

AGENDA
State Executive Council for the Children's Services Act
December 15, 2016

Department of Taxation
1957 Westmoreland Street
Richmond, Virginia

- 9:30 a.m. **Welcome and Chair Remarks – Dr. Bill Hazel**
 ➤ **Action Item** – Approval of September 2016 Minutes
- 9:45 **Public Comment**
- 10:00 **Executive Director's Report – Scott Reiner**
 • 2016 General Assembly Reports
 • FY2017 – 2018 Budget Requirements
 • Introduction of New CSA Staff
 • Resolution of Acknowledgement

 ➤ **Action Item** – Approval of Resolution
- 10:30 **SLAT Report – Dr. Tamara Temoney**
- 10:40 **Presentation: *Building Bridges Initiative and Changes to DMAS Requirements for Certificate of Need for Residential Treatment Facilities* – Dr. Allison Jackson, Magellan of Virginia**
- 11:10 **CSA Practice Guidance for Children Recommended for Psychiatric Residential Placement**
- 11:25 **Development of CSA Denial of Funds Policy – Scott Reiner for the Finance and Audit Committee**
- 12:00 **Adjourn**

2017 Meeting Schedule: March 23; April 19 (Roanoke); June 15; September 21; December 14

DRAFT

**STATE EXECUTIVE COUNCIL (SEC)
FOR CHILDREN'S SERVICES
Richmond/Henrico Rooms
1604 Santa Rosa Rd.
Richmond, VA
Thursday, September 15, 2016**

SEC Members Present:

The Honorable William A. (Bill) Hazel, Jr., M.D., Secretary of Health and Human Resources (*Chair*)
Jack Barber, Interim Commissioner, Virginia Department of Behavioral Health
and Developmental Services
The Honorable Richard "Dickie" Bell, Member, Virginia House of Delegates
The Honorable Mary Biggs, Member, Montgomery County Board of Supervisors
Sophia Booker, Service Recipient Representative
Courtney Gaskins, Director of Program Services, Youth for Tomorrow
Pat Haymes for Steven Staples, Ed.D., Superintendent of Public Instruction, Virginia Department
of Education
Bob Hicks for Dr. Marissa Levine, Commissioner, Virginia Department of Health
The Honorable Catherine Hudgins, Member, Fairfax County Board of Supervisors
Cindi Jones, Director, Department of Medical Assistance Services
Maurice Jones, City Manager, City of Charlottesville
Sandra Karison for Karl Hade, Executive Secretary of the Supreme Court of Virginia
The Honorable Sheila Olem, Council Member, Town of Herndon
Greg Peters, President and CEO, UMFS
R. Morgan Quicke, County Administrator, Richmond County
Margaret Schultze, Commissioner, Virginia Department of Social Services
The Honorable Frank Somerville, Presiding Judge, 16th Judicial District, Juvenile and Domestic
Relations District Court
Tamara Temoney, Ph.D., Chair, State and Local Advisory Team (SLAT)
Jeanette Troyer, Parent Representative
Angela Valentine for Andrew Block, Director of the Department of Juvenile Justice
The Honorable Jennifer Wexton, Member, Senate of Virginia

SEC Members Absent:

Eddie Worth, Parent Representative

Other Staff Present:

Stephanie Bacote, Audit Manager, OCS
Pamela Kestner, Deputy Secretary of Health and Human Resources
Daniela Lewy, Executive Director, Children's Cabinet
Marsha Mucha, Administrative Staff Assistant, OCS
Scott Reiner, Executive Director, OCS
Eric Reynolds, Assistant Attorney General, Office of the Attorney General
Kristi Schabo, Program Consultant, OCS
Carol Wilson, Program Consultant, OCS

DRAFT

Call to Order and Approval of Minutes

Secretary Hazel called the meeting to order at 9:02 a.m. and welcomed everyone. New members were introduced and introductions made.

The minutes of the June 23, 2016 meeting were approved without objection.

Secretary Hazel updated members on several critical issues including the shortfall in the state's biennial budget and the addiction issues (particularly opiates) that continue to plague the state. He further noted that he did not expect much legislation from the secretariat for the 2017 General Assembly Session.

Public Comment (General)

There were no public comments.

Amendments to SEC Bylaws

Members were provided a copy of the SEC bylaws with technical revisions highlighted in red. After reviewing the revisions, the amended SEC bylaws were approved without objection.

Executive Director's Report

Mr. Reiner reported on the following items:

- **FY16 Expenditure Status Update** – The 2016 CSA program year ends September 30. The rate of growth in CSA pool fund expenditures is expected to be 5.5 to 6 percent over the 2015 program year.
- **Private Day Educational Placements** – Item 285#1c of the Appropriation Act directs the SEC to “develop a robust set of options for increasing the integration of children receiving special education day treatment services into their home school districts, including mechanisms to involve local school districts in tracking, monitoring and obtaining outcome data to assist in making decisions on the appropriate utilization of these services.” In order to address this directive, a workgroup of stakeholders convened for three meetings to develop the options presented today.

Mr. Reiner presented CSA statistical and expenditure information concerning the use of private day school services. He reviewed the options the workgroup had developed for the SEC's consideration as well as additional issues and considerations for further discussion. After the report, Mr. Reiner answered questions and members discussed the workgroup's recommendations.

Public Comment – Public comment was received from William (Bill) Elwood representing the Virginia Coalition of Private Provider Associations (VCOPPA) and the Virginia Association of Independent Specialized Education Facilities (VAISEF).

Action Taken – There was considerable discussion concerning several of the options presented and their order of priority. Members also discussed the current Individualized Education Program (IEP) process and approved, without objection, adding a

recommendation for the Virginia Department of Education (VDOE) to seek a waiver from the federal Department of Education allowing for the inclusion of members of the Family Assessment and Planning Team (FAPT) in the IEP process.

A motion was made by Catherine Hudgins, and seconded by Greg Peters, to remove *Option B* from the section *Restructuring the Children's Services Act (CSA)*. After additional discussion the motion was defeated. The options will be reordered and this option will be placed last within this section of the report. Members voted to move forward with submission of the report. Greg Peters opposed.

Educational Funding for Non-CSA Placements in Residential Treatment - Mr. Reiner reported that the SEC was also directed to continue its review, with the assistance of relevant stakeholders, the issue of funding of educational costs for non-CSA placements in residential treatment. Mr. Reiner explained that a report required pursuant to the 2015 Appropriation Act on this issue was the product of several workgroups that were tasked with examining the issue. Several recommendations were presented in the report but there were a number of recommendations where the workgroups could not reach consensus.

Mr. Reiner noted that he had redistributed all the recommendations and other relevant materials to SEC members for their review. He explained that a workgroup was convened for two meetings with workgroup members reviewing the materials as noted above and developing additional/new options. Public comment was also received at these meetings.

He reviewed the options the workgroup had developed for the SEC's consideration. After the report, Mr. Reiner answered questions and members discussed the options presented.

Public Comment – Public comments were received from the following:

- William (Bill) Elwood – representing the Virginia Coalition of Private Provider Associations (VCOPPA) and the Virginia Association of Independent Specialized Education Facilities (VAISEF).
- Jim Gillespie – Fairfax County and representing the Virginia Association of Counties (VAoC).
- Rebecca Vinroot – James City County Department of Social Services and representing the Virginia Municipal League (VML).
- Cecelia Kirkman – representing SEIU Healthcare.

Action Taken – After additional discussion, a motion was made by Delegate Dickie Bell and seconded by Greg Peters to include a Joint Legislative Audit and Review Commission (JLARC) study of the issue as an option in the report to the General Assembly. The motion carried. The report was approved for submission to the General Assembly on a motion by Margaret Schultze and seconded by Cindi Jones.

SLAT Report

Tamara Temoney, SLAT Chair reported on the following:

- **Amended SLAT Bylaws** - Technical amendments to the SLAT bylaws (highlighted in red) were presented for SEC approval. The amended SLAT bylaws were approved on a motion by Margaret Schultze and seconded by Mary Biggs.
- **CSA Special Education Wraparound Funds** – SLAT was asked by the SEC to gather input and develop recommendations for the Commission on Youth (COY) request to examine issues related to use of the wraparound services for students with disabilities. This request was part of a larger two-year study by COY on the use of federal, state and local funds for private educational placements of students with disabilities.

Several surveys (general CSA, school special education directors and parents of students with disabilities) were developed and distributed to gather information from stakeholders to utilize in informing the recommendations from SLAT to the SEC in response to the COY request. At their August 4 meeting SLAT received additional input from stakeholders on the use of CSA special education wraparound funds.

Mr. Reiner and Dr. Temoney presented SLAT’s recommendations to the SEC for their consideration.

Action Taken – After further discussion the recommendations from SLAT were approved for submission to COY without objection.

Mr. Reiner will be presenting the recommendations to the Commission on Youth on Tuesday September 20.

Children’s Cabinet and Member Updates

Daniela Lewy provided an update on the work of the Children’s Cabinet. SEC members provided updates on activities related to the work of the SEC and CSA and more broadly in respect to children’s services and issues.

Next Meeting and Adjournment

There being no further business the meeting was adjourned at 2:00 p.m. The next meeting is scheduled for December 15.

OFFICE OF CHILDREN'S SERVICES

ADMINISTERING THE CHILDREN'S SERVICES ACT



IMPACT OF THE INCENTIVE MATCH RATE SYSTEM

Annual Report to the Governor and General Assembly, December 2016

In accordance with the Appropriation Act, Item 285 (C)(3)(c)

The Children's Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Children's Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

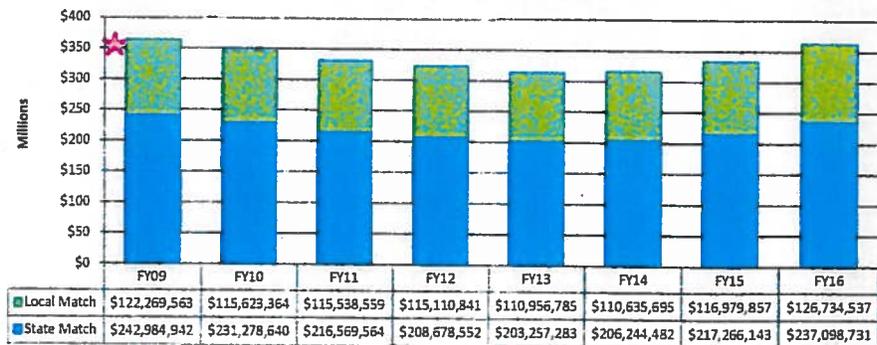
- Child and family directed care.
- Equitable access to quality services.
- Responsible and effective use of public funds.
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.

Funding for services to children and families under the Children's Services Act (CSA) is a shared responsibility of state and local governments. The incentive-based match rate system was designed to change practices so as to reduce reliance on residential care, serve children in their homes, and invest funds for the development of community based services. The incentive match rate system encourages the delivery of services consistent with the statutory purposes of the CSA, i.e., to:

- preserve and strengthen families;
- design and provide services that are responsive to the unique and diverse strengths and needs of troubled youth and families and;
- provide appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public.

Under the incentive match rate system, a locality's share of residential services is 25% above its base match rate; the locality's share of community-based services is 50% below its base match rate.

Total Net Expenditures Under the Children's Services Act



★ Implementation of the incentive match rate system

Effective Match Rate

	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16
Effective Local Match Rate	33.5%	33.3%	34.8%	35.5%	35.3%	34.9%	34.9%	34.8%
Effective State Match Rate	66.5%	66.7%	65.2%	64.5%	64.7%	65.1%	65.1%	65.2%

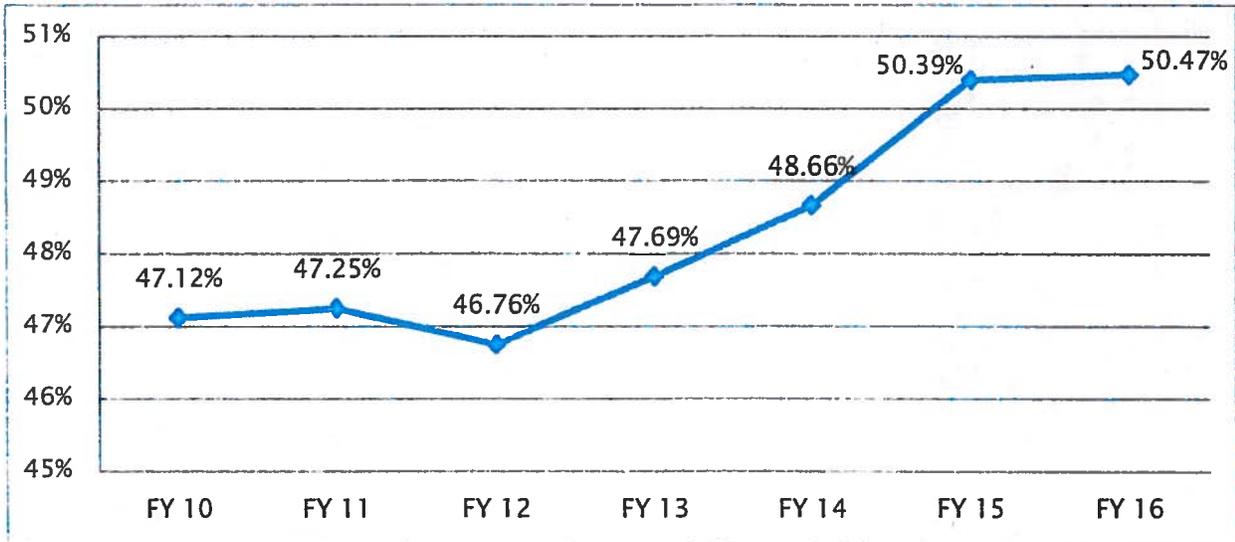
The "effective match rate" reflects the impact of the mix of services at various match rates on the average match rate for all funded services.



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Empowering communities to serve youth

IMPACT OF THE INCENTIVE MATCH RATE SYSTEM ON THE CARE AND TREATMENT OF YOUTH

Percent of Youth Served in Community-Based Settings (Target = 50%)



This metric reflects youth who have been served within their families and communities (i.e., have not required out-of-home placement including foster care).

OFFICE OF CHILDREN'S SERVICES

ADMINISTERING THE CHILDREN'S SERVICES ACT



TREATMENT FOSTER CARE SERVICES UNDER THE CSA

Annual Report to the General Assembly, December 2016

In accordance with Appropriation Act, Item 285 (K)(1)

Treatment foster care is a community-based program where services are designed to address the special needs of children. Services to the children are delivered primarily by treatment foster parents who are trained, supervised, and supported by agency staff. Treatment is primarily foster family based and is planned and delivered by a treatment team. Treatment foster care focuses on a continuity of services, is goal-directed and results-oriented, and emphasizes permanency planning for the child in care.

The Children's Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

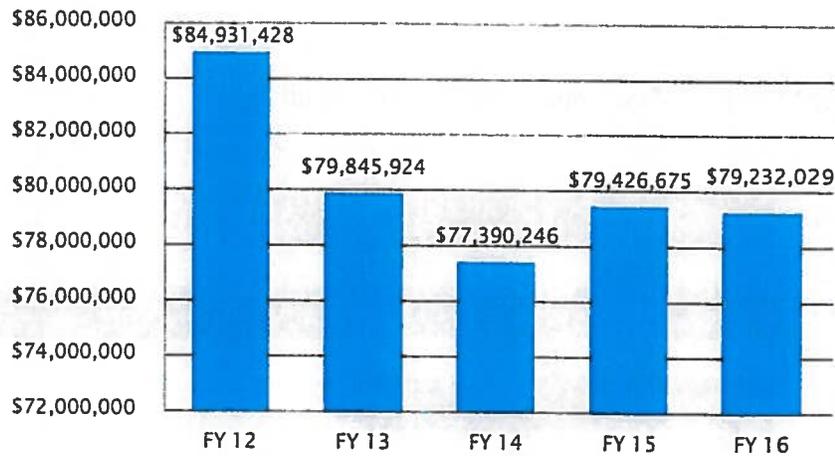
The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Children's Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

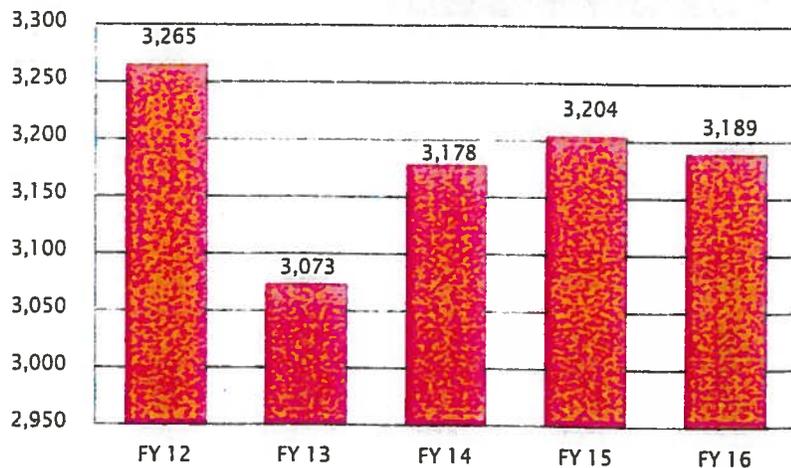
Guiding principles for OCS include:

- Child and family directed care.
- Equitable access to quality services.
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- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.

Total CSA Expenditures - Treatment Foster Care

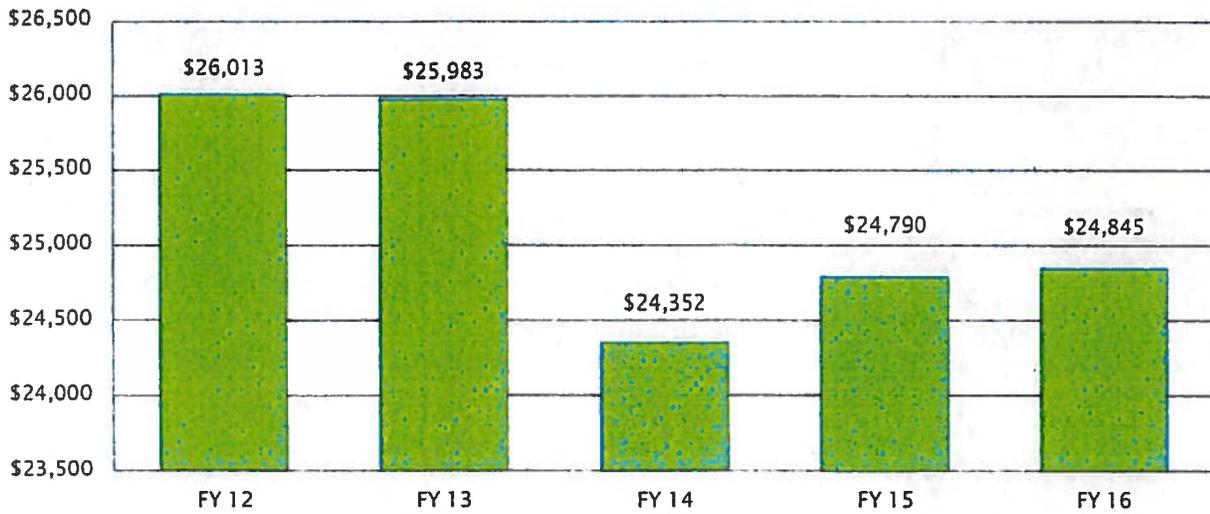


Number of Youth Served - Treatment Foster Care

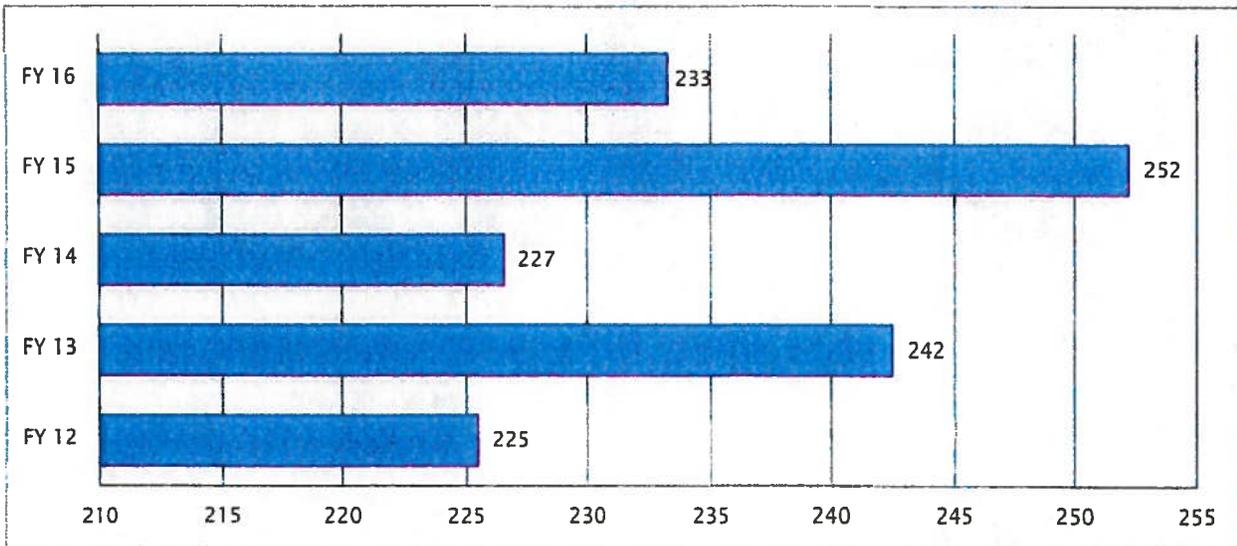


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Average Annual CSA Expenditure per Child – Treatment Foster Care



Average Length of Stay (Number of Days) Per Child



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ADMINISTERING THE CHILDREN'S SERVICES ACT



SPECIAL EDUCATION SERVICES UNDER THE CSA

Annual Report to the General Assembly, December 2016

In accordance with Appropriation Act, Item 285 (K) (2)

Children and youth with disabilities placed for purposes of special education in approved private school educational programs are included in the CSA target population and are eligible for funding (Code of Virginia §2.2-5211).

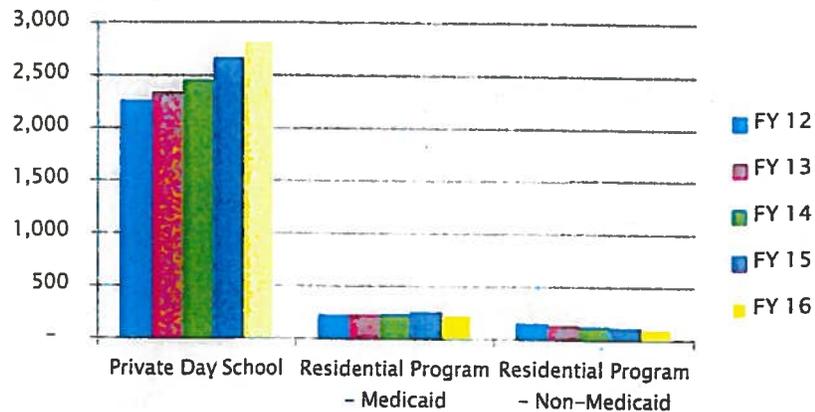
Average Annual CSA Expenditure Per Child – Special Education Services



Net CSA Expenditures by Placement Type – Special Education Services

	2014	2015	2016
Private Day School	\$ 92,737,764	\$ 104,089,305	\$ 118,382,667
Residential Program - Medicaid	\$ 7,487,250	\$ 8,079,405	\$ 8,402,814
Residential Program - Non-Medicaid	\$ 6,538,125	\$ 7,794,281	\$ 7,469,255
	\$ 106,763,139	\$ 119,962,991	\$ 134,254,746

Number of Youth Served by Placement Type: Special Education Services



FY2016 unduplicated count of youth who received services in accordance with an Individualized Education Program (IEP) requiring private school placement = 3,011.

The Children's Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

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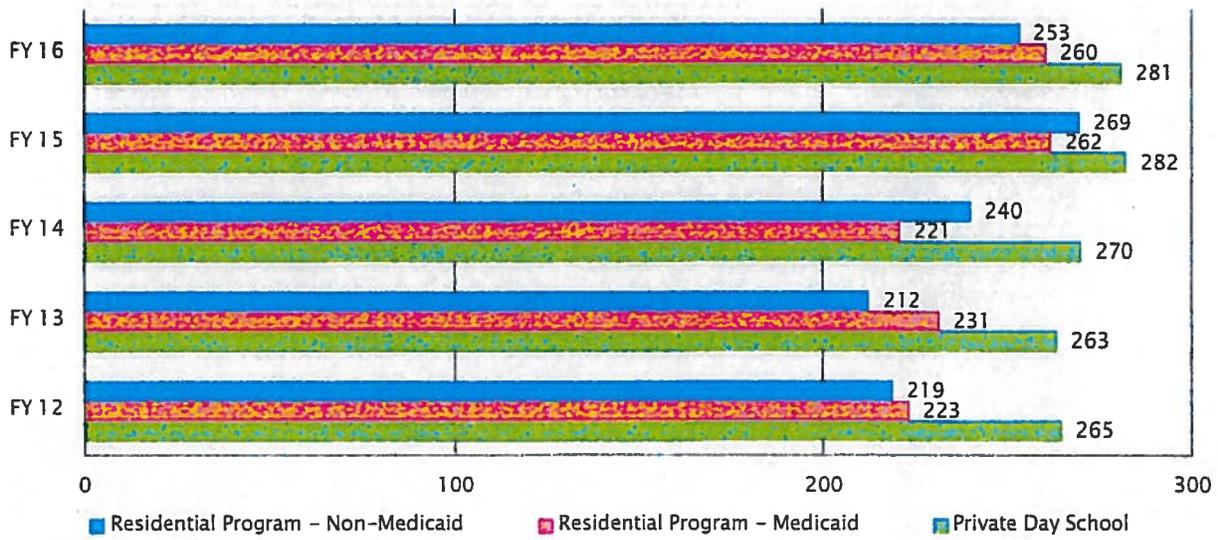
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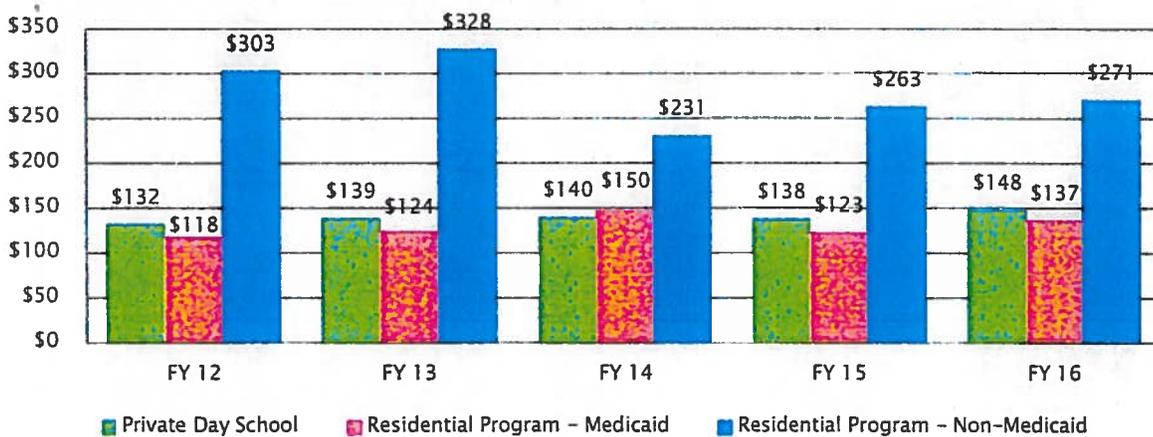
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SPECIAL EDUCATION SERVICES FUNDED UNDER THE CHILDREN'S SERVICES ACT

Average Length of Stay (Number of Days) by Placement Type

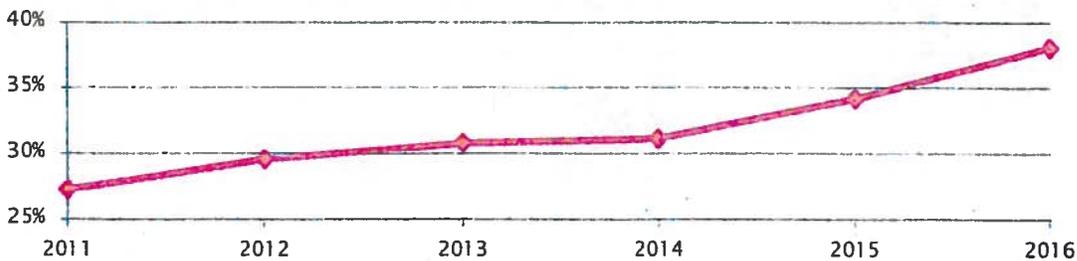


Average Cost per Child per Day by Placement Type



Note: Costs reflect CSA expenditures only (i.e., does not include Medicaid expenditures for treatment services)

Percentage of Special Education Population Designated as Autistic (in the CSA Data Set)



OFFICE OF CHILDREN'S SERVICES

ADMINISTERING THE CHILDREN'S SERVICES ACT



REGIONAL AND STATEWIDE TRAINING REGARDING CSA

Annual Report to the General Assembly, December 2016

In accordance with 2016 Appropriation Act, Chapter 780, Item 285 (B)(6)

The Children's Services Act (CSA, §2.2-5200 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

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- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



The mission of the Office of Children's Services (OCS) is to facilitate a collaborative system of services and funding that is child-centered, family-focused, and community based when addressing the strengths and needs of youth and their families in the Commonwealth of Virginia. To support this mission, OCS develops and implements a robust training plan annually. In accordance with the 2016 training plan, the following activities were implemented:

- The 5th Annual Commonwealth of Virginia CSA Conference, "*Collaboration: It's Work but It's Worth It*" was provided for an audience of 583 participants. Individual training sessions are summarized on pages 5 through 8 of this report.

Participant Summary:

116 out of 131 CSA local entities were represented

State agency participants	37
Local CSA Staff (Coordinator/UR Specialist/Other)	116
Public Agency Case Managers	47
Local Government Representatives	5
Family Assessment and Planning Team Members	124
Community Policy and Management Team Members	71
Private Providers (registrants & sponsors)	55
Advocate, Parent and/or Child Organization	11
Presenters	32

Note: Not all participants identified the category they represented

- Thirty one (31) regional and stakeholder training sessions were provided to 891 participants. Training topics, dates, and participant numbers are summarized on pages 2 through 4 of this report.
- Online training materials were made available through the Commonwealth of Virginia's Knowledge Center.
- Site-based technical assistance was provided per requests of local and regional CSA stakeholders.
- Online "OCS Help Desk" was maintained with over 850 individual requests answered.

FUNDS EXPENDED FOR REGIONAL AND STATEWIDE TRAINING

5 th Annual CSA Conference	\$ 35,000
On-line Training/Certification: Uniform Assessment Instrument	\$ 22,000
New CSA Coordinators Academy	\$ 7,381
OCS Staff Development	\$ 3,006
TOTAL*	\$ 67,387

*Total does not include costs for mileage, lodging, and training materials for training sessions conducted by the Office of Children's Services.

**TRAINING FOR CSA REGIONAL AND STAKEHOLDER CONSTITUENTS
FISCAL YEAR 2016**

(Participant evaluations of training sessions are available for review at the Office of Children's Services)

TOPIC (Trainer, Agency/Organization)	PARTICIPANT GROUP	DATE(S)	NUMBER OF PARTICIPANTS
HFW Family Support Partner Training – Richmond, VA (Youth and Family Training Institute)	ICC/HFW Family Support Partners	7/8/15 – 7/10/15	22
HFW Introduction, Days 1 and 2 Richmond, VA (Anna Antell; Youth and Family Training Institute)	ICC Providers	7/13/15 – 7/14/15	31
HFW Refresher Bristow, VA (Youth and Family Training Institute)	ICC Providers	7/15/15	25
HFW Refresher Bristow, VA (Youth and Family Training Institute)	ICC Providers	7/16/15	24
HFW and ICC Overview Rockbridge, VA (Anna Antell)	Rockbridge FAPT	8/4/15	11
CSA Basics Manassas Park, VA (Brady Nemeyer)	Manassas Park CPMT/FAPT	8/6/15	12
HFW Introduction, Days 3 and 4 Richmond, VA (Anna Antell; Youth and Family Training Institute)	ICC Providers	8/10/15 – 8/11/15	29
HFW Refresher Newport News, VA (Youth and Family Training Institute)	ICC Providers	8/12/15	18
HFW Supervisors Richmond, VA (Youth and Family Training Institute)	ICC Supervisors	9/11/15	25
CSA Basics Amelia, VA (Carol Wilson)	Amelia CPMT/FAPT	9/15/15	13

CSA Update Virginia Beach, VA (Scott Reiner)	VALHSO Conference	9/22/15	45
Blending and Braiding Funds/ CSA Update Suffolk, VA (Scott Reiner)	Suffolk CPMT/FAPT	10/8/15	19
CSA Basics Craig/Botetourt, VA (Brady Nemeyer)	Craig/Botetourt CPMT/FAPT	10/19/15	26
CSA Basics Bedford, VA (Brady Nemeyer)	Bedford CPMT/FAPT	10/21/15	10
CANS and Service Planning New Kent, VA (Carol Wilson)	New Kent FAPT/Case Managers	11/9/15	12
CSA Update Richmond, VA (Scott Reiner)	VCOPPA Annual Symposium	11/12/15	80
CSA Financial Reporting Requirements Henrico, VA (Chuck Savage)	CSA Fiscal Agents/Report Preparers	12/1/15	39
CSA Financial Reporting Requirements Portsmouth, VA (Chuck Savage)	CSA Fiscal Agents/Report Preparers	12/3/15	24
CSA Financial Reporting Requirements Galax, VA (Chuck Savage)	CSA Fiscal Agents/Report Preparers	12/9/15	26
CSA Financial Reporting Requirements Roanoke, VA (Chuck Savage)	CSA Fiscal Agents/Report Preparers	12/10/15	31
CSA Financial Reporting Requirements Warrenton, VA (Chuck Savage)	CSA Fiscal Agents/Report Preparers	12/17/15	29
CSA Overview Richmond, VA (Scott Reiner)	State Board of Social Services	2/17/16	15

Overview of CSA Richmond, VA (Scott Reiner)	VCU HHR Course	2/22/16	23
CSA Basics Hopewell, VA (Carol Wilson)	Hopewell CPMT/FAPT	2/22/16	18
2016 New CSA Coordinators Academy Richmond, VA (All OCS staff)	New CSA Coordinators	3/8/16 - 3/10/16	27
DOE Aspiring Special Education Leaders Academy Richmond, VA (Scott Reiner)	DOE Local Special Education Leaders	3/10/16	31
Pre-conference Workshop: Collaboration Learning Laboratory	Deloitte Consulting	4/26/16	88
HFW Facilitator Training, Part 1 Richmond, VA (Anna Antell)	New HFW Facilitators	5/3/16 - 5/4/16	30
Case Planning Basics Harrisonburg/Rockingham, VA (Anna Antell)	Harrisonburg/Rockingham CSA Teams	5/16/16	65
HFW Facilitator Training, Part 2 Richmond, VA (Anna Antell; UMFS)	New HFW Facilitators	6/6/16 - 6/7/16	30
HFW Family Support Partner Training Richmond, VA (Anna Antell; UMFS)	New HFW Family Support Partners	6/8/16 - 6/10/16	13

**Total Number of Participants Trained:
(Not including the Annual CSA Conference) 891**

**5th ANNUAL CSA CONFERENCE
BREAKOUT TRAINING SESSIONS
APRIL 27 - 28, 2016**

Participant evaluations for training sessions are available for review at the Office of Children's Services

TOPIC	TRAINER	NUMBER OF PARTICIPANTS
Keynote Session	Elizabeth Gaines, Senior Fellow Forum for Youth Investment, Washington, DC	583
Behaviors Related to Brain Injury: "Who is this Person?"	Debbie Coleman, Nurse - Area Manager Florida Institute for Neurologic Rehabilitation	92
Best Practices in Serving Children with Educational Disabilities in the Least Restrictive Environment	Patricia Haymes, Director, Office of Dispute Resolution and Administrative Services, Virginia Department of Education	40
Building Bridges: An Approach for Advancing Partnerships to Improve Outcomes	Jody Levison-Johnson, MSW Chief Clinical Officer Choices Coordinated Care Solutions (MD)	40
CANVaS 2.0 Overview	Carol Wilson, Program Consultant Office of Children's Services	99
Classrooms Not Courtrooms	The Honorable Ann Holton, Secretary of Education and The Honorable Brian Moran, Secretary of Public Safety and Homeland Security, Commonwealth of Virginia	1
Collaboration Multiplies Impact: Facilitating Diverse Perspectives	Nancy Toscano, Ph.D., LCSW, Vice President, Strategy and Organizational Improvement, United Methodist Family Services	25
Collaboration Multiplies Impact: How to Expand Your System of Care Through the Use of System of Care Community Teams	Rachelle Butler, MSW, System of Care Program Manager, United Methodist Family Services and Mills Jones, CSA Coordinator, Goochland County	12
Conversation with Virginia Juvenile and Domestic Relations District Court Judges	The Honorable Anita Fiilson, The Honorable Frank Somerville, the Honorable Frank Rogers, III, Juvenile and Domestic Relations Court Judges (Moderated by Sandra Karison, Office of the Executive Secretary, Supreme Court of Virginia)	89

Coordination of Service and Care for Medicaid Members in Virginia	Brendan Shane, MSW, LCSW, LIUCSW, MBA, Director Clinical Care Services, Stacie Fisher, MCO Liaison, Cheryl DeHaven, Manager, Recovery and Resiliency, Magellan of Virginia	15
Creating a Local Dedicated Funding Stream	Elizabeth Gaines, Senior Fellow Forum for Youth Investment	26
CSA and Local Government: Beyond the Fiscal Impact	Jessica Webb, CSA Coordinator and Daniel O'Donnell, Assistant County Administrator, Roanoke County	59
CSA Strategic Planning: Tool to Help Leaders Lead	Karen Reilly-Jones, CSA Administrator Chesterfield/Colonial Heights	35
Dispelling the Myth: Applied Behavior Analysis in 2015 and Why It's Effective	Crystal Collette, MS, BCBA, LBA, Autism Services Manager, Abby Hard, MS, BCBA, LBA, Coordinator of Autism School Services, Jennifer Watson Jamison, MSS, Ed, BCBA, LBA, Clinic Site Supervisor, Tara Ernst, BCBA, LAA, Greater Petersburg School Site Supervisor, Cindie Allen, MED, Grad Cert ABA, Lynchburg School Lead Counselor, Jaci Clark, Roanoke School Lead Counselor, Centra Autism and Developmental Services/Rivermont Schools	39
DMAS Residential Treatment Regulatory Changes	Brian Campbell, Senior Policy Analyst, Virginia Department of Medical Assistance Services and Staff of Magellan of Virginia IT Infrastructure Partnership	48
Family Driven Practice: Using Family Feedback to Improve CSA Practice	Paul Baldwin, CSA Coordinator, Bedford County Department of Social Services, Summer Tetterton, MS, CSA Coordinator and Brittany McGeoch, CSA Case Manager, Campbell County Youth, Adult and Community Services	52
Financial Fun Facts! Funding and Contracting Topics in CSA	Vanessa Lane, Director, Revenue Cycle Management/Accounts Receivable, Grafton Integrated Health Network	24
Fraud Risk and CSA	Stephanie Bacote, Audit Program Manager and Annette Larkin, Program Auditor, Office of Children's Services	63

Positive Effects of Support and Unity In the Workplace: It Takes Everyone	Nicole Williams Akindoyo, Mental Health and Substance Abuse Counselor, Family Maintenance Counseling Group, Inc.	71
Private School Placements and the Special Education Continuum of Services	Angela Neely, Executive Director of Special Education, Culpeper County Public Schools and President-Elect, Virginia Council of Administrators of Special Education (VCASE), Michael Asip, Director of Exceptional Education, Chesterfield County Public Schools and President, VCASE, VCASE Members	27
Promoting Educational Stability in Your Organization	Patricia Popp, PhD, State Coordinator for the Education of Homeless Children and Youth in Virginia, Virginia Department of Education and Brenda Renee Garnett, Med, Independent Living Specialist, Virginia Department of Social Services	5
Promoting Safe and Stable Families (PSSF)	Patrick Plourde, Program Consultant and Administrator, Virginia Department of Social Services – Division of Family Services	34
Records Management: Back to Basics	Corey Smith, Records Analyst, Library of Virginia	30
Supporting the Transition of Foster Care Youth into Adulthood	Em Parente, Foster Care Program Manager and Carl Ayers, Director of Family Services, Virginia Department of Social Services	109
The Strength of the Team	Betsy Clark, CSA Administrator, City of Hampton, Stephanie Afonja, Chief Executive Officer, Family Restoration, LLC	57
The Virginia Tiered Systems of Supports (VTSS): A Data Informed Approach to Promote Effective Systems of Care for School Age Children	Thomas Manthey, VTSS Coordinator, Virginia Department of Education, Sophia Farmer, VTSS Implementation Specialist, Virginia Commonwealth University – Center for School Community Collaboration	16
Transforming Children’s Mental Health Policy Into Practice: Lessons from and Other States’ Experience with Creating and Sustaining Comprehensive Systems of Care	Allison Ventura, PhD, Clinical Assistant Professor, University of Florida School of Medicine, Department of Psychiatry and Robert Cohen, PhD, Center for Child Well Being, Arizona State University	29

Transforming Juvenile Justice in Virginia	Valerie Boykin, Deputy Director of Community Programs, Kathy Kirven, Community Placement Programs Counselor, Beth Stinnett, Program Manager, Stephanie Garrison, Program Manager, Ashaki McNeil, Program Manager, Virginia Department of Juvenile Justice	59
Trauma-Informed Community Network of Greater Richmond: A Collaborative Success	Rebeca Ricardo, LCSW, Executive Director, C2Adopt	4
Trauma-Informed Leadership Teams: How to Engage, Motivate and Measure for Clear Results	Nina Marino, Director, Treatment Foster Care and Adoption, Lutheran Family Services of Virginia	44
Using a Logic Model to Effectively Identify and Measure Outcomes to Ensure an Effective System of Care	Courtney Gaskins, PhD, Vice President of Programs, Youth for Tomorrow and Member, State Executive Council for Children's Services	38
Using CSA Data and Fiscal Reports	Chuck Savage, Business Manager, Office of Children's Services	21
Utilization Review at the Local Level	Anna Antell, LCSW, Program Consultant, Office of Children's Services	74
Wraparound Loudoun	Maria Torres, Program Manager, Katalin Swanson, Team Coordinator, Mahum Hameed, Care Coordinator, and Ashleigh Albright, Care Coordinator, Loudoun County Department of Mental Health, Substance Abuse and Developmental Services	27

NOTE: conference participants had the opportunity to participate in up to six breakout sessions in addition to the Keynote Session

OFFICE OF CHILDREN'S SERVICES

ADMINISTERING THE CHILDREN'S SERVICES ACT



The Children's Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Children's Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care.
- Equitable access to quality services.
- Responsible and effective use of public funds.
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

Annual Report to the Governor and General Assembly, December 2016
In accordance with Appropriation Act, Item 285(B)(2)(d)

Since 2008 several significant strategies have been successful in decreasing the placement of children and youth into residential care. Strategies included implementation of the *Children's Services System Transformation* initiative and an incentive match rate system designed to encourage serving children and youth in community-based settings.

Total CSA Expenditures for Residential Care

	FY13	FY14	FY15	FY16
Temporary Care Facility	\$ 1,077,147	\$ 960,815	\$ 836,245	\$ 910,163
Group Home	\$ 19,026,708	\$ 17,823,470	\$ 18,294,654	\$ 17,173,408
Residential Treatment Facility	\$ 23,153,524	\$ 20,486,591	\$ 22,271,783	\$ 22,581,221
TOTALS	\$ 43,257,379	\$ 39,270,876	\$ 41,402,683	\$ 40,664,792

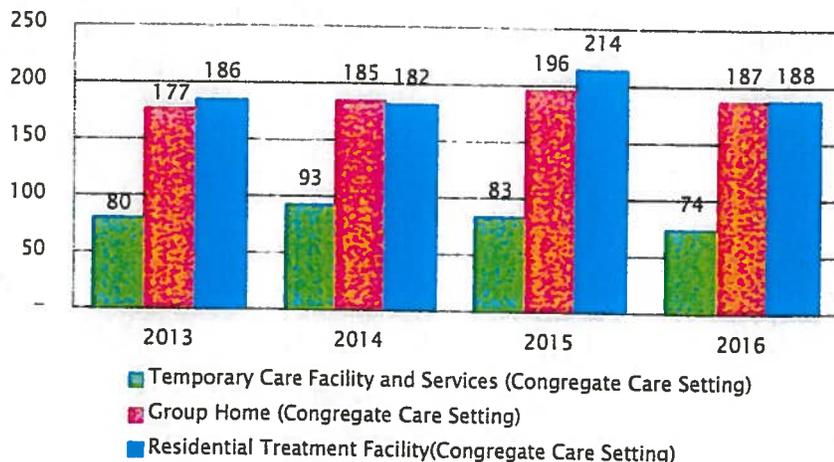
Note: Amounts do not include Title IV-E and Medicaid expenditures.

Number of Youth Served Through CSA in Residential Care

	FY13	FY14	FY15	FY16
Temporary Care Facility	145	162	178	160
Group Home	802	861	948	887
Residential Treatment Facility	1,176	1,171	1,197	1,192
Unduplicated Total	1,888	1,932	2,020	1,986

Total reflects the unduplicated count of youth across all residential settings and excludes youth placed for purposes of special education.

Average Length of Stay (Number of Days) Per Youth In Residential Care



Number reflects the average number of days per youth within the fiscal year (July 1 - June 30).

Utilization of Residential Care by Locality

See following pages

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA BY LOCALITY, FY2014 - FY2016

FIPS	Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS ACROSS ALL RESIDENTIAL PLACEMENTS											
		FY14				FY15				FY16			
		Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
001	Accomack	9	1,952	217	\$216,326	9	2,323	232	\$330,307	10	3,051	277	\$361,482
003	Albemarle	50	15,615	312	\$1,198,920	46	17,816	287	\$1,237,370	32	9,934	242	\$680,398
005	Alleghany	6	1,982	330	\$212,943	7	2,032	254	\$112,162	6	1,983	330	\$202,865
007	Amelia	0	0	0	\$0	2	541	270	\$19,004	3	526	175	\$38,602
009	Amherst	11	3,698	336	\$209,254	15	5,041	296	\$165,330	10	2,856	285	\$116,839
011	Appomattox	7	1,136	162	\$73,153	7	2,033	225	\$162,936	9	2,676	267	\$250,986
013	Arlington	61	14,955	245	\$1,470,110	58	16,073	217	\$1,190,134	43	12,511	219	\$1,251,617
015	Augusta	16	4,366	273	\$222,546	12	3,130	223	\$175,064	5	1,255	251	\$114,869
017	Bath	0	0	0	\$0	1	181	181	\$25,600	0	0	0	\$0
019	Bedford County	5	764	153	\$82,985	6	1,362	227	\$44,423	12	2,690	206	\$140,276
021	Bland	3	805	268	\$16,334	1	212	212	\$12,199	3	893	297	\$33,528
023	Botetourt	9	2,715	302	\$197,354	3	926	308	\$95,267	6	1,235	205	\$138,521
025	Brunswick	3	744	248	\$29,950	2	381	190	\$18,545	1	261	261	\$14,548
027	Buchanan	24	6,017	251	\$425,923	18	4,684	260	\$485,089	23	5,460	237	\$511,293
029	Buckingham	6	1,611	269	\$179,144	4	1,429	357	\$178,506	3	850	212	\$212,530
031	Campbell	9	1,693	188	\$337,598	13	2,631	202	\$480,812	14	3,074	219	\$470,186
033	Caroline	12	2,636	220	\$416,506	11	2,356	196	\$286,734	6	1,586	264	\$163,746
035	Carroll	4	810	203	\$124,447	4	680	170	\$63,550	14	1,895	135	\$144,430
036	Charles City	0	0	0	\$0	0	0	0	\$0	1	185	185	\$2,756
037	Charlotte	5	953	191	\$68,821	8	1,775	197	\$165,841	10	1,576	157	\$152,980
041	Chesterfield	31	2,418	78	\$587,975	31	2,561	82	\$576,393	43	4,926	111	\$955,358
043	Clarke	1	277	277	\$1,418	3	654	218	\$22,427	2	765	255	\$42,131
045	Craig	3	324	108	\$30,690	3	1,113	222	\$57,870	1	366	366	\$11,470
047	Culpeper	24	8,073	336	\$752,498	26	10,141	274	\$672,419	25	8,571	259	\$413,750
049	Cumberland	2	606	303	\$64,680	0	0	0	\$0	1	85	85	\$15,744
051	Dickenson	10	1,833	183	\$108,603	12	1,810	150	\$181,437	11	1,589	113	\$242,912
053	Dinwiddie	10	1,617	162	\$161,597	8	1,653	183	\$160,149	14	2,473	164	\$241,956
057	Essex	9	1,842	205	\$94,994	5	845	169	\$78,109	4	810	202	\$242,568
061	Fauquier	15	3,897	260	\$244,929	28	8,324	260	\$723,821	28	8,674	271	\$591,374
063	Floyd	7	1,460	209	\$69,618	3	1,063	265	\$19,757	4	1,100	275	\$75,102
065	Fluvanna	30	6,235	208	\$865,412	17	3,673	216	\$513,617	23	5,109	222	\$705,689
067	Franklin County	28	8,412	300	\$314,853	27	8,727	256	\$360,291	14	3,882	258	\$394,616
069	Frederick	16	3,090	193	\$321,587	18	4,640	220	\$528,095	21	4,954	225	\$300,722
071	Giles	6	1,973	329	\$230,034	6	2,124	303	\$102,794	11	1,514	137	\$303,190
073	Gloucester	4	302	76	\$13,069	2	251	125	\$22,816	1	52	52	\$11,829
075	Goochland	2	464	232	\$26,042	7	882	126	\$131,041	11	2,508	228	\$448,009
077	Grayson	9	1,976	220	\$121,959	5	2,278	325	\$148,210	4	1,104	276	\$101,101
079	Greene	2	501	251	\$35,779	3	614	153	\$78,106	7	2,153	269	\$108,443
083	Halifax	13	3,979	306	\$434,148	13	4,566	228	\$485,530	13	3,366	258	\$373,228
085	Hanover	11	5,791	526	\$566,100	22	6,533	217	\$439,731	14	3,319	184	\$305,296
087	Henrico	17	4,278	252	\$326,420	19	4,073	203	\$464,165	30	7,027	200	\$489,300
089	Henry	6	1,618	270	\$210,085	9	2,572	257	\$296,906	6	1,087	181	\$115,990
091	Highland	1	92	92	\$13,291	1	365	365	\$12,172	0	0	0	\$0
093	Isle of Wight	2	250	125	\$46,726	0	0	0	\$0	3	183	61	\$32,294
095	James City	6	1,377	230	\$137,819	7	1,234	176	\$59,487	1	327	327	\$6,541
097	King & Queen	0	0	0	\$0	1	343	343	\$1,317	0	0	0	\$0
099	King George	21	5,807	277	\$274,094	13	3,658	281	\$191,825	12	2,473	206	\$174,416
101	King William	4	820	205	\$81,510	2	483	241	\$95,137	2	367	183	\$38,989
103	Lancaster	9	3,415	379	\$329,563	12	5,110	365	\$442,365	10	2,931	266	\$253,044
105	Lee	8	1,217	152	\$28,430	7	1,493	186	\$310,724	4	1,018	254	\$39,015
107	Loudoun	16	1,838	115	\$297,762	18	1,766	80	\$341,482	44	7,402	139	\$813,337
109	Louisa	10	1,453	145	\$155,129	5	1,462	292	\$78,034	8	1,327	165	\$136,034
111	Lunenburg	6	2,580	430	\$141,643	8	2,547	283	\$129,448	6	2,149	358	\$104,736
113	Madison	20	5,836	292	\$534,204	18	6,890	237	\$591,423	26	9,978	262	\$988,058

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA BY LOCALITY, FY2014 - FY2016

FIPS	Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS-ACROSS ALL RESIDENTIAL PLACEMENTS											
		FY14				FY15				FY16			
		Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
115	Mathews	1	13	13	\$2,249	2	730	365	\$14,216	1	62	62	\$26,412
117	Mecklenburg	9	3,030	337	\$276,581	11	3,186	289	\$236,392	11	2,397	184	\$212,173
119	Middlesex	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
121	Montgomery	5	1,455	291	\$20,660	3	892	297	\$42,196	4	611	152	\$32,655
125	Nelson	8	983	123	\$14,646	4	348	87	\$13,763	6	1,012	168	\$61,923
127	New Kent	5	1,361	272	\$97,202	3	1,095	365	\$0	0	0	0	\$0
131	Northampton	1	148	148	\$22,748	2	477	238	\$77,838	3	737	245	\$40,557
133	Northumberland	0	0	0	\$0	1	254	127	\$2,171	3	542	180	\$34,621
135	Nottoway	10	2,541	254	\$576,335	7	2,260	282	\$226,947	6	1,783	297	\$110,311
137	Orange	10	2,054	205	\$439,843	11	1,972	179	\$378,095	16	2,429	151	\$397,034
139	Page	7	710	101	\$72,853	8	2,099	209	\$193,457	5	1,387	277	\$120,754
141	Patrick	0	0	0	\$0	0	0	0	\$0	3	306	102	\$56,610
143	Pittsylvania	10	2,648	265	\$231,309	8	1,231	153	\$81,379	12	2,098	174	\$295,504
145	Powhatan	13	2,105	162	\$237,128	10	3,260	271	\$165,044	6	1,129	188	\$68,293
147	Prince Edward	2	411	206	\$28,872	3	972	324	\$20,114	3	835	208	\$9,903
149	Prince George	2	564	282	\$49,824	2	386	193	\$56,997	2	609	304	\$58,279
153	Prince William	109	11,031	101	\$2,407,696	93	10,119	98	\$2,665,402	105	12,766	104	\$3,766,511
155	Pulaski	28	3,481	124	\$588,114	25	5,421	186	\$463,468	28	7,921	264	\$615,669
157	Rappahannock	12	4,027	336	\$283,702	12	3,311	275	\$190,044	11	3,436	245	\$191,825
159	Richmond County	1	541	541	\$28,488	2	391	195	\$12,878	1	366	366	\$51,598
161	Roanoke County	15	5,104	340	\$289,501	21	4,351	181	\$487,139	20	5,677	246	\$549,764
163	Rockbridge	14	3,229	231	\$338,757	7	1,389	198	\$178,146	7	2,090	298	\$177,236
165	Rockingham	31	7,785	251	\$1,051,737	37	9,415	247	\$977,292	29	8,434	290	\$806,598
167	Russell	11	2,348	213	\$165,966	19	3,761	197	\$116,722	29	5,330	183	\$482,645
169	Scott	5	673	135	\$93,691	6	1,241	206	\$119,360	7	979	139	\$127,968
171	Shenandoah	14	2,481	177	\$109,816	11	2,507	227	\$289,614	14	3,145	224	\$320,325
173	Smyth	3	668	223	\$6,945	6	884	126	\$133,415	10	1,746	158	\$123,590
175	Southampton	2	410	205	\$66,986	3	280	93	\$51,892	6	562	93	\$101,522
177	Spotsylvania	48	12,377	258	\$1,173,396	46	10,525	219	\$1,243,386	31	8,464	256	\$536,787
179	Stafford	18	3,559	198	\$260,969	12	2,759	212	\$273,056	12	2,655	221	\$332,203
181	Surry	1	365	365	\$71,323	2	395	197	\$922	0	0	0	\$0
183	Sussex	0	0	0	\$0	1	507	253	\$4,538	0	0	0	\$0
185	Tazewell	8	1,972	247	\$183,965	9	2,456	245	\$332,625	6	2,194	243	\$161,679
187	Warren	8	1,162	145	\$100,963	7	2,070	295	\$95,877	5	1,059	211	\$46,160
191	Washington	16	4,211	263	\$193,473	23	8,209	315	\$203,212	14	4,106	256	\$152,566
193	Westmoreland	11	3,846	350	\$316,418	9	4,440	341	\$224,742	3	931	310	\$77,851
195	Wise	20	4,019	201	\$413,652	13	3,969	283	\$391,222	14	3,332	238	\$134,940
197	Wythe	15	3,092	206	\$163,841	12	2,458	204	\$156,641	10	3,233	293	\$224,127
199	York	5	1,198	240	\$144,329	5	1,194	238	\$75,168	7	1,656	184	\$114,678
510	Alexandria	8	412	52	\$73,053	12	1,671	119	\$182,529	14	1,234	88	\$501,232
515	Bedford City	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
520	Bristol	34	9,267	273	\$226,197	47	16,846	306	\$194,328	19	6,567	312	\$253,798
530	Buena Vista	5	1,487	297	\$74,649	4	869	173	\$61,054	1	366	366	\$24,321
540	Charlottesville	44	6,894	157	\$765,809	35	6,012	150	\$723,438	31	4,045	118	\$428,017
550	Chesapeake	14	1,232	88	\$239,410	18	2,706	123	\$302,422	23	5,612	233	\$426,820
570	Colonial Heights	0	0	0	\$0	6	439	73	\$108,452	4	939	187	\$136,418
580	Covington	6	2,101	350	\$103,785	6	1,787	223	\$98,961	3	1,418	354	\$137,668
590	Danville	20	3,621	181	\$549,839	29	7,635	238	\$902,765	24	6,355	254	\$488,636
620	Franklin City	1	11	11	\$1,364	1	23	23	\$169	1	31	31	\$5,289
630	Fredericksburg	6	270	45	\$63,437	8	1,563	195	\$203,303	12	2,132	177	\$163,222
640	Galax	1	152	152	\$30,670	1	184	184	\$27,010	1	122	122	\$29,972
650	Hampton	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
660	Harrisonburg	25	5,989	240	\$832,566	21	6,377	303	\$614,571	27	6,897	255	\$703,900
670	Hopewell	9	1,103	123	\$50,450	8	2,034	254	\$155,369	6	1,799	299	\$148,989

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA BY LOCALITY, FY2014 - FY2016

FIPS	Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS-ACROSS ALL RESIDENTIAL PLACEMENTS											
		FY14				FY15				FY16			
		Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
678	Lexington	2	626	313	\$85,875	0	0	0	\$0	1	102	102	\$13,571
680	Lynchburg	62	6,431	104	\$778,746	63	6,821	96	\$696,340	53	12,993	206	\$682,431
683	Manassas City	5	717	143	\$75,783	6	956	159	\$83,759	4	531	132	\$63,524
685	Manassas Park	1	60	60	\$15,170	2	465	232	\$44,685	0	0	0	\$0
690	Martinsville	0	0	0	\$0	1	293	293	\$6,128	1	115	115	\$21,024
700	Newport News	6	1,014	169	\$109,942	8	1,275	141	\$100,007	12	2,245	140	\$174,272
710	Norfolk	40	4,048	101	\$791,670	67	6,328	80	\$803,676	65	6,330	84	\$799,928
720	Norton	5	1,472	294	\$84,685	3	299	99	\$35,683	1	330	330	\$2,881
730	Petersburg	22	6,091	277	\$834,459	39	9,915	236	\$1,077,829	33	10,503	291	\$1,153,954
735	Poquoson	2	332	166	\$59,357	2	730	365	\$82,519	2	375	187	\$2,229
740	Portsmouth	4	1,446	362	\$110,743	5	702	140	\$58,788	7	1,307	186	\$149,874
750	Radford	11	2,421	220	\$477,423	10	2,486	226	\$346,660	14	3,559	222	\$283,594
760	Richmond City	108	20,975	194	\$1,383,018	146	37,015	213	\$2,541,711	146	15,892	92	\$2,269,918
770	Roanoke City	55	3,566	65	\$924,919	47	14,757	254	\$954,916	41	9,160	157	\$760,982
775	Salem	5	1,137	227	\$26,131	5	382	76	\$56,144	5	398	79	\$47,785
790	Staunton	7	1,553	222	\$78,273	7	2,210	245	\$171,620	8	2,308	288	\$106,514
800	Suffolk	7	1,336	191	\$187,936	9	1,220	101	\$265,840	9	1,151	104	\$145,473
810	Virginia Beach	118	34,004	288	\$2,962,896	125	38,454	254	\$3,005,590	111	35,113	252	\$2,512,836
820	Waynesboro	12	2,715	226	\$205,415	14	2,981	175	\$167,592	7	1,724	246	\$143,331
830	Williamsburg	1	199	199	\$27,382	2	119	59	\$23,664	1	9	9	\$1,056
840	Winchester	5	1,494	299	\$105,198	10	2,333	194	\$257,558	15	2,204	146	\$396,836
1200	Greensville/Emporia	3	711	237	\$58,433	2	592	296	\$24,900	1	332	332	\$28,021
1300	Fairfax/Falls Church	201	18,914	94	\$3,247,240	209	17,245	72	\$3,261,362	226	13,973	55	\$2,756,509
Totals		1,932	387,506	201	\$39,270,876	2,020	456,992	226	\$41,402,683	1,986	402,276	203	\$40,664,790

The Building Bridges Initiative (BBI): Advancing Partnerships. Improving Lives.

Overview of the National Building Bridges Initiative (BBI)

Presented by:
Dr. Allison Jackson, LCSW, CSOTP
System of Care Director
Magellan of VA



Building Bridges
INITIATIVE

Advancing Partnerships. Improving Lives.



Top 5 Trends To Expect^{*} in the next 3-5 years

- 1. Expecting less money from local, state and federal governments.**
- 2. Service purchasers increasingly want to buy results and not services.**
- 3. Emphasis on durable results that can be sustained for 6 – 12 months post-residential discharge.**
- 4. Movement from child-centered to family-focused service delivery.**
- 5. Faster moves toward permanency for children not returning home.**

^{*} From Tom Woll's 40 Trends Report, January 2014



Advancing partnerships among residential and community-based service providers, youth and families to improve lives.

BBI Mission

Identify and promote practice and policy initiatives that will create strong and closely coordinated **partnerships and collaborations** between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are **family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes.**

BBI Core Principles

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)

Critical Elements

Residential-Specific Research Shows Improved Outcomes With:

- Shorter Lengths of Stay,
- **Increased Family Involvement,**
- Stability and Support in the Post-Residential Environment (Walters & Petr, 2008).



Important CA RBS Study Findings

The negative relationship between the total number of RBS placement changes and achieving permanency is highly significant, indicating that the chance of achieving permanency decreased by 84% with each additional placement. In addition, the chance of achieving permanency decreased by 28% with every additional month of a youth's average length of stay in an RBS placement.

Important CA RBS Study Findings

The chance of completing RBS decreases by 15% with every additional month of a youth's stay in an RBS placement, based on average length of stay, and the chance of completion decreases by 66% with each additional placement.

The Importance of Permanency

- Family connections are associated with improved outcomes
- Lack of permanency makes past traumatic events more difficult to manage
- Connections with family increases positive identity development
- Treatment alone does not meet the needs of youth without family connections

“Rightsizing Congregate Care: A Powerful First Step in Transforming CW Systems”, Annie E. Casey Foundation, 2009

Examples of Where BBI Work

HAS OR IS Happening

- Comprehensive State Initiatives (DE, IN, MA, CA - Initially 4 Regions/Pilots – going statewide)
- Initial/Some State Level Activities (AZ, FL, LA, MI, NH, NM, ND, OK, SC, VA, WA, WV & Georgia; in CA & MD – Provider Associations Led)
- County/City Level Initiatives (Cities: NYC, Philadelphia; Counties: Monroe/ Westchester, NY & Maricopa, AZ)
- Many Individual Residential and Community Programs Across the Country

Steps Being Taken Across the Country

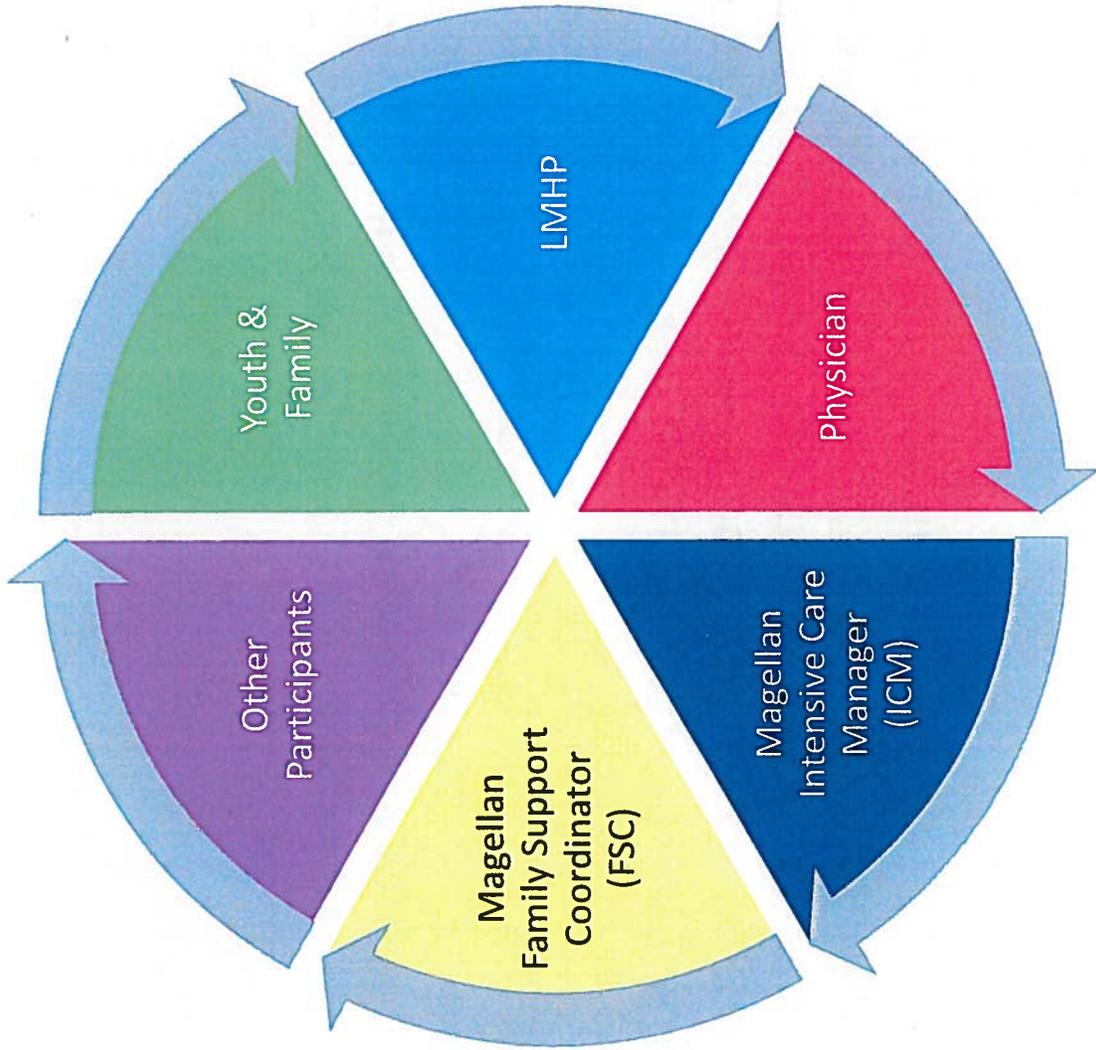
- Using BBI documents to provide guidance to residential and community providers
- Holding regional and/or statewide BBI forums
- Rewriting regulation/licensing based on BBI principles/practices
- Developing BBI teams and developing plans for state-specific projects
- Revising fiscal strategies to support replication of BBI informed program models



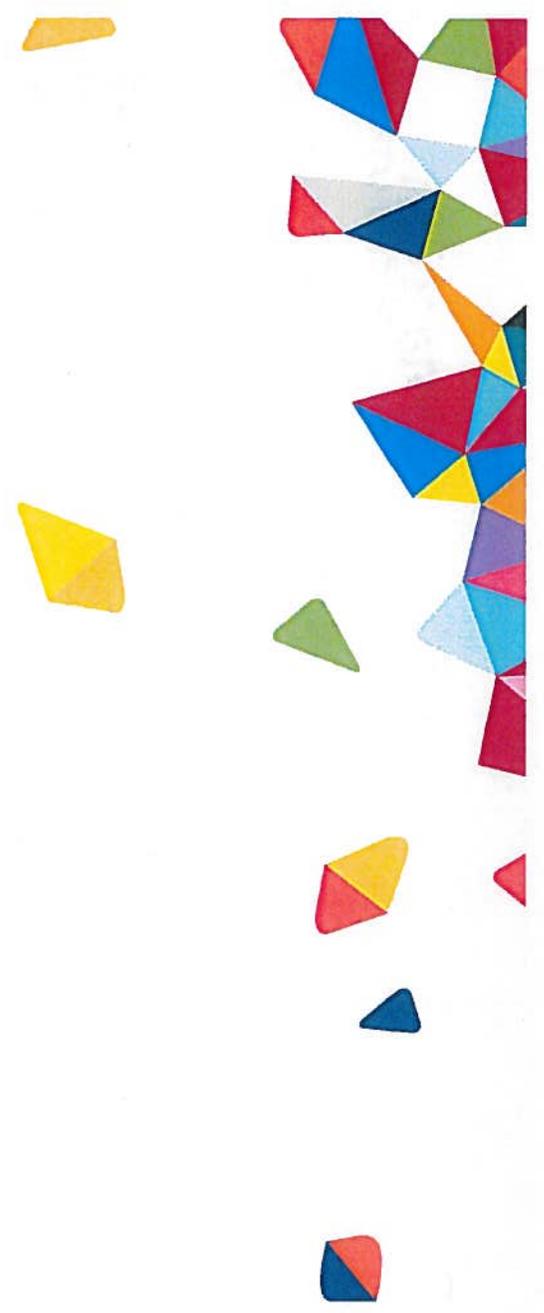
Independent Assessment, Certification & Coordination Team (IACCT)

- Magellan will serve as a single point of entry for youth at risk of admission to residential treatment. For all Medicaid funded residential admissions, referrals must be made to Magellan, and the admission will be coordinated by the Independent Assessment, Certification and Coordination Team (IACCT).
- This team will consist of various professionals who will collaborate to provide assessments or assist in gathering medical and behavioral health treatment records that will be used to fully assess the youth and family needs in order to formulate a preliminary plan of care.

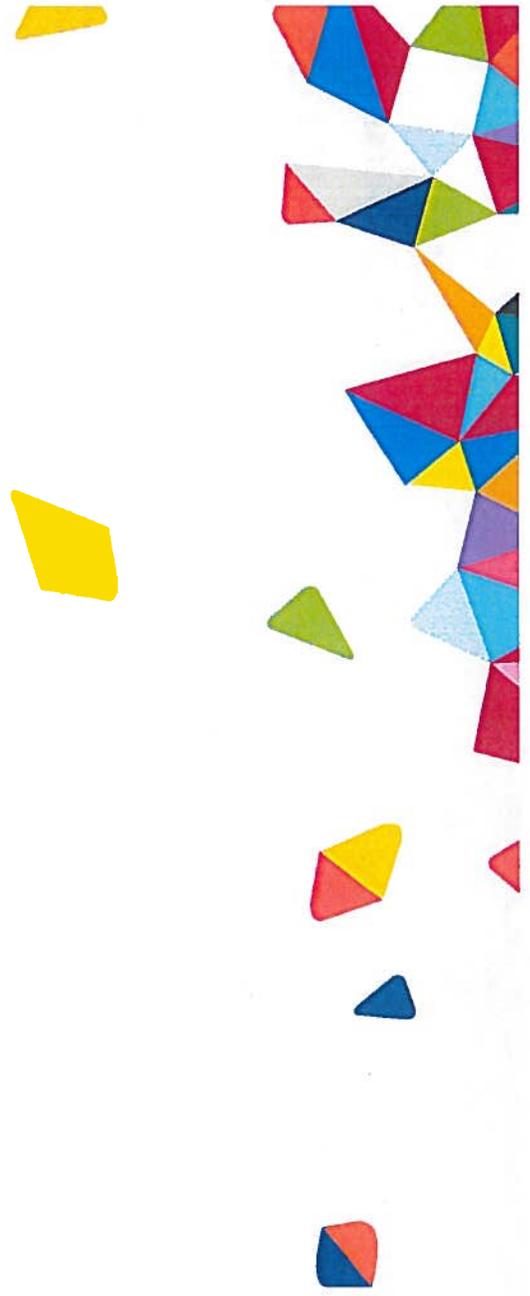
IACCT Team Members



Your Guide to the IACCT



Physician Engagement Process



Additional Information and Resources

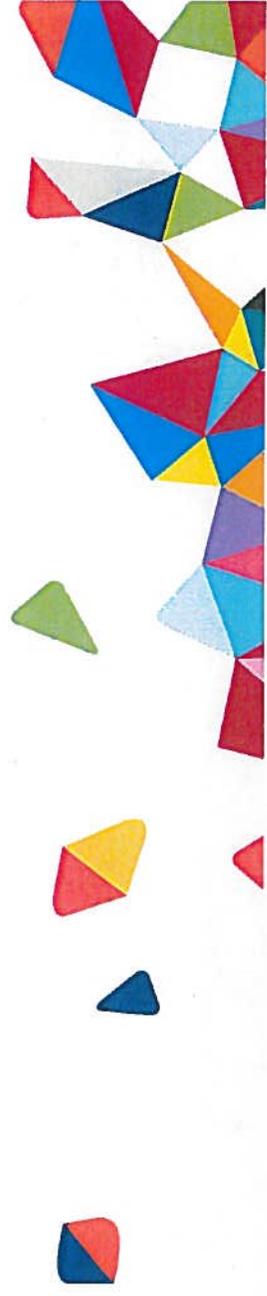
Magellan of Virginia - Residential Program Process

DMAS Behavioral Health, Addiction and Recovery Treatment Services

<http://dmasva.dmas.virginia.gov/Content/pgs/obh-home.aspx>

Building Bridges Initiative

<http://www.buildingbridges4youth.org/resources>

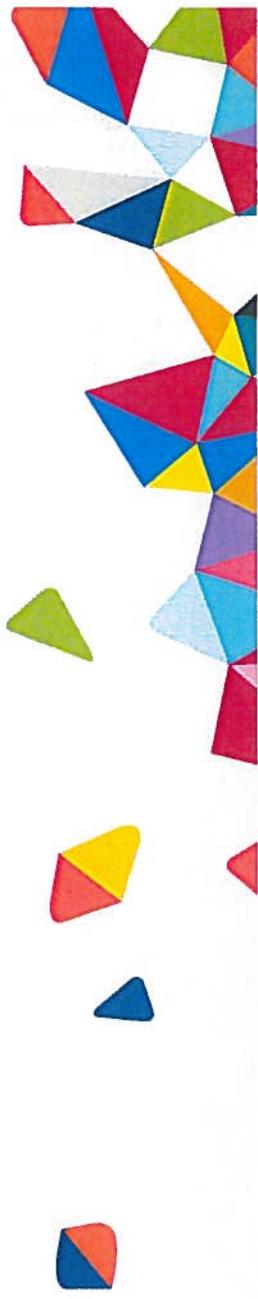


Additional Information and Resources

Magellan of Virginia - Psychiatric Residential Treatment Facility changes
<http://magellanofvirginia.com/for-providers-va/psychiatric-residential-treatment-facility-changes.aspx>

DMAS Behavioral Health, Addiction and Recovery Treatment Services
<http://dmasva.dmas.virginia.gov/Content/pgs/obh-home.aspx>

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Additional Information and Resources

Magellan of Virginia - Psychiatric Residential Treatment Facility changes

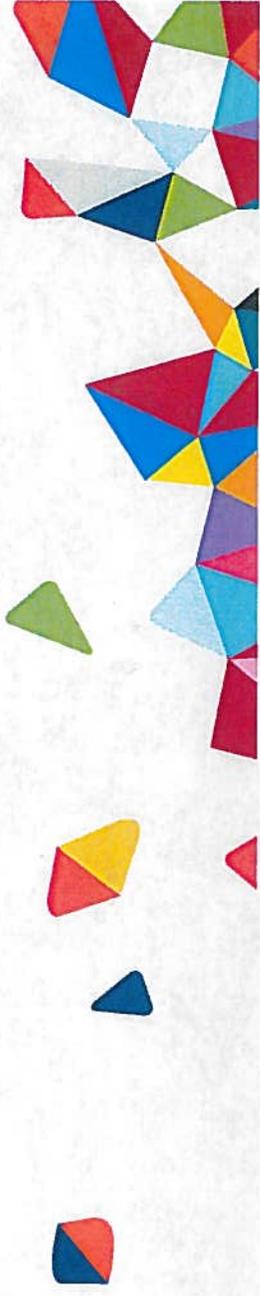
<http://magellanoftreatment.com/for-providers-va.aspx>

DMAS Behavioral Health, Addiction and Recovery Treatment Services

<http://dmasva.dmas.virginia.gov/Content/pgs/obh-home.aspx>

Building Bridges Initiative

<http://www.buildingbridges4youth.org/resources>



Resources/Further Information

BBI



**Building Bridges
INITIATIVE**

Advancing Partnerships. Improving Lives.

Go to BBI Website:

www.buildingbridges4youth.org

Documents & articles to support field, e.g.:

- *Fiscal Strategies that Support the Building Bridges Initiative Principles*
- *Cultural and Linguistic Competence Guidelines for Residential Programs*
- *Handbook and Appendices for Hiring and Supporting Peer Youth Advocates*
- *Numerous documents translated into Spanish (e.g., SAT; Family and Youth Tip Sheets)*
- *Engage Us: A Guide Written by Families for Residential Providers*
- *Promoting Youth Engagement in Residential Settings*



Endorse the BBI Joint Resolution

- Go to BBI Web Site (www.buildingbridges4youth.org)
- Read BBI Joint Resolution (JR)
- E-mail Dr. Gary Blau (Gary.Blau@samhsa.hhs.gov) or Beth Caldwell (bethcaldwell@roadrunner.com) that You Would Like to Endorse BBI JR
- Be Put on List Serve to Receive BBI Newly Developed Documents
- Be First to be Invited to BBI Events

Advancing partnerships among residential and community-based service providers, youth and families to improve lives.



2014 Book: Residential Interventions for Children, Adolescents and Families: A Best Practice Guide

There are several options for ordering:

- toll free phone: at 1-800-634-7064
- fax: 1-800-248-4724
- email: orders@taylorandfrancis.com
- website: www.routledgehealth.com (20% discount w/ web orders using code IRK71; free global shipping on any orders over \$35)

Orders must include either: the Title: *Residential Interventions for Children, Adolescents and Families: A Best Practice Guide* **OR** the ISBN: 978-0-415-85456-6

Note: As a federal employee, Gary Blau receives no royalties or any other remuneration for this book. Any royalties received by Beth Caldwell and Bob Lieberman will be used to support youth and family empowerment consistent with BBI.



BBI Guides/Tips Sheets/Informational Documents Available by Early/Mid 2017

- How-to Guide for Transforming to Short-term Residential (AECF)
- Guide for Judges on Best Practices in Residential (w/ ACRC & AECF)
- Fiscal Strategies for States/Communities for Funding Residential Transformation
- Easy to Implement Fiscal Strategies for Oversight Agencies
- Lessons Learned and Fiscal Strategy Recommendations from a Successful Transformational Leader
- Analysis of Medicaid Regulations that Impact Residential Best Practices; Recommendations for Improvement
- Tips for Working with and Supporting Adoptive Families
- Preventing Residential for Children < 12
- Wraparound Interventions for Residential & Communities
- Tip Sheet on Collaboration Strategies between Child Welfare and Residential on Implementing Permanency Practices
- Strategies Oversight Agencies can take To Address Dis-proportionality of Youth of Color in Residential Programs

Advancing partnerships among residential and community-based service providers, youth and families to improve lives.



Additional RBS Resources

Information on the California RBS Reform Coalition project and other County models can be found at: www.rbsreform.org

Advancing partnerships among residential and community-based service providers, youth and families to improve lives.



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**Guidance for CSA Community Policy and Management
Teams Regarding the DMAS/Magellan Independent
Assessment and Care Coordination Team (IACCT)
Process**

December 20, 2016

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**Guidance for CSA Community Policy and Management Teams Regarding the
DMAS/Magellan Independent Assessment and Care Coordination Team (IACCT)
Process**

December 20, 2016

I. Introduction

Effective January 1, 2017, the Virginia Department of Medical Assistance Services (DMAS) will implement new regulations (12VAC30-50-130) which involve major changes to the Psychiatric Residential Treatment Service Program (current Level C and Level B placements). Included in these changes is the establishment of a revised process for determining if a Medicaid-eligible child meets medical necessity criteria and issuing the Certificate of Need required for Medicaid funding of such placements. DMAS and Magellan of Virginia, DMAS' contracted behavioral health services administrator, have developed relevant guidance and training regarding how these new practices, known as the Independent Assessment and Care Coordination Team (IACCT) will function.

This document is intended to provide guidance for local CSA programs about the interface between FAPT/CPMT processes under the Children's Services Act (CSA) and the DMAS/Magellan IACCT process. This guidance will address work flow, decision making authority, and fiscal responsibility. *Please note: the authority to obligate CSA funds is in all cases retained by the local CPMT. DMAS/Magellan, through the IACCT process, in all cases retains authority to obligate Medicaid funds to pay for the covered components of such placements.*

II. Children in the Custody of a Local Department of Social Services (LDSS)

(Note: All placements of children in the custody of an LDSS will be initiated by the LDSS as the legal guardian through established VDSS regulations and policies as well as local CSA policies governing "emergency" and "non-emergency" placements. As the legal guardian, LDSS will be expected to participate in the defined IACCT processes in addition to the current FAPT requirements.)

- A. “Non-Emergency Placements”: These are children in the custody of an LDSS who are presently in a viable foster care placement [family foster home, treatment foster care, or other setting where they can be safely assessed and reside (e.g., psychiatric hospital, juvenile detention center)] and for whom the LDSS is recommending a placement change to a residential treatment facility (Level C) or therapeutic group home (Level B).
1. If the child's Medicaid eligibility is already established, it is strongly encouraged that referrals by the LDSS family service worker to the Family Assessment and Planning Team (FAPT) for consideration through established LDSS and CSA local policies and to the IACCT for that locality be carried out in such a manner as to minimize delay in consideration of the referral by both entities. For example, the referral to the FAPT and the IACCT could be made concurrently. The LDSS family service worker should collaborate, to the extent possible with the IACCT on the recommendation for residential or alternate community-based services.
 - a. If the CSA process and the IACCT results in a recommendation and approval of a residential placement (issuance of the Certificate of Need (CON) and CSA approval):
 - funding will be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. For Level C placements, room and board and daily supervision costs are either billed directly to the LDSS (if the child is Title IV-E eligible) or included in the Medicaid billing if the child is not Title IV-E eligible). For foster children placed in a Level B therapeutic group home, room and board is paid either through Title IV-E or CSA as room and board in such facilities is not a Medicaid covered expense.
 - the local Medicaid match is collected by the OCS for transmittal to DMAS.
 - b. If the IACCT issues a Certificate of Need, but the CSA does not authorize the placement, no CSA funds may be used.

2. If the child's Medicaid eligibility has not yet been established (or is suspended due to a placement in a juvenile detention setting or commitment to the Department of Juvenile Justice), the CPMT may "guarantee" the cost of the treatment services pending the Medicaid eligibility determination (or reinstatement), at which time eligibility is made retroactive to the date the child entered LDSS custody or had Medicaid eligibility reinstated. If the child in LDSS custody is determined to be ineligible for Medicaid (e.g., child is undocumented for immigration purposes, child has parental resources that make them ineligible for Medicaid), CSA will be fully responsible for the cost of CSA approved placements. These children will typically be assessed by the CSA team prior to referral to the IACCT, as they are not yet Medicaid eligible. Alternatively, they may fall under the "Emergency Placement" provisions found below.

3. If CSA approves the placement but the IACCT does not issue of a Certificate of Need:
 - CSA is authorized to cover the full cost of the placement for a period to be approved by the CPMT. The FAPT/CPMT should work with the IACCT and Magellan to determine and arrange the appropriate services to meet the child's needs and an alternative to residential placement should be implemented as soon as practicable.
 - Room and board and daily supervision costs are either billed directly to the LDSS (if the child is Title IV-E eligible) or to CSA.
 - the local Medicaid match will not be collected by CSA as Medicaid will not be paying for any part of the placement.
 - local policy will determine whether CSA will approve such placements and for what period of time or alternatively, the implementation of non-residential services in collaboration with Magellan's case management staff may be required.
 - if a child in foster care is ordered by the court to be placed in a residential treatment facility (Level B or Level C), the CSA shall cover the full cost of the placement in accordance with the court order, even if the IACCT does not authorize the placement.

- the local CSA will report on these cases (Certificate of Need not authorized by the IACCT) to the Office of Children's Services (OCS) using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).
4. If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility would be required for CSA purposes.
- B. "Emergency Placements": Children in the custody of an LDSS who are in immediate need of placement in a residential treatment facility (Level C) or therapeutic group home (Level B) and who do not meet the criteria to receive crisis intervention, crisis stabilization or acute psychiatric inpatient services may require emergency placements in residential or group home programs. These are defined in the DMAS regulations as "emergency admissions" or "placements". Such "emergency placements" are authorized under the CSA (§2.2-5209) for up to 14 days at which time the "routine" FAPT and CPMT approval processes must occur. The circumstances under which the LDSS initiates an emergency placement or admission are the same as under current CSA and LDSS practice. Emergency placements in residential facilities for children in foster care should generally be an action of last resort after other less restrictive placements are explored and ruled out.
1. According to 12VAC30-50-130, the Certificate of Need for such emergency admissions shall be completed by the facility-based team responsible for the child's plan of care within 14 days of admission and submitted to Magellan. The certification shall need to cover the full period of time after admission and before for which claims are made for reimbursement by Medicaid. The facility admitting a foster child under the "emergency placement" process shall work with the legal guardian (LDSS) to refer that child to the IACCT in the locality

where the LDSS holds custody within five days of admission, but the Certificate of Need will be completed by the facility team, not by the IACCT.

2. All children placed in a residential treatment facility or therapeutic group home under LDSS/CSA emergency placement authority shall immediately be referred by the LDSS family service worker to the Family Assessment and Planning Team (FAPT) for consideration through established local CSA practices.
3. If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility would be required for CSA purposes.
4. Once the child is referred to the FAPT/CPMT and the placement is no longer under the “emergency” provisions (i.e., after 14 days following the placement), the same guidance as applies to “non-emergency” placements of children in LDSS custody will apply. Reauthorization for Medicaid funding after the Certificate of Need for the initial emergency admission will be pursuant to the established Magellan procedures and criteria.

III. Students with Education Disabilities Placed Pursuant to an Individualized Education Program (IEP)

- A. Students placed in Level C residential facilities due to this setting being specified as the Least Restrictive Environment (LRE) on their IEP shall be referred to FAPT and/or CPMT for funding of such placements according to local CSA policy.
- B. If the child is Medicaid eligible at this time, the parents/legal guardian should be asked (and assisted as needed) to make a self-referral to the local IACCT to determine if the child meets medical necessity criteria which would (potentially) allow the treatment component of the placement to be paid by Medicaid. Parents/legal guardians of students placed for educational reasons cannot be compelled to be referred to IACCT as they are entitled to a free and appropriate public education independent of any utilization of Medicaid funds to support such placements. If the child is also in foster care, the LDSS shall make a referral to the IACCT in their role as legal guardian.
- C. When the parent/legal guardian agrees to a referral to IACCT:
- if the IACCT process results in an approval of the placement with Medicaid funding due to existing medical necessity criteria:
 - funding would be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. If the child is also in foster care, room and board would be billed as for a foster child (Title IV-E or Medicaid).
 - the local Medicaid match is collected.
 - no parental contribution can be assessed.
- D. The IEP remains the governing authority for the placement. If at any time, Magellan/DMAS discontinues authorization for the placement, CSA will become fully responsible for the cost

of the placement as long as the IEP remains in effect with residential placement as the LRE.

- E. If the child is placed in a non-Medicaid facility (including those designated exclusively as residential schools and not psychiatric treatment facilities) in accordance with the IEP the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility would be required for CSA purposes.
- F. If the parent/legal guardian declines to refer to IACCT or the IACCT determines that the child does not meet medical necessity criteria, CSA shall be fully responsible for the full range of costs associated with the educational placement.
- If the IACCT does not authorize the Certificate of Need, the local CSA will report on such cases to the Office of Children's Services (OCS) using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).
- G. Children currently served through CSA through an IEP for private day educational services, may at times, be placed directly by their parents in a residential treatment setting for non-educational reasons (i.e., the placement in the residential setting is not the least restrictive environment specified on the child's IEP). In such instances, the private day education becomes "functionally unavailable" and the cost of the child's educational services in the residential setting becomes the responsibility of the CSA. The cost of the child's non-educational services (treatment) in the residential setting is not the responsibility of CSA and will be funded via Medicaid, as appropriate or the parent. CSA may review and consider whether the child meets criteria for a CSA Parental Agreement, in which case the guidance provided in that section of this document would apply. The local Medicaid match

will be collected for children with private day IEPs placed in residential settings by their parents as these are considered to be CSA cases.

IV. Child in Need of Services / CSA Parental Agreement and “Non-Mandated” Children

(Note: This section refers to children who have already come through the CSA process for eligibility and service planning processes.)

- A. Determination of CSA eligibility as a Child in Need of Services (CHINS) or as a CSA-eligible “non-mandated” child will be made by the FAPT in accordance with existing CSA and local CPMT policy. Once eligibility for CSA has been established, the FAPT then determines (and the CPMT approves) if placement in a Level B or Level C facility is appropriate and initiates a CSA Parental Agreement.
- B. If the child is Medicaid eligible, the parents/legal guardian should be asked (and assisted as needed) to make a self-referral to the local IACCT to determine if the child meets medical necessity criteria. The CPMT should establish policy that all CSA Parental Agreements for Medicaid eligible children be referred to the IACCT for consideration for Medicaid funding. This is consistent with CSA requirements that Medicaid funding shall be utilized when possible. Local CPMT policy should establish whether CSA Parental Agreements for residential placements for Medicaid-eligible children should be made contingent on completion of the IACCT process and an approval for Medicaid funding of the applicable components of the placement (i.e., treatment and room and board).
- C. If the IACCT process results in an approval of the placement:
- funding would be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. For Level C placements, room and board costs are included in the Medicaid billing. For children placed in a Level B therapeutic group home, room and board is paid through CSA as room and board in such facilities is not a Medicaid covered expense.
 - the local Medicaid match is collected.
 - parental contribution should be assessed and collected.

- D. If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility would be required for CSA purposes.
- E. If the IACCT process does not result in approval of the placement:
- CSA is authorized to cover the full cost of the placement for a period to be approved by the CPMT.
 - local policy will determine whether CSA will approve such placements and for what period of time and whether such a determination from the IACCT will require the implementation of alternative services in collaboration with Magellan's case management staff. The CPMT may wish to establish policy making such placements via CSA Parental Agreement contingent on IACCT approval for Medicaid-eligible children. The FAPT/CPMT should work with the IACCT and Magellan to determine and arrange appropriate services to meet the child's needs and arrange an alternative to residential placement as soon as practicable.
 - if the child is determined to be a CHINS via a court finding and the court order is for residential treatment, the CSA shall cover the full cost of the placement in accordance with the court order.
 - the local Medicaid match will not be assessed as Medicaid will not be paying for any part of the placement.
 - the local CSA will report on cases in which the Certificate of Need not authorized by the IACCT to the Office of Children's Services (OCS) using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).

V. Medicaid-Eligible Children Referred Directly to IACCT

- A. Parents/legal guardians of Medicaid-eligible children not previously described in this guidance document may be referred to IACCT without current involvement in the CSA process. Such children may be referred by other service providers, a residential facility, or directly by the parent. In such cases, the DMAS regulations and Magellan work flow require that, with the parent's consent, the IACCT will notify the local CSA office. CSA eligibility determination and service planning will then occur according to state and local CSA policies. The IACCT teams, Magellan Intensive Case Management staff and the CSA office in each locality are encouraged to develop protocols for information exchange. The local CSA program should develop policies and procedures regarding how to integrate these children and families into existing CSA processes, as appropriate. Existing CPMT parental referral policies should be reviewed and in many instances may be sufficient to address these children under the new IACCT process.

VI. Children Becoming Eligible for Medicaid after 30 Days in Placement ("Family of One" Eligibility)

The DMAS regulations (Psychiatric Services Supplement A (page 19) specify that:

"All individuals entering psychiatric residential treatment care utilizing private medical insurance who will become eligible for enrollment in the state plan for medical assistance within 30 days following the facility admission are required to have an independent certification of need completed by the team responsible for the plan of care at the facility will provide the certificate of need using the facilities treatment team within 14 days from admission.

Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify the BHSA of the individual's status as being under the care of the facility within 5 days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT."

- A. For children who are already known to CSA as described elsewhere in this guidance document, the FAPT should upon authorizing, recommending or making an IACCT-approval contingent placement through CSA, gain parental consent and refer the child to the IACCT upon becoming Medicaid eligible as specified in the regulations. Parents should be advised that if they wish avail themselves of the Medicaid benefit after 30 days in placement, this is a requirement of the state Medicaid program. Guidance provided in this document is applicable to these situations, depending on the CSA eligibility category of the child.
- B. Local CSA policy should be developed, if needed, for instances in which parents decline to seek Medicaid eligibility and there are no other CSA mandates (i.e., placements for educational purposes).

VII. Medicaid Member Provider Choice and CSA Funding

- A. In accordance with federal Medicaid requirements, Virginia DMAS regulations also require that the individual and their parent or legally authorized representative shall have the right to freedom of choice of Medicaid-approved service providers. Many local governments and their CSA programs have established contractual agreements with providers of residential placements resulting in a limited set of provider options.

- B. Medicaid members retain the right to freedom of provider choice for Medicaid funded services. However, this provider choice does not extend to non-Medicaid covered services (e.g. education in the residential setting). Under circumstances in which the member's parent wishes to receive residential treatment in a facility not under contract with the locality, CSA is not obligated to fund the non-Medicaid covered components of the program. Parents opting to place their children in facilities not under contract with the local CSA program may be responsible for the non-Medicaid covered components of the placement.

- C. Local CSA programs, parents of Medicaid-eligible children being considered for residential placement and the Magellan Intensive Care Management team serving the locality are encouraged to work collaboratively to select placements that will best meet the needs of the child and provide maximum funding for necessary services.

VIII. CANS, IACCT and the CSA CANVaS Software

- A. Magellan requires that all children being authorized for Medicaid-funded residential treatment have a valid, recently completed Child and Adolescent Needs and Strengths (CANS) assessment.
- B. Children known to CSA:
1. For children currently **referred to an IACCT** from a FAPT/CPMT, the CANS should be completed by the CSA case manager (LDSS, CSB, CSU, school or CSA staff) in accordance with state and local CSA requirements, entered into the CSA CANVaS on-line software. CSA continues to require a CANS assessment, completed by the designated CSA-related personnel, and entered into the CANVaS system.
 2. With proper consent of the parent/legal guardian in accordance with local CSA consent requirements, local CSA offices may provide copies of previous CSA-related CANS assessments to the IACCT.
 3. Children **referred from an IACCT** to a FAPT and who are determined to be eligible for CSA funding and for whom an individual family service plan (IFSP) is being developed will require a "CSA completed" CANS, entered into the CANVaS system even if the IACCT has already completed a CANS. IACCT will not be utilizing the CSA specific version of the CANS and will not have access to the CANVaS system. This is to protect the integrity and security of the CSA CANVaS system as many IACCTs will be private providers not authorized to access the CANVaS system.
- C. For children not known to CSA and for whom a referral has been made to IACCT:
1. the IACCT will complete the CANS and enter the information into the Magellan proprietary CANS data system in accordance with Magellan requirements.
 2. children not currently open to CSA cannot have a CANS entered into the CANVaS system, even if completed by CSB personnel serving as the LMHP in an IACCT.

Data Collection for CSA / IACCT Interface
To be implemented for CSA Referred/IACCT Not Approved Cases
(On-line Data Reporting Accessible by a Local Report Preparer via CSA Website)

Data Elements:

1. Month when IACCT determination is made (Select One from list)
2. Locality (Select One from list)
3. Last Name (open text)
4. Date of Birth (xx/xx/xxxx)
5. SSN (xxx-xx-xxxx)
6. Type of Placement Sought (Select One)
 - Psychiatric Residential (Level C)
 - Therapeutic Group Home (Level B)
7. Referral Source (select one major category and one sub-category)
 - DSS (Y/N), If yes:
 - Emergency (Y/N)
 - Non-Emergency (Y/N)
 - IEP/Educational Placement (Y/N), If yes:
 - IEP specifies residential as LRE (Y/N)
 - IEW specifies private day as LRE (Y/N)
 - CSA Parental Agreement (Y/N). If yes:
 - CHINS Court Ordered (Y/N)
 - CHINS FAPT Determined (Y/N)
 - Non-Mandated (Y/N)
8. Was this case already in residential placement when opened by CSA? (Y/N)
9. Reason for Non-Approval by Magellan (Select One)
 - Doesn't Meet Medical Necessity
 - Parent fails to complete IACCT Process
 - IACCT Unable to Engage Physician
 - Other

10. Alternate service recommended by IACCT (select all that apply)

- Intensive In-Home (Y/N)
- Therapeutic Day Treatment (Y/N)
- Mental Health Skill Building (Y/N)
- Crisis Stabilization/Crisis Intervention (Y/N)
- Psychiatry (Y/N)
- TFC (Case Management) (Y/N)
- Other Outpatient Services (Y/N)

11. Was Decision Appealed to DMAS? (Y/N)

12. If yes, Outcome of Appeal?

- Denial upheld (Y/N)
- Denial overturned (Y/N)
- Other (Y/N)

13. Final CSA action (Check all that apply)

- Alternate services via Medicaid
- Alternate services via CSA
- Place child residential without Medicaid funding



Office of
Children's Services

Considerations Regarding the CSA Denial of Funds Policy and Process

State Executive Council for Children's Services

December 15, 2016

Prepared on behalf of the SEC Finance and Audit Committee

1



Office of
Children's Services

The Issues

- Current OCS practice following audit findings is not fully supported by written SEC policy
 1. Audit finding of non-compliance under SEC Policy 4.6
 2. Referral of findings with financial implications to internal OCS review team with recommendations made to OCS Director
 3. OCS Director reviews and issues findings to locality
 4. Locality may use current SEC Dispute Resolution process (SEC Policy 3.4)

2



Desired Outcomes

- Transparency
- Fiscal and programmatic accountability
- Fairness, consistency and reasonable flexibility
- Continuous quality improvement

3



Governing Statutes and Policies

- §2.2-2648. 19 and §2.2-2648.20
- Chapter 780, Item 285.B.4. (Appropriation Act)
- SEC Policy 4.6 ("Denial of Funds")
- SEC Policy 3.4 ("Dispute Resolution Process")

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Areas of Non-Compliance

- Statutory
- Policy
- Dimensions of Non-Compliance
 - Severity
 - Chronicity
 - Linkable to specific expenditures vs. general administrative deficiencies

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Policy Development Proposal

- Delineate findings that “should” result in denial of funds, such as:
 - Ineligible youth served
 - Ineligible services provided
 - Failure to have any FAPT/CPMT approval of eligibility and/or services
 - Repeat issues of non-compliance cited in previous audits or failure to properly execute corrective action plans

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Office of
Children's Services

Policy Development Proposal

- Delineate findings that “should not” result in denial of already reimbursed funds
 - Audit findings not specifically tied to expenditures (e.g., deficient CPMT policies or practices, improper/inadequate documentation not associated with eligibility of youth/services)
 - First-time findings for which adequate corrective action plans have been submitted (e.g., missing CANS; lack of UR on cases)

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Office of
Children's Services

Policy Development Proposal

- Delineate findings that result in a “hold” on future reimbursements until corrective action is implemented and verified
 - Findings not tied to specific expenditures
 - Subsequent/repeat findings after an initial finding without adequate corrective action

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Risks to Be Avoided

- "All or nothing" approach
- Perceptions of "punitive" approach
- Not achieving desired outcomes

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Next Steps

- SEC to authorize Finance and Audit Committee to develop a proposed policy
- Proposed policy to be considered in accordance with SEC Public Participation Policy (2.4) adopted in 2016

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