

MINUTES – February 7, 2013
STATE & LOCAL ADVISORY TEAM (SLAT)
COMPREHENSIVE SERVICES FOR AT RISK YOUTH & FAMILIES
Richmond Room
1604 Santa Rosa Road
Richmond, VA 23229

Members Present: Victor Evans, SLAT Chair, CSA Coordinators' Network; Jeannie Decker, CSA Coordinators' Network; Molly Cheek, VCOPPA; Penny Combs, VCOPPA; The Honorable Anita Filson, Virginia Council of Juvenile and Domestic Relations District Court Judges (VCJDRDCJ); Deborah Johnson, DOE; Janet Lung, DBHDS; Pam Fisher DBHDS; Therese Wolf, VDSS; Scott Reiner, DJJ; Emily McClellan, DMAS; Shawn Rozier, League of Social Services Executives; Ronald Belay, CSU Directors' Association; Mark Hinson, Parent Representative; Susan Clark, Virginia Council of Administrators of Special Education (VCASE); Chuck Walsh, Virginia Association of Community Services Boards (VACSB)

Members Absent: Karen Tompkins, VCOPPA; Joanne Boise, VDH

Guests and Staff Members Present: *Guest list attached.* Susan Clare, Annette Larkin, Janice Graham, Stacie Fisher, Stephanie Bacote, Marsha Mucha

Introductions and Chair Remarks

Victor Evans, SLAT Chair, called the meeting to order at 9:35 a.m. He noted that the agenda was very full, with several important tasks to be completed at today's meeting.

Approval of Minutes

The minutes of the December 6, 2012 meeting were approved on a motion by Shawn Rozier, seconded by Scott Reiner and carried.

Public Comment (General)

Public comment on Intensive Care Coordination (*attached*) presented by Karen Reilly-Jones on behalf of the Chesterfield/Colonial Heights CPMT.

Executive Director's Report

Susan Clare reported on the following items:

- A service development meeting was held this week in Gate City. Eighteen providers and eight local representatives participated in the meeting.
- Plans are underway for the 2nd Annual CSA Conference to be held at the Hotel Roanoke and Conference Center. This year the conference will be two full days (April 30 and May 1) with a half-day preconference session for CSA coordinators on April 29. Registration will open on Monday, February 11, 2013.
- OCS has two bills before the 2013 Session of the General Assembly. Both have passed the House and Senate.
 - 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.
- Other bills of interest in the 2013 Session of the General Assembly:
 - HB1742 – Increases the period within which a youth may request restoration of independent living services from 60 days to 180 days. This bill was left in House Appropriations but a companion bill (SB862) passed the Senate and has been referred to House Committee, HWI.
 - HB1743- Establishes that youth who were in foster care at the time of commitment to DJJ may request independent living services when discharged from juvenile justice after the age of 18. This bill has passed the House. Companion bill (SB863) has passed the Senate and has been referred to House Committee, HWI.
- The Governor’s 2013 proposed budget amendments are significantly below the CSA FY13 – FY 14 appropriation and reflect the slight continuing decline in CSA costs.
- General Assembly proposed budget amendments for 2013 include allowance of unspent CSA appropriations at the end of each fiscal year to be reinvested to address service gaps in the program based on recommendations from the SEC. Additional GF in the amount of \$91,106 would be added to the CSA budget for additional CSA costs to provide services to youth who are leaving DJJ and were previously in foster care. This would be contingent upon the final passage of SB863.
- The Virginia Wraparound Center of Excellence will open February 11, 2013. The Center will oversee training and other activities related to the Systems of Care philosophy and the High Fidelity Wraparound model.
- Upcoming CSA stakeholder training events include: New VDSS Director’s Learning Academy, Judicial Conference for Juvenile and Domestic Relations District Court Judges and the Northern Virginia CPMT Symposium.

OCS Program Auditor, Stephanie Bacote, reported the following:

- Five on-site audit reviews have taken place. A summary of audit observations is available on the CSA website.
- “Self-audits” have been received from those localities with a due date of January 31, 2013 and notices have been sent to localities with “self-audits” due March 31, 2013 and June 30, 2013. Since issuance of the notices, 21 requests for assistance have been received and responded to. Validation of the reported self-assessment results will begin this month.
- As part of the OCS continuous quality improvement process, a client feedback survey is given to the CPMT chair at the conclusion of an audit.
- The Office of the State Inspector General is proposing a directive to establish a dual reporting relationship with internal audit functions in the State. This structure promotes greater oversight and independence of internal auditors.
- Audit sessions at the CSA Conference will be used as an opportunity to talk about internal controls and coordinated and strategic planning for localities.

OCS IT Manager, Preetha Agrawal, reported the following:

- OCS has completed the IT migration to a new server. Data has been converted from an Access database to an SQL Server Microsoft relational database.
- These changes have corrected prior access issues to web applications. OCS is moving towards making the statistical reports section of the OCS website more dynamic.

- OCS is working with Thomas Brothers and Harmony to provide those localities that use their software the ability to upload data for data integration and analysis.

Review of Proposed Policy: Use of State Pool Funds for Medicaid Eligible Services

Victor Evans reported that, at the SEC's December 20, 2012 meeting, the SEC recommended disseminating the proposed policy for a 60-day public comment period. The SEC also asked SLAT to review the proposed policy and to provide feedback to the SEC at its March 14, 2013 meeting.

Susan Clare noted that two documents (*Proposed Policy FAQ's* and *Chart of Selected Medicaid Behavioral Health Services from DMAS*) have been distributed that provide additional information and clarification regarding the intent of the proposed policy. She noted that, during the public comment period, recommendations are invited regarding how the proposed policy could be revised to improve clarity of intent, how flexibility to address specific areas of concern might be built into implementation, and specific training that might be necessary to ensure implementation in a manner that is in keeping with the mission and vision of CSA.

The SEC will review the public comments at their March 14, 2013 meeting.

Public Comment: Proposed Policy: Use of State Pool Funds for Medicaid Eligible Services

Steve Jurentkuff - Specialized Youth Services of Virginia, Inc. (Vice President and Government Affairs Chair, VCOPPA)

- VCOPPA opposes the proposed policy.
- The proposed policy states that the policy is needed to “ensure that clinical need/medical necessity criteria to access behavioral health services are equitable for all youth, i.e., those who are Medicaid eligible and those who are not.” What if the youth has private insurance or is uninsured?
- Equitability already exists under the Comprehensive Services Act.
- The CSA assessment is not clinically-based; those kinds of assessments should be left to insurance companies.
- Propose establishing a workgroup to further review the proposed policy.

Abigail Schreiner – Extra Special Parents

Written comments attached.

Kathy Ralston – VLSSE

- The proposed policy is not in alignment with the intent of CSA.
- CSA does not fit into a medical model.
- How does the proposed policy address federal standards of addressing all the needs of a child? What about court ordered services?
- Licensed mental health professionals are not always available to FAPTs.

Karen Reilly-Jones on behalf of the Chesterfield/Colonial Heights CPMT

Written comments attached.

Ray Ratke – Lutheran Family Services of Virginia

- The proposed policy strikes at the heart of CSA, its flexibility and team-based approach to providing services.

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- The proposed policy does not improve access to services.
- Medicaid's standard sets the bar very high to be eligible for services.

Stephan Stark – National Counseling Group

- The FAQ sheet on the proposed policy was helpful.
- The intention and spirit of CSA allows for best practices.
- Localities understand the needs of their children and families.
- Localities understand the deficits in their own areas and must do what is practicable and look at their options for providing services. The proposed policy detracts from this understanding and renders localities impotent.
- Localities are somewhat paranoid due to their need to understand the audit process and this proposed policy adds to their paranoia.

Betsy Clark – Hampton CSA Office

- Hampton has long been creative and flexible in service planning and also good stewards of the funding it receives. This has been in place long before the VICAP process in Medicaid.
- The proposed policy would undermine FAPTs. FAPTs are familiar with the children and families in the communities they serve.
- The proposed policy will continue to place barriers in place and delay in providing services.

Jim Gillespie - Fairfax – Falls Church CSA Office

Written comments attached.

Victor Evans on behalf of the CSA Coordinators' Network

Written comments attached.

SLAT Member Discussion and Decision on Recommendation to Forward to SEC

There was considerable discussion among SLAT members. It was again noted that the proposed policy is not intended to restrict access to non-behavioral health services but to ensure that access to behavioral health services is equitable and to ensure that state funds are not used to purchase behavioral health services that are not clinically/medically indicated for youth where such criteria have been established.

A number of SLAT members expressed concerns about the potential impact to services and the need for more data on current locality practices regarding use of state pool funds for youth when Medicaid has denied funding for behavioral health care services. After further discussion, a motion was made by Shawn Rozier, seconded by Ronald Belay and carried (*two opposed*) as follows:

SLAT recommends that the SEC not approve the proposed policy as written. SLAT recommends 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.

SEC Goals and Strategies

Goal 1, Strategy 1

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Policies that govern use of funds (CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative)

Mr. Evans reported that Joanne Boise was not able to attend today's meeting and, therefore, the review of the Virginia Department of Health's program would be deferred.

Goal 1, Strategy 5

Inadvertent fiscal incentives (Medicaid match, family-of-one eligibility, education costs, adoption subsidy)

Mr. Evans asked if any of the members had examples to share. Two examples were provided:

- Decline in the reimbursement rates to foster parents when a child's VEMAT assessment indicates improvement.
- Parental residential placements versus the FAPT process and residential placements made through CSA parental agreements.

SLAT Training Committee Report

Shawn Rozier provided a written report to SLAT. He reported that the Training Committee has met twice and identified priority items to review in consideration of their charge:

- Develop a work plan for assessment of training needs by stakeholder group
- Develop a work plan for promotion of training opportunities
- Develop a work plan for review of training outcomes and feedback
- Review the OCS training plan

In order to address the first item, the Training Committee has developed a recommended training needs assessment that SLAT members can complete and return to Mr. Rozier by March 8, 2013. The assessment is to be completed from the perspective of the stakeholder group they represent on SLAT.

The Training Committee will meet on March 15, 2013 to review the training assessments from the SLAT members and provide SLAT and OCS with a report of trends and recommendations identified by the assessments in time for the SLAT's April 4, 2013 meeting. The assessment and a copy of the FY12 -13 CSA Training Plan will be emailed to SLAT members.

Nominating Committee

Mr. Evans reported that, per the SLAT bylaws, it was time to appoint a Nominating Committee to recommend a chair and vice-chair for the upcoming year (*July 1, 2013 – June 30, 2014*). He appointed the following SLAT members to serve as the Nominating Committee: Karen Tompkins, Mark Hinson, Janet Lung, and Susan Clark.

Agency Member Updates

Mr. Evans reported that the terms to SLAT for parents, judges, local DSS and school representatives would expire on June 30, 2013. He asked those representatives to begin reviewing the appointment process for the groups they represent so that timely appointments can be made to SLAT.

Judge Filson reported that a Judicial Conference for Juvenile and Domestic Relations District Court Judges would be held in Charlottesville, April 23 and 24, 2013.

Mr. Rozier thanked OCS and VDSS staff for their legislative work on the independent living definitions and clarification of eligibility for independent living services.

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Molly Cheek noted that she was happy to be a new member of SLAT and part of the group.

Adjourn

There being no further business, the meeting adjourned at 12:00 p.m.

February 7, 2013

GUEST State and Local Advisory Team (SLAT) Sign-in Sheet

Name	Organization	Email Address
Lillie M. Jones	Danville CSA Office	lillie.jones@dss.virginia.gov
SHARON A. MINTER	CSA - Manassas City	sminter@manassasva.gov
Greg Fisher	UMES	gfisher@umes.org
Pam Fisher	DBHDS	pamela.fisher@dbhds.virginia.gov
KYLE MCMAHON	INTERCEPT	kcmahon@INTERCEPTYOUTH.com
Dave Byers	Children's Services VA	davebyers@Crossroads
Abigail Schreiner	Extra Special Parents	aschreiner@esparents.org
Stephan Stark	NCG	stephan.stark@nationalcounselinggroup.com
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Ray Ratke	LFSCVA	
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Eric Reynolds	OAG	ercynlds@oag.state.va.us
Jim Gillespie	Fairfax CSA	

Although this policy attempts to establish quality services and the opportunity to utilize community based services such as Intensive Care Coordination, the proposed policy “*Intensive Care Coordination*” should not be approved in the current draft.

Proposed Policy “Sections A: Definition of Intensive Core Coordination” and “Section B: Population to be Services by Intensive Care Coordination” are acceptable and supportive of localities’ approach to child-centered, family -focused, and community based services planning. However, Sections C and D should be altered based on the issues and concerns identified below:

Proposed Policy:

“Section C: Providers of Intensive Care Coordination”

“Providers of ICC *shall* meet the following staffing requirements:”

1. “Employ at least one supervisor/management staff who has completed training in the national model...”
2. “Employ at least one staff member who has completed training in the national model...”

“Providers of ICC shall ensure supervision of all ICC coordinators to include clinical supervision at least one per week...”

The concerns with these requirements are related to accessibility and availability of providers of ICC. Providers of this service may be from public CSBs or through the private provider network. It is concerning by adding specific service delivery expectations may cause providers to opt out of offering this service and therefore creating barriers to services for children and families. Many localities currently face the challenge of available providers to meet their service needs to begin with, by passing this policy may cause providers fewer incentives to reach out to underserved areas.

Recommendations:

1. Request an impact statement with current ICC providers (public and private) to fully understand breath of implications in the passing of this policy.
 - Accessibility to services- is it cost effective for providers?
 - Identify responsible party to oversee requirements (Same or different for public/private providers?)
2. Review (and make available for other stakeholders) “High Fidelity Wraparound” training and time requirements prior to approval for a full comprehension of training expectations.

“Section D: Training for Intensive Care Coordination”

Recommendation:

Add “private provider network” in the coordination and consultation for training.



Extra Special Parents Response to

OSC Proposed Policy: Use of State Pool Funds for Medicaid Eligible Services

Good morning, my name is Abigail Schreiner and I represent Extra Special Parents, also known as ESP. ESP is a privately-owned treatment foster care agency with three offices operating throughout the Commonwealth of Virginia. ESP is opposed to the proposed policy regarding “the Use of State Pool Funds for Medicaid Eligible Services.” If this policy is implemented, it will be harmful to children as it will influence the level and quality of service delivery.

Decrease in Quality of Services.

The purpose of this policy is to ensure equitable access to services for all youth, but it has the potential to do just the opposite. This policy will limit the services available to a wide range of youth who are denied case management funding through Medicaid and currently receive CSA support. In order for Medicaid to approve case management funding, the child must have high scores on the child behavioral/emotional needs and child risk behaviors portions of the CANS as well as an Axis I diagnosis on the DSM IV. These subjective criteria do not take into account all the needs associated with Treatment Foster Care.

In our agency’s experience, children under five years old are usually denied Medicaid-funded case management because they are typically not old enough to have an Axis I diagnosis and the CANS tool used for children under five does not address the criteria used by Medicaid.

Furthermore, Medicaid decision making criteria does not take into account the needs of medically fragile children. In our agency, we had a child who had a rare genetic disorder called Sansfilipo syndrome. This child could not walk, talk, or eat on his own. He could not communicate his needs. He could not dress himself or use the bathroom. Although the child was denied TFC case management funded through Medicaid, with the help of community resources, including TFC case management funded by CSA, this child’s foster parents were able to meet all his physical and medical needs and provide him a stable and loving home.

Under this policy, funding denials would put agencies in an ethical bind because they must either continue to provide services that are not funded, re-name those services in order to receive CSA reimbursement, or fail to provide needed services to vulnerable children.

Currently, the local FAPT and CPMT are responsible for the funding decision when case management funding is denied by Medicaid. The requirement of a clinical assessment by a



licensed mental health professional in order to qualify for CSA funding disempowers the entire CSA and undermines the multidisciplinary approach of FAPT.

Children May Be Prematurely Stepped Down.

Another detrimental consequence of this policy is that children who are denied TFC case management funding through Medicaid will then be deemed non-therapeutic by the CSA. When a child with therapeutic needs first enters care, he or she may not have an Axis I diagnosis and it may take more than 14 days for a mental health provider to determine the diagnosis. Without funding from the CSA, localities may be forced to classify all of these children as non-treatment foster care. Therefore, the children will not get the services they need in order to meet their treatment goals and establish permanency. If this policy is implemented it must clearly state that children will not be stepped down to a lower level of care based on Medicaid's subjective criteria. By moving to a Medicaid model for CSA, we are undermining the intent of the Comprehensive Services Act.

As a private child-placing agency that strives to put the needs of children first, and as a member organization of the FFTA, VALCPA and VCOPPA, Extra Special Parents opposes the proposed policy.

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The proposed policy “*Use of State Pool Funds for Medicaid Eligible Services*” does not align with the Comprehensive Services Act (CSA)’s intent and purpose. Actually, the proposed policy contradicts many fundamental aspects of the Act itself and self proclaimed purpose to “reduce the use of state pool funds” is built on assumptions and misrepresentations of current local practices.

The State and Local Advisory Team/ State Executive Council should carefully examine the “Statement of Need” based on misleading statements and generalizations rather than facts.

Examining the Statement of Need:

- “It is *common local practice* to utilize CSA funds to purchase clinical behavioral health services for youth who do not meet the clinical need/medical necessity requirements established for the use of Medicaid funding.”
 - Can “common local practice” be defined?
 - Where is the data to support this statement?
 - Given much progress with CSA, What is the real issue?
 - 13% decrease in total CSA expenditures since 2008
 - 25.55% less children in foster care
 - 14% increase in children in permanency placements
 - 42.14 % less children in congregate care
- “Guidance *circumvents the intent and purpose of the VICAP...*to ensure that behavioral health services are appropriately matched to the clinical needs of youth...”

CSA and Medicaid have different approach and purpose to services. CSA is a separate and independent program from Medicaid and should not be expected to perform similar assessments to access services.

- VICAP is an independent assessment for Medicaid billable services based on clinical needs.
- To access CSA funds, localities evaluate and assess the needs and strengths of youth and families through:
 - Established State and Local CSA policies and procedures
 - CSA eligibility criteria
 - Family and child centered approach
 - Best practices
 - Family Assessment and Planning Team
 - Local procedures to ensure accessibility
 - Established Duties and Responsibilities (COV § 2.2-5206)
 - Community partnerships
 - Child and Adolescence Needs and Strengths (CANS)assessment

- “Such differing requirements for access to services *could be* considered discriminatory against Medicaid eligible youth...”

There is an assumption that children in need of services are not allowed access to services.

- What information can be provided to support this statement?
- If equity is an issue, is there overflow impact on other systems? (i.e. Corrections, foster care, state psychiatric hospitals, etc.)

Examining the Proposed Policy:

“...For non-Medicaid eligible youth, the FAPT shall document the youth’s clinical need/medical necessity for any type of Medicaid Service and such documentation shall include the signature of a licensed mental health professional.”

Let’s start by remembering the Core Intent of CSA is “to create a collaborative system of services and funding that is *child centered, family-focused, and community based* when addressing the needs and strengths of troubled and at-risk youths and their families in the Commonwealth.” COV § 2.2-5200.

The purpose of the CSA is to be a locally directed program in order to best meet the unique needs of the community through invented leadership and child and family individualized service planning.

This policy would require a change in fundamental purpose of the Family Assessment and Planning Team (FAPT) process and against the Code of Virginia in regards to

- 1) Membership (COV § 2.2-5207), and
- 2) Duties and Responsibilities of the FAPT (COV § 2.2-5206).

FAPT Membership

Currently, FAPT membership is selected from community agencies “who have the authority to access services within their respective agencies.” The proposal would require a clinical licensed professional available for review and service authorization. Issues to acknowledge regarding this proposal include:

- Current FAPT membership does not require a “license mental health professional” Is this policy proposing to change the Code of Virginia as well?
- Proposed policy is not clear on the role of the “license mental health professional”
 - Voting FAPT member?
 - Override FAPT consensus?
 - Potential conflict of interests?
- Not all localities have access to a “license mental health professional” to fill this proposed expectation.

- Potential liability issues for the “licensed mental health professional” if there are recourse/appeals/audit findings to the decision?
- Creates another barrier to services for children and families.

FAPT Duties and Responsibilities

This policy proposal requires that the local FAPT conduct “Medicaid” assessments prior to authorizing clinical/ behaviors services. First and foremost, the FAPT is not intended for clinical assessment, per Code of Virginia, and should not be expected to function as so. This proposed policy:

- Neglects current CSA state and local policies, procedures, and practices to ensure assessment, evaluation, and oversight that have yielded successful outcomes statewide.
- Creates barriers that goes against the Intent of CSA to :
 - “Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families”
 - “Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes” COV § 2.2-5200.

Case Examples:

1. Thirteen year old boy placed in a residential treatment center to address sexually acting out on his 5 year old brother in the home. Older child is before the court for the sexual offences, however community determined a therapeutic placement was more appropriate than being ordered into corrections due to many factors: his age, potential for therapeutic progress, highly engaged family willing and eager to work on reunification, and past emotional/behavior issues.

Four months into placement, Medicaid denies funding due to child no longer meeting medical criteria. However, the community and treatment team determine that he needs to continue treatment to reduce sexual acting out behaviors and risks of re-offending. FAPT authorized continue placement utilizing CSA funds.

Options with proposed policy:

- a. Child removed from placement prior to completion and returned home
- b. Child placed into a lower lever group home (if medically necessary)- disrupting services, adding another placement that heighten risks factors
- c. Child could be ordered into foster care to prevent return home
- d. Locality pay for continued stay if possible @ \$4,000 a month (incl. education costs)

2. Sibling group of four enter into foster care for abuse and neglect. The Department of Social Services did not have available home for the sibling group, plus the oldest child demonstrated a need for a higher level of care. The FAPT supported DSS in placing all children with a Therapeutic foster care agency. The oldest child is the only one determines in meeting the need for Medicaid funded case management. The other three are placed on the lowest level with the TFC agency, but also billed for case management @ \$326.50 per month.

Children adjusted well to TFC home, and soon the DSS foster care goal of adoption was approved. However, the process of termination of parent rights (TPR) was prolonged with appeals and court continuances. The children remained in the home for 20 months prior to moving to permanency. The oldest child improved significantly and Medicaid denied funding a year into the placement. The FAPT supported the need for the siblings to be together and the stabilized placement with the TFC home.

Options with proposed policy

- a. Place children in different homes
- b. Move children into different home(s) once Medicaid denied
- c. Locality could attempt to negotiate with TFC provider to lower rates
- d. Pay with local funds to support placement (case management services (reflects a small portion of TFC fees) for all three for the entire stay is \$25,467)

Recommendations:

- Do not support this policy as proposed.
- Gather, study, and evaluate data and facts relating to statements made in “Statement of Need.”
- Review the minutes reflecting conversations on this matter that occurred last year at the February 2012 SLAT meeting; and
- Validate and support localities on successes through partnering rather than additional state mandates and policies with negative impacts on services for children and families.



County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

February 7, 2013

Comments to the State and Local Policy Team on the Proposed Policy on Use of State Pool Funds for Medicaid Eligible Services

By: Jim Gillespie, Fairfax-Falls Church CSA Manager

- A. The proposed policy should clearly state that is not applicable to IEP-required private special education services.
- B. Has the proposed policy been reviewed by VDSS for compliance with the CFSR and other state and federal child welfare requirements? It is unclear, for example, whether denying case management services to a youth in TFC compromises achievement of CFSR goals.
- C. Requiring a clinical review by a licensed mental health professional is an unfunded state mandate that goes beyond the legal requirement for CSB participation on the Family Assessment and Planning Team. It should be funded by the state just as the VICAP is.
- D. Treatment Foster Care Case Management (TFC): Unlike other Medicaid covered services Medicaid-covered case management in TFC is not specifically a "clinical" service, and children without serious behavioral health issues in TFC may need it too. As a matter of fact, to the extent TFC providers actually provide active case management the \$326 monthly rate is a bargain. It doesn't typically make sense for localities to tell providers not to provide case management for children who don't meet the Medicaid clinical need criteria.
- E. Residential Services:
 1. Is the requirement that FAPT documentation of the youth's clinical need/medical necessity include the signature of a licensed mental health professional in addition to the Medicaid-required Certificate of Need?
 2. In our experience about half of Kepro residential denials are overturned on appeal, and that the appeal process can take 3-4 months. Given the high rate of appeals being overturned it doesn't make sense to discharge youth whom the FAPT believes still need treatment. While the appeal process is pending could the FAPT convene and re-determine clinical need/medical necessity, as stated in the new policy?

Fairfax County is committed to nondiscrimination on the basis of disability in all county programs, services and activities. Reasonable accommodations will be provided upon request. For information, call the CSA Program at 703-324-7938 or TTY 711.

Fairfax-Falls Church Comprehensive Services Act for At Risk Children, Youth and Families
12011 Government Center Parkway, 5th floor
Fairfax, Virginia 22035
Ph: 703-324-7938, FAX: 703-324-7929; TTY 711
www.fairfaxcounty.gov

Re: Proposed Policy: Use of State Pool Funds for Medicaid Eligible Services

Subj: Feedback from a Survey of CSA Coordinators

CSA Coordinators were asked to provide responses to specific sections of the proposed policy in order to assess the extent of agree or disagree with statements presented. Attached is a copy of the survey questions and the responses received.

There was widespread disagreement with the statements presented to justify the need for and approval of the proposed policy, as follows:

1. In the section titled “**Statement of Need**”, the following statements were seen as mischaracterizations:
 - a. Existing guidance from OCS provides FAPTs and CPMTs the ability to “circumvent the intent and purpose of the VICAP, i.e., to ensure that behavioral health services are appropriately matched to the clinical needs of youth and to protect against the use of state funds for unnecessary high-cost community-based behavioral health services.”
 - i. All respondents disagreed with that statement.
 - ii. This statement is an inaccurate indication of how FAPTs and CPMTs fulfill their responsibilities.
 - iii. One of the responses that represented everyone’s concerns was: “As the DBHDS continues to narrow the scope of what IHH svcs can provide, it has become increasingly evident to FAPTs that there are many times where the level of clinical need for the child & family require a level of care in the home that can only be described as intensive. FAPT looks at the entire scope of needs and may recommend IHH svcs based on what is presented. Our community does NOT circumvent the process because we may recommend that intensive home-based svcs be implemented, as the focus may be vastly different from the narrow scope of the IHH service provided under Medicaid. The intent and purpose of VICAP is to look at the clinical needs of the child, while the intent and purpose of FAPT is to look at the overall needs of the child & family. While that may include clinical needs, FAPTs may see the value in utilizing an intensive home based service to address more than just the child’s behavioral and mental health needs.”
 - b. Current practice consists of “Such differing requirements for access to services could be considered discriminatory against Medicaid eligible youth who must meet specific clinical/medical criteria to gain access to services when their non-Medicaid eligible counterparts do not for the same services.”
 - i. All respondents disagreed with that statement.
 - ii. Describing the work done by FAPTs and CPMTs to develop IFSP as truly individual service plans that account for each families’ unique circumstances as “discriminatory” misrepresents how CSA works at the local level to properly use available resources.
 - iii. One of the responses that represented everyone’s concerns was: “You are comparing a specific Medicaid service with an individualized plan of services for a youth and family that are being assessed by FAPT. I don't believe the two should be compared. While Medicaid uses a medical approach, the FAPT utilizes a holistic approach to ensure the best interests of children are fulfilled.”
2. In the section titled “**Statement of Need**”, the following statement was presented without rationale to inform the reader why this occurs – “While local practices vary across the state, it is common for local CSA teams to utilize CSA funding to initiate and/or continue Treatment Foster Care Case Management and Level A, B, and C Residential services when such services are denied through the Medicaid authorization process.” Here are some of the many reasons why localities took this action:
 - a. Child in TFC for a year, behaviors improve, adoption process not yet completed, and Medicaid denies.
 - b. Local DSS workers are required to minimize placement changes. If a child is in a TFC placement that is considered a pre-adoptive placement or removing the child could be detrimental, how can Medicaid’s denial of case management be allowed to make the decision about a step down?

- c. Clients in DSS custody – especially the older more seriously mentally ill or delinquent – are difficult to place in normal foster homes as a step-down when Medicaid stops. Until a new placement is secured, they remain in a facility after denial of Medicaid funds. The allowance of 14 days to react to a denial of Medicaid funds is unrealistic.
 - d. Placing siblings together in the same TFC home when only one sibling meets criteria and others do not.
 - e. Child needs RTC or TFC due to behavioral (not psychiatric needs) such as sexual reactive behaviors and substance abusers.
3. The final paragraph in this section that starts with “In summary, policy is needed to:” is not supported and is seen as antithetical to the intent and purpose of CSA, as follows:
- a. Contrary to the claim to “ensure that clinical need/medical necessity criteria to access behavioral health services are equitable for all youth, i.e., those who are Medicaid eligible and those who are not”, this policy will create an inequitable process of applying Medicaid criteria to clients with no Medicaid privileges.
 - b. Rather than “ensure that state funds are not used to purchase behavioral health services that are not clinically/medically indicated for youth”, this policy will unfairly deny at-risk youth and families the services needed to provide child-centered, family-focused, community-based, and least restrictive services based on a comprehensive assessment of each client.
4. In the section titled “**Projected Impact of the Proposed Policy**”, the following statement was presented as justification to approve the proposed policy: “There is an endless host of services, limited only by community and provider creativity, which are not Medicaid services and would not be impacted by adoption of the proposed policy.”
- a. All respondents disagreed with that statement.
 - b. Such a claim misrepresented the realities faced by localities’ abilities to serve their at-risk youth populations.
 - c. One of the responses that represented everyone’s concerns was: “The proposed policy will have a very significant impact. It is likely to have a profound impact on some of the youth we serve. Only in an ideal world does boundless creativity replace the need for adequate resources. The resources that are too often lacking are community-based providers who are flexible, foster parents who are sufficiently resilient and capable in caring for troubled kids, judges who are open-minded, and public schools that are tolerant and accommodating to children of differing needs. In some smaller localities, there are simply too few providers, and the risk of operating under a private business or non-profit model (i.e., to avoid losing money) is too great.”

CONCLUSION: Since the intent and purpose of CSA is to comprehensively serve a locality’s at-risk youth population, many felt it would be ill advised to emphasize the use of a Medicaid medical model to have undue influence over service planning decisions. Therefore, the recommendation to reject this proposed policy is widespread.