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**STATE EXECUTIVE COUNCIL (SEC)
COMPREHENSIVE SERVICES ACT FOR AT RISK YOUTH AND FAMILIES
Charterhouse School Auditorium, UMFS
3900 W. Broad Street
Richmond, VA
Thursday, March 14, 2013**

SEC Members Present:

The Honorable William A. (Bill) Hazel, Jr., M.D., Secretary of Health and Human Resources
The Honorable Richard “Dickie” Bell, Member, Virginia House of Delegates
Lelia Hopper for Karl Hade, Executive Secretary of the Supreme Court of Virginia
Jim Stewart, Commissioner, Department of Behavioral Health and Developmental Services
Michael Farley, CEO, Elk Hill, Inc.
Dr. Cynthia Romero, Commissioner, Virginia Department of Health
Margaret Schultze, Acting Commissioner, Virginia Department of Social Services
Cindi Jones, Director, Department of Medical Assistance Services
Greg Peters, CEO, UMFS
Martin Nohe, Parent Representative
The Honorable Patricia O’Bannon, Member, Henrico County Board of Supervisors

SEC Members Absent:

Karin Addison, Assistant Secretary for Children’s Health and Education
The Honorable John Edwards, Member, Virginia Senate
Mary Bunting, Hampton City Manager
John Eisenberg for Superintendent Patricia Wright, Virginia Department of Education
Mark Gooch, Director, Department of Juvenile Justice
Joseph Paxton, Rockingham County Administrator

Staff Members Present:

Matt Cobb, Deputy Secretary of Health and Human Resources
Eric Reynolds, Assistant Attorney General, Office of the Attorney General
Susan Cumbia Clare, Executive Director, Office of Comprehensive Services (OCS)
Stacie Fisher, Program Consultant, OCS
Janice Graham, Program Consultant, OCS
Ty Parr, Financial and Data Consultant, OCS
Brady Nemeyer, Program Consultant, OCS
Marsha Mucha, Administrative Staff Assistant, OCS

Call to Order and Approval of Minutes

Secretary Hazel called the meeting to order at 9:35 a.m. He welcomed Dr. Cynthia Romero as the new Commissioner of the Virginia Department of Health and Eric Reynolds as the new counsel to the SEC from the Attorney General’s Office.

The minutes of the December 20, 2012 meeting were approved without objection.

Public Comment

Dr. Hazel remarked that there were a number of people signed-up to give public comment probably on the revised draft policy regarding use of state pool funds for community-based behavioral health services. He explained that, before hearing comment, he would like to provide some background information concerning the draft policy.

Dr. Hazel explained that one of the powers and duties of the Council is to deny state funding to a locality, where the CPMT fails to provide services that comply with the Comprehensive Services Act (CSA), any other state law or policy, or any federal law pertaining to the provision of any services. He further explained that, regardless of guidance disseminated in the past, for the purposes of determining the use of CSA pool funds for the purchase of community-based behavioral health services, OCS must apply the regulations and policies established by DMAS regarding the appropriateness of such services.

Further, in accordance with the Appropriation Act, pool funds shall not be spent for any service that can be funded through Medicaid for Medicaid-eligible children and youth except when Medicaid-funded services are unavailable or inappropriate for meeting the needs of a child.

Mr. Reynolds consulted with the Office of the Attorney General’s counsel for DMAS and determined that, when CSA statute was being developed, the intent was that CSA statute be consistent with the statutes and policies of other relevant state agencies, including DMAS. In fact, after the 1998 Joint Legislative Audit and Review Commission (JLARC) review of the Comprehensive Services Act, the Director of DMAS was added as a representative to the SEC based on a recommendation made in that report.

Public comments heard:

Catherine Pemberton, representing the Virginia League of Social Services Executives (VLSSE)

- Noted the six (6) purposes of the CSA Act.
- Proposed policy would significantly inhibit flexibility in the use of funds and decision-making at the local level.
- Proposed policy would take away funding decisions from localities.

Kathy Ralston, representing the VLSSE

Written comments attached.

Tamara Temoney, representing the VLSSE

- She noted that, under the 2009 Family Services Review conducted by the VDSS, Virginia was not meeting the permanency goals for children and youth as outlined in the Adoption and Safe Families Act.
- Since that time, many localities have been committed to decreasing the number of children in foster care.
- The proposed policy will add layers to that process and would be detrimental to the achievements made through the Children’s Services System Transformation.

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Carla Taylor, representing the VLSSE

- The requirement to have a licensed mental health professional approve services would be detrimental to the FAPT process and those who are most familiar with the child and/or youth, their family and their particular needs.
- Would add an additional meeting to the process.
- Could potentially cause conflict with juvenile court orders and liability issues for FAPTs.

Carl Ayers, President, VLSSE

- Proposed policy would restrict a locality's ability for local collaboration to meet each community's unique needs.
- Proposed policy is not child-centered, family-focused or community-based.
- Consider the recommendation from SLAT on this draft policy.

Suzanne Adcock, representing the VLSSE

- As a member of the Board of Supervisors, I represent the interest of local government.
- Localities have been greatly affected by the recession and, the proposed Medicaid policy could potentially add an additional burden to localities by increasing costs.
- Our locality has confidence in FAPT and the decisions they make. This proposed policy would take away decision-making at the local level.
- The program costs to implement the proposed ICC policy would impact rural localities and would amount to an unfunded mandate.

At this point in the public comment, Secretary Hazel noted that the allotted time on the agenda for public comment had expired. He asked the SEC members if they wished to continue receiving public comment. A motion was made by Michael Farley, seconded by Greg Peters and carried to continue receiving public comment from all those who had signed-up.

Karen Tompkins on behalf of Molly Cheek, a member of SLAT representing the Virginia Association of Private Provider Associations (VCOPPA)

- SLAT recommended not moving forward with the draft policy so what is presented today is a misrepresentation of what took place at SLAT.

Stephen Jurentkuff, VCOPPA

Written comments attached.

Brad Bryant, People Places, Inc.

- If we need to save money, say so.
- Support CSA or give over to DMAS.
- We seem to be all over the place.

Janet Areson, Virginia Municipal League (VML)

- Agree with comments made.
- This draft policy is a prescription with a lot of side effects.
- Will the workgroup be looking at the whole policy?

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Ray Ratke, Lutheran Family Services

- CSA is a model for the country.
- This proposed policy moves us in the wrong direction.
- Fewer families and children will get the help they need.

Penny Combs, People Places, Inc.

- Struck by the timing of the policy change as we will celebrate 20 years of CSA in May.
- CSA is hailed around the country as a model.
- I have served on FAPT and know the considerable time, energy and effort that FAPTs invest in service planning. This proposed policy will significantly change how decisions are made.
- Orientations to the wrap-around initiative are underway. May as well not do wrap-around if this policy passes.

Karen Reilly-Jones, Chesterfield/Colonial Heights CSA

- If we are trying to clarify the Code of Virginia, need guidelines rather than policy.
- The need for the proposed policy is not based on any data or proof.
- Have not had an opportunity to comment on the revised draft policy presented today.

Dave Williams, Phillips Programs

Written comments attached.

Stephan Starks, National Counseling Group

- Support approval of the SLAT recommendation on the proposed policy.

Abigail Schreiner, Extra Special Parents

- Opposed to policy and policy substitute.
- Will initiate limited access to services.
- Medicaid model does not meet all the needs of a child.
- CSA is not an insurance company but is a collaborative, multi-dimensional process to serve clients and their families.
- Undercuts local decision-making.

Cate Newbanks, Voices for Virginia's Children

- Let decisions be made at local level.
- Foster families have to fight for needs of the child. The Virginia Enhanced Maintenance Assessment Tool (VEMAT) was implemented and now rules have changed. The VEMAT financial reimbursement rates to foster families have decreased 30%.

Denise Gallop, Hampton DSS

- This proposed policy will stunt the voice of families.

Mark Hinson, Parent Representative to SLAT

- Encourage the SEC to accept the recommendation from SLAT.

Becky China, City of Richmond CSA

- Supports implementation – everyone is not on the same page.
- Because of the provision in the Appropriation Act that, if the appropriate services could be funded through Medicaid then Medicaid be used first, providers were driven to develop services that focused on access to Medicaid dollars.
- Suggest we encourage localities to use evidence-based practices and help providers to develop evidence-based services.

Beau Blevins, Virginia Association of Counties (VACO)

- Support the comments from the League and VML.

Executive Director's Report

Mrs. Clare reported on the following items:

- Delegate Bell sponsored two CSA bills in the 2013 General Assembly Session:
 - HB1646 – Amends CSA statutes to clarify that any child/youth eligible for foster care services is eligible for CSA funding and that funding is sum sufficient for the services provided. Amends DSS statutes to clarify the definition of foster care services and independent living services.
 - HB1683 – Amends CSA statute to add Medicaid funded community-based services to the list of services that shall be reported by OCS.
- The Virginia Wraparound Center of Excellence opened on February 11, 2013. Orientation to Wraparound sessions are being held this week in Northern Virginia, Richmond and Tidewater. Two additional orientation sessions are planned for Bristol and Salem.
- Plans are underway for the CSA Conference to be held at the Hotel Roanoke and Conference Center on April 30 and May 1, 2013. A pre-conference session for CSA coordinators will be held on April 29. So far, 240 participants are registered to attend the conference with 62 pre-conference participants and 30 provider/vendors registered. The conference registration fee will increase on April 1, 2013.
- A link to CSA audit observations is posted on the CSA website. Mrs. Clare noted that a summary of the types of audit findings has also been provided to members with their meeting materials.
- Three years of CANS, OASIS and VEMAT data have been transferred to SAS for data integration. Twenty localities that use Thomas Brothers software for data collection will be uploading CSA and Title IV-E expenditure data. A prototype of the data integration and analysis system will be available in May.

Services Gap Survey Summary

Brady Nemeyer reported on the annual survey. Mr. Nemeyer reported that one of the primary responsibilities of the CPMT is to coordinate long range, community-wide planning to develop resources and services needed by children and families in the community. The 2006 Virginia General Assembly amended Chapter 781 of the Code of Virginia to further specify this requirement. On an annual basis, the CPMT shall report to OCS on gaps and barriers in services needed to keep children in the local community.

Mr. Nemeyer reported that the 2012 survey reflects the sixth year that these data have been collected by OCS on the service gaps and barriers for CSA youth in Virginia. For the 2012 survey, 111 surveys were returned.

Mr. Nemeyer highlighted the following from the report:

- 15 of the most reported statewide gaps remain in the top 20
- Crisis intervention and stabilization, intensive substance abuse services and transportation remain the top three reported service needs
- Increased reported service needs for: school-based family support; therapeutic foster care and one-on-one classroom support
- Decreased reported needs for: respite; intensive care coordination and developmental prevention
- Statewide reports of new community services have decreased over the past year

Mr. Nemeyer noted that localities also report on the top barriers to community service availability and changes in community services capacity.

A short discussion took place after Mr. Nemeyer's presentation concerning how the survey is used. Mrs. Clare reported that the SEC's Finance Committee is examining the findings of the Services Gap Survey as a strategy to address service development and to meet identified needs. She further reported that the first in a series of meetings between localities and private providers on service development was recently held in Gate City. Future plans include utilizing data to address service gap needs and perhaps making changes to the survey instrument.

SLAT Report

Victor Evans, SLAT Chair reported. Mr. Evans reported that the terms to SLAT for parents, judges, local DSS and school representatives would expire on June 30, 2013.

Mr. Evans further reported that there are several strategies listed under the goals of the SEC's Biennial Plan where SLAT was asked to take the lead. SLAT has begun working on those strategies. One of the strategies is to examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process, e.g., Medicaid match, family-of-one eligibility and education costs.

SLAT members were asked to seek examples from their localities of the unintended consequences of fiscal incentives or disincentives and how they affect problem-solving at the local level. Mr. Evans reported that two examples were provided at SLAT's February 7, 2013 meeting. Those examples were:

- The VEMAT assessment process of reduced levels of payment which may be an incentive for foster care parents or TFCs to minimally facilitate improvements with the foster care child.
- The cost to localities to partially pay for Medicaid residential services when a child is placed through the FAPT/CPMT approval process, but if the child is placed directly by the parents without going to a FAPT, there is no local partial payment for the same residential services.

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Mr. Evans explained that SLAT was seeking input from the SEC on whether or not these examples met the strategy regarding examining and addressing inadvertent fiscal incentives as noted above. Dr. Hazel answered in the affirmative.

Mr. Evans reminded members and guests that, at the SEC's December 20, 2012 meeting, the SEC directed SLAT to provide the SEC with copies of the applicable SLAT meeting minutes and to assist with identifying who would be impacted by the proposed policy regarding use of state pool funds for community-based behavioral health services. SLAT was also directed to revisit the issue and provide a presentation to the SEC at its March 2013 meeting. He reported that public comment was heard at SLAT's February 7, 2013 meeting.

Mr. Evans further reported that the themes that were common during the public comment period and discussion at SLAT were:

- The topic of managed care is worthy of examination
- Stakeholders would like to be involved in such an examination
- The proposal undermines the progress made to fulfill the intent and purpose of CSA

Mr. Evans reported, that after further discussion at SLAT, the SLAT membership recommended (11 to 2 vote) that the SEC not approve the proposed policy as written. SLAT recommended that the SEC task SLAT or a stakeholder workgroup to work with OCS to review potential impacts of the proposed policy and develop recommendations for addressing identified issues in the proposed policy.

Dr. Hazel thanked Mr. Evans for his report. He noted that it seemed there were at least four different considerations to keep in mind concerning the proposed policy: statutory requirements, DMAS policy, CSA language and the appropriate way to move forward to address the issues noted earlier in the meeting.

Other Business Items

Second Reading of Proposed Policies

Mrs. Clare reported on the two proposed policy recommendations for SEC approval. She noted that both policies had been widely disseminated for a 60-day public comment period. Revisions to both draft policies were made to address concerns noted in the public comments received.

- *Intensive Care Coordination* – ICC guidelines have been incorporated into the revised draft policy; allows private providers to become providers of ICC; includes training requirements for all ICC providers in high-fidelity wraparound; and defines “out-of-home care” and “at-risk of placement in out-of-home care”.
- *Use of State Pool Funds for Medicaid Eligible Services* – The revisions to the draft policy focus on three community-based behavioral health services: Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services.

Recommended Workgroups

OCS recommends to the SEC that two stakeholder workgroups be established:

- *CSA Service Names and Descriptions* – The purpose of this workgroup would be to establish standardized service names and corresponding descriptions in order to enhance the value of data analysis when reporting the services purchased under CSA, and to establish clear distinction between various services.
- *Standardizing Levels of Care in Treatment Foster Care* – The purpose of this workgroup would be to address two of the issues identified by the original TFC Workgroup:
 - There is a need for private child placing agencies to offer basic level, i.e. non-treatment, foster care services.
 - There is a need for greater uniformity across private child placing agencies in the offered levels of treatment foster care.

The workgroup would also examine DMAS regulations and provider requirements for TFC-CM and licensing requirements of VDSS for Licensed Child Placing Agencies and provide recommendations to ensure clarity and consistency across agency recommendations.

Karen Lawson provided background information and spoke about the Virginia Independent Clinical Assessment Process (VICAP) at DMAS. There was a great deal of discussion. Dr. Hazel reminded everyone that, while implementation issues and education on the use of state pool funds for Medicaid eligible services can be addressed, the law must still be followed. Mrs. Jones suggested that an educational meeting be scheduled specifically for local DSS folks.

The two workgroup recommendations were approved without objection. Another workgroup made up of the SEC Executive Committee and several members of SLAT will examine the larger issues around the proposed policy. This group will report to the SEC. The June SEC meeting will be moved to July due to conflict of SEC members.

A request will also be made of the Attorney General’s Office for a secondary review of the statutes as reported above relative to Medicaid eligibility and the use of state pool funds for Medicaid eligible services.

Request to SLAT Regarding SAMHSA Grant

Mrs. Clare reported that SLAT has been asked to work with the SAMHSA grant implementation team to coordinate the SLAT’s look at funding streams and meet the grant requirement for development of a “fiscal plan” for system of care.

Adjournment

There being no further business the meeting was adjourned at 12:07 p.m.

SEC

Proposed Policy: Use of Pool Funds for Medicaid Eligible Services

March 14, 2013

Good morning, my name is Kathy Ralston and I am the director of Albemarle County Department of Social Services. I am here today representing the VLSSE. The League has many concerns with the original policy as proposed and I was to speak to one of the concerns that the newly revised policy has tried to address.

The original proposed policy assumed that CSA can be categorized as a medical insurance program or that service delivery would fit neatly into this type of model. CSA is not an insurance program and the intended purpose of the Comprehensive Services Act was to allow localities to have the freedom needed to address the needs of children and families in their individual communities and to improve outcomes. The assessment of needs used for the children and families served includes but is not limited to their medical needs, and goes well beyond to wellbeing, safety and permanency. Since Children's Services Transformation began in November 2007, localities have dramatically reduced the number of children needing costly services by providing quality preventative services that alleviate the need for more restrictive services later. Recent history has shown that communities have saved the Commonwealth \$117 million between fiscal year 2009 and 2012, largely due to the Transformation effort but supported through the original intent of CSA.

In the revised version of the policy, TFC and residential placements have been removed but the proposed work group is only charged with looking at TFC. Does this mean that for residential placements FAPT will continue to have discretion to determine clinical necessity for continued placement and thus use of CSA funding when Medicaid funding is denied? The revised policy seems to be silent on this yet for local departments of social services the ability to continue placement using CSA funds is critical to being able to meet federal mandates. We hope that this was intentionally left out, thus allowing CSA funds to be used in the best interest of the child and family. However, the revised policy and proposed work groups just recently published and seemingly outside the norm of standard public comment process, have not been able to be thoroughly vetted by the League.

Further, the revised policy seems to say in the opening paragraph that OCS shall deny funding to localities that do not comply with all federal and state policies. However, that is exactly what social services would be doing if we complied with this policy now. In short we are at risk of being out of compliance with our federal mandate as well as at risk of being out of compliance with OCS policy. This puts us in a no-win situation. The revised policy goes on to say that OCS must apply the DMAS regulations and policies for community based behavioral health services. This seems to be in conflict with the requirement to follow all federal and state policies if we are picking one agency policy to follow. We encourage the SEC to seriously consider the recommendation from the SLAT to first pull back from the policy in its entirety until a more thorough analysis of the whole policy can be conducted by either the SLAT or other endorsed stakeholder group. The stakes are too high for negative impact on foster children, the VDSS system and local government for this to be rushed through without broader consideration and in fact targeted consideration with DSS and local government representatives.

Thank you for the opportunity to provide comment today.

Virginia Coalition of Private Provider Associations

Statement on Revised Proposed CSA Policy: Use of State Pool Funds for Medicaid Eligible Services

While appreciative of the recent revisions, we continue to oppose this policy because it undermines the core of the CSA process, FAPT and CPMT authority, local decision-making and limits CSA's ability to provide proactive, preventative care. Although it might be financially beneficial to private providers, because they would not be limited to Medicaid rates for the services provided in place of Intensive In-Home, Therapeutic Day Treatment and Mental Health Support, we do not believe this policy is in the best interests of families and children, nor localities or the State.

The proposed policy change is based on the erroneous assumption that if a client does not meet the DMAS definition of medical necessity, then providing the service is inappropriate and the client could be better served by a lower, less costly level of care. That is false because there are many other legitimate reasons a clinical service would be appropriate even if the child does not meet medical necessity as defined by DMAS; for instance, when a family needs assistance in meeting the child's needs, such as in instances of neglect or abuse. Social Services uses intensive in-home services to stabilize families and maintain children in families where potential child abuse is present. The DMAS standard is that the child is at-risk of removal due to the child's behavioral or emotional problems, which may not be the case. Instead children may be at-risk for removal due to the parents' behavioral or emotional issues.

Removing these tools will likely result in the increased incidence of children being removed from homes to preserve the children's safety. Clinically skilled practitioners are needed in these situations. A less clinically focused service will not yield the desired results. A clinical assessment is critical to understanding the depth and breadth of the problem and determining an appropriate treatment approach.

Managed care approaches are aimed at defining when an insurance company will pay for a certain type of service or procedure. It is a medical model based upon the symptoms of the patient. It is not a proactive approach, it does not take into consideration the circumstances of a child living within a family and the needs of the family to support the success of that child, nor should it. It is designed for the meeting the purposes of that system. So, it is no more appropriate to apply the standards of CSA to a managed care company than it is to apply the standards of a managed care company to CSA.

Currently FAPT teams are charged with determining the best services for a child and their family and in doing so can prevent further damage to the child and preserve their placement within the family. Adopting a managed care mindset and applying it to the CSA process eliminates this proactive approach because managed care is inherently

reactive. The client must display symptoms that meet the DMAS criteria for medical necessity. FAPT teams and CPMTs have a very different purpose and process and can act proactively to prevent costly out-of-home placements and safely preserve children in their own families. Disempowering FAPTs and CPMTs would result in making it even more difficult for them to act proactively and increase expense and utilization of higher levels of care.

The following is a list of the concerns VCOPPA has about this policy:

1. This policy is based on a false assumption – that if a child does not meet the DMAS definition of medical necessity, behavioral health services are not appropriate to be provided and the child’s needs could be met by a less expensive, non-clinical level of care.
2. The policy does not allow FAPT teams and CPMTs to act proactively to prevent out of home placements providing clinical (intensive in-home) services based upon the family's need rather than based upon the child's behavior (which is the DMAS criteria).
3. The policy does not allow FAPT teams and CPMTs to provide the level of service they determine is needed to meet the needs of the child and their family which will result in higher costs and utilization of higher levels of care.
4. If this policy is accepted, it provides a precedent and other Medicaid funded services (such as foster care and residential treatment) will soon be subsumed under the same policy.

VCOPPA’s position is that the CSA system works very well to meet the needs of children *and* families under current policies. There does not seem to be a compelling need to change the authority of FAPT teams and CPMT’s. This is a change that would have the unintended consequences of weakening FAPT team’s ability to provide services proactively to prevent placements at more costly higher levels of care and possibly cause the increased incidence of removing children from their homes to preserve their safety. What, if anything that might be gained is not worth the risk this policy change might precipitate.

Finally, it is our recommendation that the SEC follow the advice of the SLAT on this issue. After much discussion and consideration, SLAT recommended a more moderate and prudent course. This would include postponing a final decision on this matter at least until SLAT or stakeholder workgroups can more fully review the proposed policy for its full impact and make further recommendations back to the SEC. This seems a much more reasonable approach, rather than rushing through a policy that has obviously raised such serious concerns in a number of quarters. The fact that OCS issued a revised draft policy before the original public comment period had even expired raises a number of concerns, highlighting both the flaws in the original policy, while at the same time lending to the feeling that this policy is being rushed through, since the *revised* draft was circulated with little time for analysis and response before the March 14th meeting of the SEC.

Comment on the OCS Proposed Policy: Use of Pool Funds for Medicaid Eligible Services
Recommendation to the SEC from the Director of OCS March 4, 2013

David L. Williams, Ph.D. Vice President, Phillips Programs
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Private Provider

March 14, 2013

Phillips Programs is a non-profit Virginia corporation that has been providing services to children with disabilities and their families since 1967. Phillips provides day special education, therapeutic foster care, and a variety of in-home services. I had the honor, as the President of the Virginia Association of Independent Specialized Education Facilities (VAISEF), to be the private provider representative on the Coordinating Council set up by Secretary Howard Cullum and chaired by Kim McGaughey that created the original legislation for the Comprehensive Services Act. In addition I then served on the State Management Team (precursor to the SLAT) that recommended the policies and procedures for implementation of CSA.

I wrote in opposition to the proposed new policy on "Use of State Pool Funds for Medicaid Eligible Services" from the Office of Comprehensive Services date December 21, 2012. Those comments were submitted to OCS and I assume they are available to the SEC as well as the SLAT. I appreciate that the revised draft policy of March 4, 2013 now under consideration removed some services from this new policy (Therapeutic Foster Care case management and Residential Treatment) but the basic premise remains the same and directly overturns 20 years of CSA policy. Not only does this proposed policy strike at the heart of CSA it will result in the delay, disruption or prevention of previously available services for troubled and at-risk children and youth.

The intent of CSA is to create a collaborative system of services and funding that is child-centered, family-focused and community based. This proposal removes the collaborative element and places overriding authority with a single 'independent service authorization' process. It removes 'community flexibility in the use of funds' and subverts the intent of CSA to 'authorize communities to make decisions'. According to the CSA legislation, and reiterated in many OCS memos, the local FAPT is responsible for making service decisions and it is the role of the CPMT to approve funding for these services. The proposed policy directly contradicts the CSA legislation and is contrary to the intent of CSA. The essence of CSA is to have local agencies in collaboration with families, i.e. those that know the child best, make decisions that they collectively determine are in the best interests of the child and family. That a child's total needs from the point of view of all the agencies involved together with the family as a partner in the process would decide what services best met those needs. This current proposed policy carves up the child and slices out his 'behavioral health' needs from the total child, removes the community decision process and places it with a single agency, and turns the family from a cooperative partner into a protagonist pleading with the system.

In addition to being a 180-degree change of policy, in a practical sense this proposed policy would reduce access to services for children and families. The original proposed policy explicitly stated that the intent of the policy was to 'protect against the use of state funds for unnecessary high-cost community-based behavioral health services.' 'Unnecessary' by definition means that they do not meet the Medicaid requirement, even though the CSA process has determined them to be necessary. I'm not sure what the definition of 'high-cost' is. It is hard for me to believe that communities, who have some financial responsibility as well, would be approving 'high-cost', 'inappropriate' services. Even if that is the case, regulating out the ability of CSA to provide some services does not seem to me to be the appropriate solution. Clearly having to go through two doors to obtain services will delay the access to services and will reduce access to those services. Fewer children and families will be served. And these are the very services that CSA so passionately advocated for as the disincentives for residential services were being put in place.

The VICAP process itself has been less than satisfactory from the point of view of children and families. Fewer Children are being served. I understand from some comments I have read, that 50% of those denied services via the VICAP process were over turned on appeal. If we had a staff member who was wrong 50% of the time we would certainly consider some type of intervention. The proposed process will delay and deny services to children at risk and their families. I am concerned that children will be denied services that could prevent them reaching the stage of needing more intense services. I am concerned that children who become temporarily stabilized will be denied the continuation of services to prevent their deterioration. And many of the families most in need are least able to navigate the system to access the services in the first place.

Finally, in addition to concerns about the philosophical change in providing services, and in the practical negative impact of the implementation of these policies, I am also concerned that this policy will suck funds out of direct service and into the 'management' of the services. Note the sentence in the proposed policy: "State Pool Funds may be used to purchase an independent clinical assessment conducted in accordance with DMAS requirements for such assessment." Early on there was intense discussion about how CSA pool funds could be used and the decision was made that basically the 'funds should follow the child' – i.e. should be used to provide services and should not go for 'institutional' uses. These VICAP assessments cost CSA over 4 times the amount paid to the actual service provider for the required initial service assessment necessary for KePro approval for Intensive In-Home Services. At a time when the upcoming budget for CSA is being drastically reduced it is discouraging to see CSA pool funds siphoned off for 'administrative' purposes.

From the beginning CSA has sought additional funding sources for CSA, but it was always clear that if those funding sources would not pay then CSA would. I am pleased that Medicaid funds can be used to enhance CSA funds for certain prescribed services previously funded solely by CSA. But it seems inappropriate to now turn the process on its head and come back and say that if Medicaid denies payment then localities can no longer pay for these services out of CSA. It is even more egregious to now say to CSA that these services that you have used for years must now go through the (Medicaid's) approval type process even for children not Medicaid eligible. This policy is bad for children, bad for families, bad for communities, bad for Virginia and destroys the essence of CSA as a flexible community-based interagency system. The ramifications of this proposed policy are potentially far-reaching. I urge you to reject this proposed policy.