calendar year 2000, all publicly funded youth placed into residential treatment services were placed through the local CSA team. Effective in January, 2000 Virginia's state Medicaid plan was amended to include coverage for residential treatment services. This action was designed to relieve the fiscal burden on local governments and the Commonwealth through the use of federal funding for such services. The state plan created routes outside of the CSA process for certification of a youth's need for treatment. While these alternative routes ensure Medicaid funding for treatment services, they do not provide for the funding of educational services that are required by the licensing authority to be provided in the treatment facilities.

The State Executive Council, at its April 2014 meeting, directed the Office of Comprehensive Services (OCS) to (i) document the problem of the lack of public funding for educational services for youth who have been placed outside of the CSA process into Level C Residential Treatment Facilities (RTF) and for whom Medicaid funding is authorized, and (ii) identify potential solutions. In response, OCS conducted five roundtable discussions across the state to gather input, collected input through an on-line survey, and facilitated stakeholder problem-solving through the SEC's retreat in June 2014. The retreat's small group provided recommendations to the SEC at the September 2014 meeting. These recommendations were not favorably acted upon. The SEC then appointed a taskforce comprised of SEC members/designees to further review this issue and develop specific recommendations to be provided to the SEC in December 2014.

TASKFORCE DESCRIPTION

The taskforce met on October 30, 2014 with the following SEC members/designees in attendance: Paul McWhinney, Joe Paxton, Michael Farley, Mary Bunting, Karen Kimsey, and Lelia Hopper. Additional attendees included Melanie Bond (CSA Coordinator) and Brad Burdette (LDSS Director) who served as

advisors to the task group. Susie Clare, OCS Executive Director, and Scott Reiner, OCS Assistant Director, facilitated the meeting; Marsha Mucha, OCS Administrative Assistant, provided administrative support.

UNDERLYING PREMISE STATEMENTS

1. Youth admitted to a Level C RTF with authorization for Medicaid funding are presumed to be in the target population identified in §2.2-5211 and are presumed eligible for state pool funds in accordance with §2.2-5212.

    - §2.2-5212(A)(4) Youth are eligible for foster care services per §63.2-905, i.e., the youth is a "child in need of services" who requires services beyond normal agency services or services to prevent or eliminate the need for out-of-home placement (mandated funding), and/or
    - §2.2-5212(A)(1) or §2.2-5212(A)(2) The youth has emotional or behavior problems and requires services beyond normal agency services and/or services by at least two agencies (non-mandated funding).

2. Youth who meet medical necessity criteria for residential treatment services are entitled to services in accordance with 12VAC30-60-50 and 12VAC30-130-860.

3. Medicaid eligible clients have the right to select the provider from which to obtain needed services In accordance with 12VAC30-10-490.

4. The placement of a youth by his/her parent into a Level C Residential Treatment Facility (RTF) for non-educational reasons and authorized for Medicaid funding based upon a "non-CSA" Certificate of Need is considered to be an "emergency placement" in accordance with §2.2-5209.

RECOMMENDED PROCESS	ACTION NEEDED
At time of admission to an acute care facility, the acute care facility shall: • obtain consent from the parent to release confidential information regarding the youth to the local CSB and local FAPT; • refer the youth to the local CSB.	DMAS: Amend regulations to add provider requirement for acute facilities to refer admitted youth to the local CSB for discharge planning. <u>Recommended actions:</u> Amend §16.1-338 C, 16.1-339 C: require referral to CSB following voluntary admission to psychiatric facility of consenting and objecting minors. Amend § §16.1-338 C and §16.1-339 C 2: Require CSB to engage in discharge planning for minors admitted to acute psychiatric

Stricken language reflects amendments by the State Executive Council, Dec. 18, 2014

	facility: Amend paragraph 2 or add a new section that applies to both voluntary and involuntary commitments and sets out more fully what is expected from the CSB and why this coordination is established in relation to funding through CSA.
At the time of admission to a Level C RTF, the RTF shall: • obtain consent from parent to release confidential information about the youth to the local CSB and the local FAPT; • inform the parent of the need for local community review of services; • inform the parent of the potential for development of a plan for alternative services, i.e., community-based services; • inform parent of potential fiscal responsibility for educational services if local community develops plan for alternative services but parent wishes to maintain the RTF placement; • refer youth to the local CSB.	DMAS: Amend regulations to add provider requirement for Level C RTF to obtain consent for release of information and refer youth to the appropriate CSB.
Upon notice from Level C RTF that a youth has been admitted, the CSB shall immediately refer the youth to the local FAPT.	SEC: Adopt policy that CSB shall refer youth to FAPT upon receipt of notice that child has been admitted to RTF (See Attachment A)
The FAPT shall review the case and develop an Individual Family Services Plan (IFSP) for the youth within 14 days of the CSB receipt of referral from the RTF.	SEC: Adopt policy that FAPT shall meet within 14 days of CSB's receipt of notice that child has been admitted to RTF (See Attachment A)
There are multiple options available to the FAPT when reviewing a youth admitted to a Level C RTF: 1. FAPT may determine the RTF placement, including its educational services, is necessary to meet the youth's needs. If the FAPT so determines: • The FAPT shall develop an IFSP for RTF. • The locality shall assume responsibility for the RTF placement beginning on the date of admission. Local responsibility includes payment of the daily cost of educational services and the local match on treatment services. 2. FAPT may determine the youth's needs can be met through community based services. If the FAPT so determines: • The parent/provider shall assume responsibility for the cost of educational services beginning with the first day of placement. • The locality shall assume responsibility for community-based	SEC: Adopt policy regarding locality fiscal responsibilities as outlined (See Attachment A)

services per the IFSP. • If discharge from the RTF is delayed pending implementation of the IFSP, the locality shall assume responsibility for the RTF placement beginning day 15 post admission through the date of discharge when the IFSP is implemented (i.e., daily cost of educational services, local match on treatment services). • If the parent rejects the services outlined in the IFSP, the parent shall assume responsibility for the child's placement at the RTF. The local CPMT appeal process will be available to the parent. ~~3. FAPT may determine the RTF is necessary to meet the youth's needs, but that the school division can provide educational services to the student at the RTF. If the FAPT so determines:~~ ~~• The locality shall assume responsibility for the RTF placement beginning with the 1st day of admission, i.e., the locality shall assume responsibility for the local match on treatment services and shall assume responsibility for providing educational services to the youth at the RTF.~~ ~~• The parent and/or provider shall assume responsibility for the daily cost of educational services from the 1st day of admission up to the first day of educational services provided by the school division.~~ ~~• If the provision of educational services does not begin on day 15 of admission, the locality shall assume responsibility for the payment of the daily cost of educational services provided by the RTF beginning day 15 post notice received by the CSB through the date educational services by the school division are initiated.~~ If the FAPT fails to meet and/or fails to develop an IFSP within 14 days of the receipt of notice by the CSB that the youth has been admitted to the RTF, the locality shall assume responsibility for the RTF placement beginning on the first day of admission, i.e., payment of the daily cost of educational services and the local match for treatment services.	

ADDITIONAL RECOMMENDATIONS

1. Actions should be taken to improve public awareness of and access to local CSA teams to reduce the number of non-CSA placements into residential programs for non-educational reasons.

2. The recommended SEC policies and procedures should become effective 7/1/2015 for all Level C RTF admissions and re-admissions occurring 7/1/2015 or later.

Stricken language reflects amendments by the State Executive Council, Dec. 18, 2014

3. Policies should not apply to continuing stay placements with admissions made prior to 7/1/2015, except that the RTF shall refer all youth to the local CSB, and the CSB shall refer to FAPT, as part of every youth's discharge planning. Magellan should be tasked with ensuring such referral by the RTF.

4. Should the SEC adopt the recommendations of this taskforce, a workgroup should be established to develop guidelines for implementing proposed policies (see Attachment B).

5. The SEC should amend the "Interagency Guidelines for Foster Care for Specific CHINS" to address the premise that youth meeting medical necessity criteria for residential treatment services are eligible for foster care services as CHINS and are eligible for CSA funding.

ATTACHMENT A

Proposed Policy

FAPT Review of Child/Youth Placed into a Residential Treatment Facility

When a child/youth has been placed by his/her parent into a residential treatment facility (RTF) through a process other than through the Family Assessment and Planning Team (FAPT) the child/youth shall, with parental consent, be reviewed by the FAPT.

Upon receipt of notice by an RTF that a child/youth has been admitted to the RTF outside of the FAPT process, the local CSB shall refer the child/youth for assessment by the FAPT. The FAPT shall, in accordance with §2.2-5209, assess the youth within 14 days of the CSB's receipt of notice of the child/youth's admission to the RTF and shall develop an Individualized Family Services Plan (IFSP) for services appropriate to meet the needs of the child/youth.

If the FAPT determines that residential treatment is the most appropriate service to meet the needs of the child/youth, the CPMT shall authorize necessary funding for the RTF beginning on the date the CSB received notice from the RTF of admission.

If the FAPT determines that the needs of the child/youth can be appropriately met through services other than residential treatment services, the CPMT shall authorize necessary funding for the RTF beginning on day fifteen (15) of the RTF placement until the date services in the IFSP are initiated.

~~If the FAPT determines that residential treatment is the most appropriate service to meet the needs of the child/youth and that the local school division will assume full responsibility for the provision of educational services within the treatment facility, the CPMT shall authorize necessary funding for the RTF beginning on the date the CSB received notice from the RTF of admission and funding for educational services will terminate on the date the local school division initiates educational services.~~

REFERENCE DOCUMENT I

COMMONWEALTH of VIRGINIA

Susan Cumbia Clare, M.Ed
Executive Director

OFFICE OF COMPREHENSIVE SERVICES

Administering the Comprehensive Services Act for At-Risk Youth and Families

TO: Mira Signer, NAMI-Virginia
Cate Newbanks, FACES
Jennifer Faison, VACSB
Catherine Pemberton, VLSSE
Mike Asip, VCASE
Mike Morton, CSU Directors' Association
Debbie Pell, VCOPPA
James Campbell, VACO
Kimberly Winn, VML
Greg Winge, CSA Coordinators Network
Margaret Nimmo Crowe, VOICES
Mary Bauer, Legal Aid Justice Center

FROM: Susan Cumbia Clare, Executive Director
Office of Comprehensive Services

DATE: January 22, 2015

SUBJECT: Workgroup Nominations

On behalf of the State Executive Council for At-Risk Youth and Families (SEC), I am seeking nominations for individuals to represent stakeholder organizations on a workgroup to examine issues related to youth who are placed by parents into Level C residential treatment facilities for non-educational reasons. The SEC seeks review of specific recommendations made by an SEC taskforce appointed to address planning and funding issues for this population. This population includes youth have been placed by their parents, have been authorized for placement and funding through Medicaid, but have not been authorized for placement by the local CPMT. Placements for these youth lack public funding for required educational services and lack the benefits of planning for community-based supports, transition, and/or discharge.

Specifically, the SEC seeks the workgroup to consider a policy implementation date and to address areas of concern around the timeframes for FAPT review of cases referred by treatment facilities and assumption of local fiscal responsibility for approved placements.

In addition to stakeholder representatives, the workgroup will include several members from the original taskforce and state child serving agencies. The workgroup will be co-chaired by Pat Haymes, Department of Education, and Lelia Hopper, Office of the Executive Secretary of the Supreme Court. The workgroup will report its recommendations to the SEC on March 19, 2015. To ensure completion of the work by that time, meetings have been scheduled for February 12,

February 25 and March 4, 2015. In addition to the meetings, it is anticipated that workgroup members will be asked to review materials prior to the first meeting and between meetings.

Please submit up to three nominees from your organization to marsha.mucha@csa.virginia.gov by Friday, January 30, 2015. The workgroup will be appointed by the SEC Executive Committee from the nominees received and, subsequently, specific meeting information will be communicated directly to workgroup members.

REFERENCE DOCUMENT J

Nominee	Nominated by	Role
Lesley Abashian	CSA Coordinators Network	CSA Coordinator
Wanda Barnard-Bailey	VML	Deputy City Manager
Phyllis Savides	VML (member VLSSE)	Assistant DSS Director
Cristy Gallagher	NAMI - Virginia	Parent
Cristy Corbin	NAMI - Virginia	Parent
Jamie Molbert	VCOPPA	Private Provider
Gail Giese	VCOPPA	Private Provider
Michael Farley*	SEC	Private Provider
Sandy Bryant	VACSB	CSB
pending nomination and appointment	VACSB	CSB
Amy Walters	Legal Aid Justice Center	Family Advocate
Ron Belay	CSU Directors Association	CSU director (CPMT)
Angie Neely	OCS (no nominees from VCASE)	Schools (CPMT)
Joe Paxton*	SEC	County Manager
Lelia Hopper*	SEC	Supreme Court
Karen Kimsey*	SEC	DMAS
Paul McWhinney*	SEC	VDSS
Paul Gilding	DBHDS	DBHDS
Pat Haymes	DOE	DOE

**member of orignial SEC taskforce*

REFERENCE DOCUMENT K

CROSS-SYSTEMS ELIGIBILITY CRITERIA

§ 2.2-5212. Eligibility for state pool of funds

A. In order to be eligible for funding for services through the state pool of funds, a youth, or family with a child, shall meet one or more of the criteria specified in subdivisions 1 through 4 and shall be determined through the use of a uniform assessment instrument and process and by policies of the community policy and management team to have access to these funds.

1. The child or youth has emotional or behavior problems that:
   a. Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
   b. Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
   c. Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.

2. The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.

3. The child or youth requires placement for purposes of special education in approved private school educational programs.

4. The child or youth requires foster care services as defined in§ 63.2-905.

Eligibility for foster care services via CHINS

A child may be determined eligible foster care services as a "child in need of services" (CHINS) by the court or by the Family Assessment and Planning Team (FAPT). The FAPT must determine that the child meets both of the following conditions established by the Code of Virginia § 63.2-905:

1. The child is a "child in need of services" in accordance with§ 16.1-228:
   (i) a child whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of the child or
   (ii) a child under the age of 14 whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of another person; however, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be a child in need of services, nor shall any child who habitually remains away from or habitually deserts or abandons his family as a result of what the court or the local child protective services unit determines to be incidents of physical, emotional or sexual abuse in the home be considered a child in need of services for that reason alone.

2. The child:
   (i) has been identified as needing services to prevent or eliminate the need for foster care placement,
   (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or
   (iii) has been committed or entrusted to a local board or licensed child placing agency.

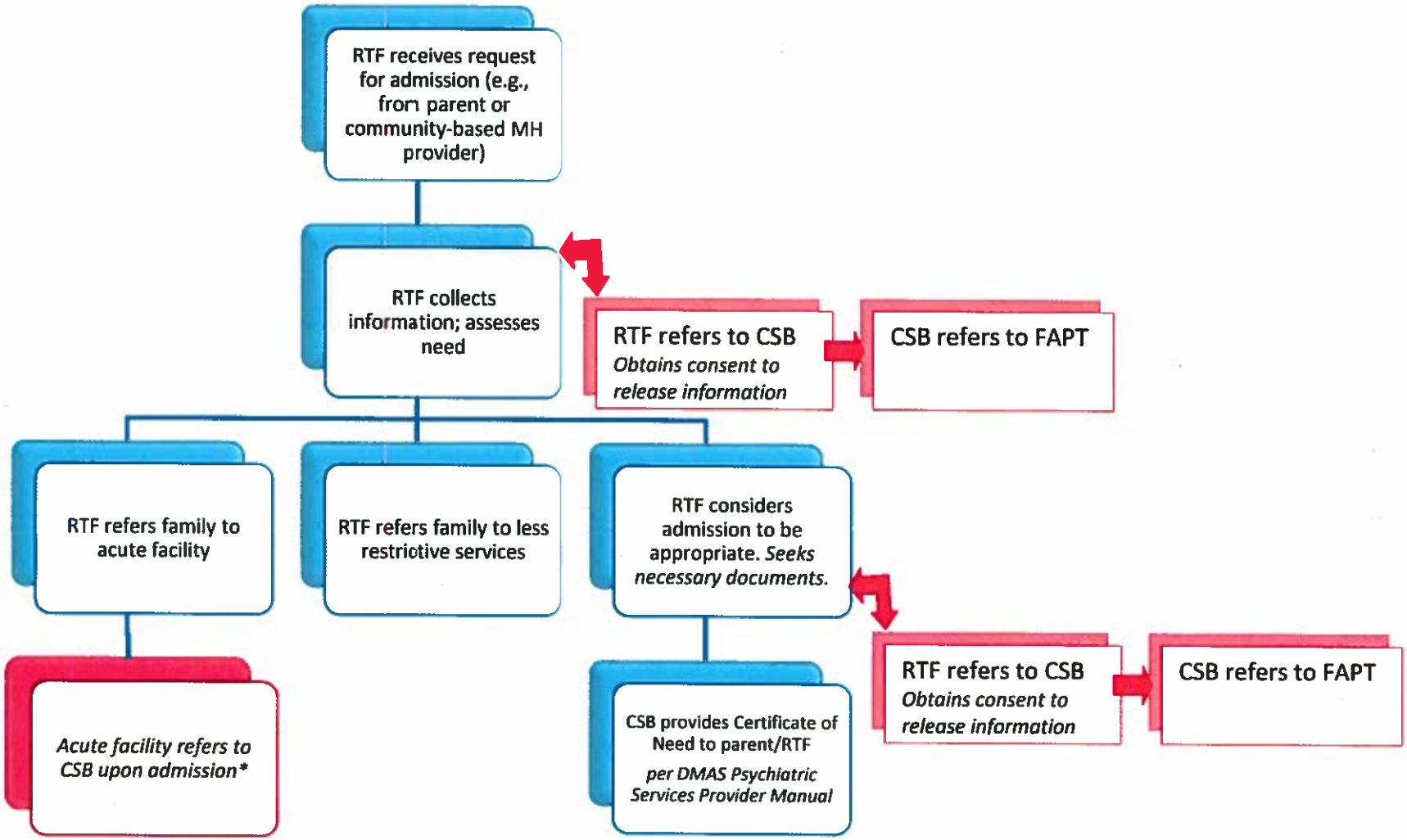
DMAS Eligibility- Level C Residential Treatment

Severity of Illness (both 1 and 2 must be met):

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by DMAS to determine whether a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the individual. *One or more* must be present:
   a. The individual is currently receiving community-based care with evidence of failure at a less restrictive level of care
   b. The individual's identified condition is escalating; or
   c. The individual's condition is a reoccurrence of a previous acute psychiatric condition.
2. Individuals must have been diagnosed with a psychiatric disorder. There must be documented evidence of recent onset of *one or more* of the following conditions:
   a. The individual is unable to function in a less restrictive environment evidenced by dysfunction in interpersonal, family, education, or development;
   b. The individual has a history of acute psychiatric episodes and currently is not making progress or cooperating with the treatment plan in a less restrictive level of care;
   c. There are recent increased threats of harm or aggression towards self or others;
   d. The individual is unable to function safely in the community without jeopardizing the safety of self or others;
   e. There has been recent stabilization of symptoms during a psychiatric hospitalization but the individual needs a structured 24 hour therapeutic environment to prevent regression, solidify gains, and/or further resolve complex psychiatric symptoms; or
   f. Recent outpatient treatment has failed. Ambulatory care resources available in the community do not meet treatment needs because the individual suffers one or more complicating concurrent medical disorders which the family is not effectively addressing (e.g., conduct disorder with seizures, depression with insulin-dependent diabetes mellitus).

REFERENCE DOCUMENT L

Medicaid funded non-CSA admission from community setting to Residential Treatment Facility (RTF)



Blue boxes represent existing procedures.
Red boxes represent proposed procedures.

REFERENCE DOCUMENT M

DRAFT

Non-CSA Residential Placements Workgroup
February 12, 2015
Fellowship Hall, Virginia Home for Boys and Girls
8716 W. Broad Street
Richmond, VA

Attendees:
Lesley Abashian
Wanda Barnard-Bailey (by phone)
Phyllis Savides
Cristy Gallagher
Cristy Corbin
Jamie Molbert
Gail Giese
Michael Farley
Sandy Bryant
Ivy Sager
Amy Walters
Angela Neely (by phone)
Lelia Hopper
Karen Kimsey
Paul McWhinney
Paul Gilding
Pat Haymes

Absent:
Ron Belay
Joe Paxton

Staff:
Susan Clare
Scott Reiner
Marsha Mucha

Guests:
Bill Elwood
Brian Campbell

The workgroup convened at 9:30 a.m. Facilitators for the workgroup were Pat Haymes, Virginia Department of Education and Lelia Hopper, Office of the Executive Secretary, Supreme Court of Virginia. Members were welcomed and introductions were made.

The issue before the workgroup was review of policy and procedures recommended to the SEC for addressing Medicaid funded youth placed in Level C residential treatment facilities outside of the CSA process. The proposed policy and procedures were recommended by an SEC appointed taskforce. This workgroup was established by the SEC to review and advise the SEC on specific areas of concern that arose in SEC discussion of recommendations .

Ms. Haymes presented background information regarding changes in funding and processes over time that have led to the current issue and Ms. Hopper reviewed prior activities to address the issue. (Numerous background materials were provided to the workgroup). Ms. Hopper also presented the charge from the SEC to the workgroup. The workgroup is to consider a policy implementation date and address expressed areas of concern around the timeframes for:

- FAPT review of cases and development of an IFSP for the youth within 14 days of the CSB receipt of referral from provider
- Locality assumption of fiscal responsibilities

Ms. Hopper explained that the workgroup is to provide recommendations regarding the proposed policy and procedures to the SEC at its March meeting. Specific implementation issues that are identified during discussion will be set aside for consideration by a policy implementation workgroup to be

convened at a later date. Ms. Hopper advised that, while language has been proposed in the General Assembly regarding study of this issue, the charge to this workgroup is not altered by the possibility of General Assembly action.

Workgroup members began their discussion by reviewing the underlying premise statements presented by the SEC Taskforce at the December meeting of the SEC. Overall comments reflected on the efforts within the child serving system to reduce residential care, differences in access to local planning and services across the state, and the disparity in access to services between Medicaid eligible youth and other youth. Ms. Hopper noted that these issues were discussed as part of the SEC Taskforce's discussion as well. She further noted that the intent of the SEC Taskforce's recommendations was to ensure that all children have access to the services that best meet their needs, whether residential or community-based. Children accessing services through the FAPT process have a much better opportunity for less restrictive placements and access to more robust community services. The need to reduce residential placements outside of the CSA process was highlighted.

Discussion points included:

- (Taskforce premise #1) If a child meets the medical necessity standard established by Medicaid for residential treatment, that child meets Child in Need of Services (CHINS) criteria, and therefore eligible for CSA and included in the mandated population. A comparison chart of eligibility criteria that was previously prepared and presented to the SEC will be distributed to workgroup members.

- (Taskforce premise #3) Medicaid eligible client's right to select service provider. There is need for implementation workgroup to address potential conflicts with FAPT/CPMT approved providers.

- (Taskforce premise #4) Placements being considered to be an "emergency placement." There is need to reword this statement for clarity that it references definition of emergency placement in CSA Code language. There is need to address circumstances where there is opportunity for review of placement prior to admission.

- Who may issue the Certificate of Need (CON)? DMAS reviewed federal v. state requirements. State requirements can be amended per emergency regulations.

- Requirement for 14-day FAPT following emergency placement. Localities are very concerned about the cost to localities if FAPT were not able to hear the case in a timely manner. Frequency of FAPT meetings varies widely among localities.

- How to better link inpatient psychiatric hospitals to communities for discharge planning purposes. Earlier referrals may enable FAPT review before residential placement occurs.

Next, members began a review of the recommended process and the actions recommended for these cases to access FAPT. Discussion points raised concerned:

- Concern for what would be expected of CSBs – capacity and fiscal impact. This is new role for CSBs, i.e., not part of existing performance contracts. If not the CSB, who will prepare

presentation of case to FAPT? Who does case support? Sandy Bryant will seek capacity and fiscal impact statement from VACSB to accept and process referrals to FAPTs. Need implementation workgroup to define what CSB actions are required to refer a case to FAPT.

- Could funding to CSBs be available through Medicaid targeted case management funds? Other sources (e.g., funding for Case Support through CSA)? These are matters to be considered by implementation workgroup.

- Option for Magellan/MCO to refer to FAPT? Local CSA offices would have to be willing to accept the referrals.

- FAPT review after a placement occurs creates adversarial position with parents if FAPT recommends different services. Parents have the choice to (or not to) access services/funding. The need to work collaboratively with parents is inherent in the work of CSB's.

- Will create challenge to meet 14-day process to have community-based services in place if FAPT decides community-based services are appropriate.

- While the 14-day process does not allow time for assessment and information gathering, considerable information will be available from providers/physicians.

- What about a waiver process so localities wouldn't be penalized if they didn't meet the 14-day timeframe?

- Requests for additional data were made including:

    - Placements by provider to locality (DMAS will provide)
    - Residential placements by locality (included in background materials)
    - Adoption assistance funded RTF placements (data not available)

The workgroup's next meeting is February 25.

DRAFT

Non-CSA Residential Placements Workgroup
February 25, 2015
Fellowship Hall, Virginia Home for Boys and Girls
8716 W. Broad Street
Richmond, VA

Attendees:
Lesley Abashian
Wanda Barnard-Bailey (by phone)
Phyllis Savides
Cristy Gallagher
Cristy Corbin
Jamie Molbert
Gail Giese
Michael Farley
Sandy Bryant
Ivy Sager
Amy Walters
Angela Neely
Lelia Hopper
Karen Kimsey
Paul McWhinney
Paul Gilding
Pat Haymes
Joe Paxton (by phone)

Absent:
Ron Belay
Amy Walters

Guests:
Bill Elwood
Brian Campbell

OCS Staff:
Susan Clare
Marsha Mucha

The workgroup convened at 9:40 a.m. Facilitators for the workgroup were Pat Haymes, Virginia Department of Education and Lelia Hopper, Office of the Executive Secretary, Supreme Court of Virginia. Members were welcomed and introductions were made. Notes from the February 12 meeting were reviewed.

Ms. Haymes reminded members of the issue before the workgroup and the discussion points from the February 12 meeting regarding premises 3 and 4 of the Task Force Recommendations to the State Executive Council (SEC) presented to the SEC at its December 18, 2014 meeting. The workgroup is to consider a policy implementation date and address expressed areas of concern around the time frames for FAPT review of cases and development of an IFSP for the youth within 14 days of the CSB receipt of referral from provider and locality assumption of fiscal responsibilities.

Mrs. Kimsey (DMAS) provided additional information to workgroup members concerning federal and state requirements for issuance of CONs and determination of level of need for placement in an RTF. Mr. Campbell (DMAS) provided data regarding RTF CSA and non-CSA placements by facility, and "new Medicaid eligibles" by locality.

Discussion points included:

- Taskforce premise #3 –
  Concerning a Medicaid eligible client's right to select service provider. There was question about a parent's choice of a non-Medicaid enrolled provider. It was noted that there is always an option for a provider to become an enrolled Medicaid provider.
- Taskforce premise #4 –
  Placements considered to be "emergency placements." The purpose of this premise statement is to establish the legal basis for FAPT review and use of state pool funds after a placement has occurred. Relevant Code Section is §2.2-5209, does not define "emergency placement," but rather addresses the need for FAPT review in 14 days of such placement in order to access pool funds.

  If the workgroup wishes to enable a longer time frame (rather than the 14 days) for FAPT review, statutory change would be required to enable retroactive use of state pool funds. Such recommendation from the workgroup would affect the implementation date of the proposed policy.

  It was suggested that perhaps the language could require a referral to FAPT within 14 days but allow up to 30 days for FAPT to make final service determinations.

- Timely referral to CSB by RTF provider -
  Members of the group discussed preference for cases to be referred to the CSB and FAPT prior to rather than after admission to an RTF, e.g., Could process begin at date of admission to acute care facility as part of discharge planning? It was noted that the proposed process includes referral to the CSB at the time of admission to an acute care facility. It was suggested that the proposed language clearly indicate that the referral to the CSB is for dischange planning consistent with the discharge planning role for temporary detention order (TDO) cases and discharges from state hospitals. It was suggested that the proposed process be amended to require the RTF, when considering admission of a child from the community, to refer the case to the CSB at some point during its admission review. OCS was asked to bring proposed language to the next meeting.

- Parking lot issues -
  Access to FAPTs and/or timely access to FAPT is an issue in some localities even for public agency served youth.

  There is need to increase awareness of and access to CSA. Need for education of private mental health professionals, families and schools.

The next workgroup meeting is scheduled for March 4, 2015.

DRAFT

Non-CSA Residential Placements Workgroup
March 4, 2015
Fellowship Hall, Virginia Home for Boys and Girls
8716 W. Broad Street
Richmond, VA

Attendees:
Lesley Abashian
Wanda Barnard-Bailey (by phone)
Phyllis Savides
Cristy Gallagher
Jamie Molbert
Gail Giese
Michael Farley
Sandy Bryant
Ivy Sager
Angela Neely (by phone)
Lelia Hopper
Karen Kimsey
Paul Gilding
Pat Haymes

Absent:
Ron Belay
Amy Walters
Joe Paxton
Cristy Corbin
Paul McWhinney

Guests:
Bill Elwood
Brian Campbell
Janet Areson
Karen Reilly-Jones

OCS Staff:
Susan Clare
Scott Reiner
Marsha Mucha

The workgroup convened at 9:40 a.m. Facilitators for the workgroup were Pat Haymes, Virginia Department of Education and Lelia Hopper, Office of the Executive Secretary, Supreme Court of Virginia. Members were welcomed and introductions were made. Notes from the February 25 meeting were reviewed.

Ms. Haymes reminded members of the charge to the workgroup. She also noted that, since this is the workgroup's last meeting, today's work would involve reaching consensus on consideration of a policy implementation date and expressed areas of concern around the time frames for FAPT review of cases and development of an IFSP for the youth within 14 days of the CSB receipt of referral from provider and locality assumption of fiscal responsibilities.

Mr. Campbell (DMAS) provided an update regarding data reported at the February 25 meeting for "new Medicaid eligibles" by locality. The number of new Medicaid eligibles reported at the February 25 meeting had been underestimated; the numbers reported on February 12 are accurate. Corrected data by facility and by locality will be provided. Workgroup members were asked to discard the data provided on February 25.

Ms. Haymes reviewed flow charts depicting the existing steps to RTF non-CSA admissions and depicting proposed steps for referral to the CSB and FAPT. . Workgroup members expressed desire to require that referrals from RTFs to the CSB (and thus FAPT) would occur as early as possible during the

admission process and that all children for whom admission was sought by families would be referred to the CSB (and thus FAPT).

Members discussed securing the necessary documentation from parents in order to release information to the CSB. Members generally endorsed development of a set of "universal documents" that would be given to parents outlining collaborative processes, funding options and parental responsibilities.

Members next reviewed and discussed the the SEC Taskforce's recommended procedures with draft changes based on the workgroup's February 25 discussion. The workgroup revised the procedures to include:

- Language clearly indicating that, at time of admission to an acute care facility, the acute care facility shall refer the youth to the local CSB for discharge planning consistent with the discharge planning role for temporary detention order (TDO) cases and discharges from state hospitals.
- RTF referral to the CSB in conjunction with the process of assessment for admission to an RTF.
- Providing the "universal notice" to parents and obtaining parental consent to release information.
- Upon referral from the RTC to the CSB, the CSB should immediately refer the youth to the local FAPT. The CSB assesses the appropriateness of the request to an RTF and, if appropriate, completes the CON as soon as practical but within 10 working days of receipt of the referral from the RTC. FAPT would review the case and develop an IFSP. If the FAPT review occurs after an admission, the FAPT shall meet within 14 calendar days of admission to the RTF.
- If the CSB determines admission is not deemed appropriate and declines to sign the CON, the case will be reviewed by FAPT as any other case before FAPT and the 14 day timeframe would not apply.

Workgroup members agreed that the parking lot issues, including specific implementation concerns, will be included as an addendum to the final report.

Because of the level of detail planning that will be required for policy implementation and the fiscal impact of changes, the workgroup decided not to recommend an implementation date to the SEC. Workgroup members supported the concept that there could be soft roll-out of certain procedures prior to adoption of regulatory and policy changes and supported expressing to the SEC the workgroup's agreement that all parties should make efforts to ensure early involvement of the local community in service planning for youth and families receiving and/or seeking high-end behavioral health services.

Ms. Haymes and Ms. Hopper sought consensus from the workgroup on the processes proposed by this workgroup which were captured on chart paper. All members of the workgroup confirmed consensus.

Revisions will be made to the document per the group's recommendations and will be distributed electronically to members of the workgroup for their review. The purpose of this review will be to ensure the prepared document accurately reflects the discussion and consensus reached by the workgroup. To ensure compliance with requirements for public meetings, workgroup members were asked to send email responses individually to Marsha Mucha rather than to "reply all." OCS will incorporate member edits into the document as appropriate and will redistribute drafts as needed before distributing the final version of the report to the entire workgroup. The workgroup was reminded that its report will be presented at the SEC's March 19 meeting. Depending on the SEC's

decision, any proposed policy will be distributed for a 60-day public comment period. The first opportunity for the SEC to adopt any policy will be its June meeting.

Ms. Haymes and Ms. Hopper thanked the workgroup members for their hard work and recognized the significant accomplishments made by the group.